# 3

# Psychological and psychiatric aspects of recounting traumatic events by asylum seekers

EVERT BLOEMEN, ERICK VLOEBERGHS, CELINE SMITS

Evert Bloemen is a physician, specialised in the mental health of refugees and asylum seekers. He treats refugees and asylum seekers in an outpatient mental institute. He works as trainer and advisor within Pharos, centre of knowledge on refugees and health and is among others engaged in writing about the medical aspects of the Dutch asylum procedure.
Erick Vloeberghs is a medical anthropologist. He has worked with refugees as a therapist and has done research among refugees and asylum seekers within Europe (NL) and abroad. He is currently leading the international affaires within Pharos, centre of knowledge on refugees and health.
Celine Smits is a psychology student at Utrecht University.

## 1 INTRODUCTION

Many asylum seekers have experienced serious traumatic events in the past, such as torture and other humiliating and inhuman atrocities. The asylum procedure concerns the evaluation of these experiences. In an interview with the asylum authorities, the asylum seeker must recount what has happened to him and what the reason for his flight has been. This interview is of vital importance for the appraisal of the asylum application. In order to be able to tell about their past, asylum seekers must rely on their autobiographical memory. However, the biological, socio-cultural and psychological processes which coincide with traumatization can obstruct the storing of traumatic events and the 'consultation' of the autobiographical memory.

Asylum seekers are commonly reluctant to tell their story of stressful and traumatic experiences. They make every effort to forget them. Often, they do not share even with family members or friends the fact that they have been beaten, raped, and subjected to electrical shock, mock executions and other terrorizing events. Talking means reviving memories and reliving the terror and anguish. They often believe that other people will not understand or believe their stories. For all these reasons they try to bury these experiences of the past.

On the basis of the scientific body-of-knowledge concerning traumatization in general there are doubts whether a traumatised asylum seeker has the capacity to tell, in the short time availabe in the asylum procedure, the full story concerning the events which have led to the flight.

This article focuses on two questions: which psychological and psychiatric factors can obstruct asylum seekers remembering their traumatic memories and speak about these experiences within the context of the asylum application, and what exactly is the impact of those factors on the quality of the statement of asylum seekers? The objectives are twofold: to relate this growing knowledge about trauma and memory to the situation of asylum seekers and to promote the use of this learning in the asylum procedure. This knowledge corresponds with the guidelines of the Istanbul Protocol. Within these guidelines it is established that medical, psychological and psychiatric examination can be of great value for the assessment of an asylum claim.

In order to answer these questions, this article starts with a description of the impact of traumatic experiences on (mental) health and ends with a discussion on important factors which have a negative influence on remembering and verbally representating of traumatic memories. The article successively reviews the (working of) the memory system for normal and traumatic memories, and the impact of shame and silence, distrust, concentration and physical complaints on the ability of asylum seekers to give information about their background.

## 2 CONSEQUENCES OF A TRAUMATIC EXPERIENCE

In order to understand the problems which asylum seekers can have with giving an account of their often painful and intrusive experiences, it is important to have some knowledge about the impact and consequences of traumatic experiences. When examining intrusive life events it is important to distinguish between a traumatic event and a traumatic experience. The first is an objective fact, the second is an individual perception of the event. The experience can be coloured by strong emotions, as well as by weak memories. Because of this, the experienced event, the fact, *becomes* a subjective interpretation of the event. The way in which someone has experienced the facts are of vital importance for the memorizing and reconstruction of the event and other factors that are in play in traumatization.

Traumatization is to be considered as the total of emotional and physical processes and expressions which take place during the traumatic experience and for a long time afterwards. This can result in a regular processing of the event or a stagnated one, and all gradations in between.[1] Exactly these very much individually coloured emotional and physical processes give cause to the fact that the traumatic event itself is not always that clear to picture when someone must speak about it. Within the asylum procedure it is the asylum seeker who often gets blamed for this, whereas from the perspective of health and traumatization the process of remembering can be explained.

### 2.1 THE REACTION AND PROCESSING OF TRAUMATIC EVENTS

A stressful experience goes accompanied by a number of characteristic responses, which can differ strongly from individual to individual. These responses have neurobiological, physical as well as psychological components.

The neurobiological response to a threatening experience has to do with the alarm system of the body, also called the 'fight, flight & freeze' system. This system is activated by feelings of threat and enables the body to undertake action. The interrelated feedback system of neurotransmitters and hormones such as adrenalin, cortisol, serotonine and catecholaminen – produced by the hypothalamus, hypofyse and the adrenals – stands at the basis of this 'fight, flight & freeze' system. Adrenalin brings the body in a state of emergency. One of the functions of cortisol is that it prepares the body to the impact of stress. While catecholamine prepares the body for action, serotonine ensures the regularisation of the situation and the response afterwards. After a threatful situation, usually the body repairs and regains its balance (homeostase).

When encountering a traumatic event however, a person has no control over the situation; he can do nothing to alter it. The alarm system will get dysfunctional. The system can remain dysfunctional long after the traumatic

event has taken place. Such a permanent dysfunctional situation is also called chronic stress. In cases of chronic stress we speak of overstimulation of the 'fight, flight and freeze' system. Because of the continuing production of several hormones, the body gets out of balance. This imbalance contributes to problems traumatised persons experience, such as: emotional numbing, incontrollable impulses, aggressiveness, concentration problems and memory impairments.[2]

On the physical level, during imminent danger the body is made ready to escape the threat and therefore the muscles will stretch. If this situation of vigilance continues long after the traumatic event has taken place, the body will come in a state of alarm at the slightest cue. In fact the same physical and mental mechanisms are activated as at the time of the traumatic event itself. This chronic vigilance can lead to all kinds of physical impairments such as overstretched and painful muscles, (irregular) heartbeats, feelings of suffocation, nausea and trembling.[3]

When considering the psychological responses after a traumatic experience, we have to bear in mind that the event is felt as an acute disintegration of life. It goes accompanied by feelings of intense powerlessness, anxiety and helplessness. In the perception of the individual it is no longer possible to take action and escape the situation. In a very threatening situation, the consciousness narrows itself to solely having attention for the direct danger and how to escape it. Attempts are made to shut out feelings which do not contribute to the rescue, such as pain and fear. This happens to enable the person to react instantly towards the threat. When confronted with a traumatic experience this mechanism becomes maladjusted and cannot function effectively.[4] The distortion leads to psychological impairments such as intrusions of the traumatic experience (nightmares, flashbacks) and the avoiding of situations which resemble the traumatic event. This avoiding can go up to the point that each contact is readily experienced as threatening.

The first phase of the traumatic experience is centered around fear, anger and pain. This can go paired with denial and isolation, and feelings of numbness, awe and shock. In case of severe traumatization these symptoms can last a long time. Psychiatric disorders can develop eventually.

In the normal course after a traumatic experience, the phase of intrusions and avoidance is easily released. This is to be considered a healthy way, as it allows the recovery of the memory inch by inch. That is, together with the emotional cargo and interpretation and the giving of meaning to what has happened. At this stage a traumatised individual oscillates from a strong and intruding memory of the event or flashback to moments of numbness and silence. After due time and with help and social support, a traumatised individual gets more control over its situation, emotions and memory. Then real mourning takes place for what has been dealt with. The experience can slowly find its place in one's life history, and feelings of solidarity with others are

repaired. Biochemically, the proportions and levels between hormones and neurotransmitters repair themselves and the body will recapture its balance.

Scientific literature shows few good descriptions of what it exactly is 'to process' traumatic events. It is clear that processing is a dynamic procedure in which someone's functioning is not impeded by memories or behavioral patterns that can be traced back to the traumatic experiences. This means the processing has a positive outcome if a person functions well socially after the traumatic experience, even though some post traumatic complaints can still remain. Research shows that the idea of processing the traumatic experience 'for once and for always' does not coincide with reality. Rather, the experience learns us that apparently processed traumatic events after a number of years can surface indiscriminately and cause problems again. This frequently happens when getting older, having less possibilities for coping (for example because of retirement, less physical ability) or after encountering mourning and loss. This illustrates that in absolute sense we perhaps never can speak of a complete processing of traumatic experiences.

A number of factors, which have great influence on the course of the reactions after a traumatic experience and therefore on the capacity to come to terms with such an experience, are briefly commented on below:[5]

- *The kind and size of the stressor*
  The kind, size and duration of the traumatic experience(s), as well as the number of experiences, stipulates the seriousness of the disintegration. A succession of traumatic events during an extended period reinforces the idea of uncontrollability and impotence, and contributes to a physical and psychological exhaustion. Foreseeability also contributes to the further course of reactions. If someone expected the event and was able to anticipate to it, the shock is frequently less large. Finally, the man-made character of traumatic experiences of many asylum seekers has its influence on the seriousness of responses afterwards. Accidents and natural disasters have another impact than traumatic events whereby people relate to each other in the form of maltreatment or torture.
- *Meaning and context*
  The giving of meaning to what happened is important for the continuation of daily life. Looking back at an experience does of course not take place in a vacuum. The cultural, social and political context in which the traumatic event occurred has a strong influence on the perceptions, feelings and meaning as well as on the value an individual gives to that experience. Traumatization within the framework of war, chaos and impunity places the experience in another context then traumatization within the familysphere. The context of a political war with resistance and solidarity frequently acts as a buffer against traumatization.[6] Asylum seekers have to deal with bereavement, they feel strange in the new country and most of the time lack social embeddedness. The asylum procedure is of pivotal importance to asylum seekers and often forms the central context of their existence, which at that moment, is focused at secu-

rity and recognition of their claim for protection (asylum). The way the reception and asylum procedure is arranged and provided for, gives meaning to their (future) existence as well as to the traumatic experiences from the past. *How* the new country relates and reacts to the asylum claim as such can contribute to a better processing and convalescence.

- *Relief and support*
  Most frequently a traumatic experience leads to a loss of resources, such as the relief and the social support of family, friends and public agencies. These are significantly important factors that influence the further course of life. If there is sufficient social support and relief after a traumatic experience, it is possible to connote the experience with a more positive meaning than if that social support was not available.[7] Taboos concerning sensitive subjects, such as sexual torment and rape, can however lead to the impossibility to discuss this type of experiences. This will reinforce feelings of loneliness and isolation. In fact the traumatization itself then becomes a social problem; by telling about it, someone would be positioned outside the community.[8]
- *Earlier traumatization*
  Earlier traumatic experiences make the reactions to a next traumatic experience stronger. Research shows that they are an important predictor for problems with the processing at a later stage, and for the development of psychiatric complaints and disorders.
- *Personal characteristics*
  Every individual has different ways of dealing with difficult situations. The term coping is important in this. Coping is defined as the use of (internal and external) resources to turn away the possible loss or to compensate the suffered loss.[9] Many coping strategies are used, such as: seeking diversion, asking for social support, physical exercise, avoidance behaviour, working hard, using drugs and isolation. For asylum seekers, their flight to Europe can be considered as a form of coping, while others preferred to remain in their own country. One coping strategy is not necessarily better than the other. What works for one, does not need to work for someone else. The circumstances as well as one's personal vulnerability and/or problems all play an important part in the use of coping strategies. This means that not every coping strategy is equally effective for each situation. Coping strategies are part and parcel of someone's character, coping is part of the individual. Certain personal competencies also play a partin handling traumatization. These are: self-confidence, social skills, optimism and effectiveness.[10] Traumatic experiences however, can damage the capacity of coping and even the individuality. This leads to frequently heard statements like: 'in former days I was active, but not anymore…' or 'since then, I don't recognize myself anymore, it feels as if I'm a completely different person…'.
- *Genetic predisposition for fear*
  According to recent research there are indications that genetic factors play a role in the reaction of people to stress and fear.[11] The interplay of genetic infor-

mation and other, above mentioned, factors lead to differences in sensitivity for fear. Panic has a genetic component as well. The genetic component should not be regarded as the sole cause of fear and panic, though its contribution to it is significant, if still not quantified.

The majority of persons who experience a traumatic event know after some time how to continue living without much restrictions. We then speak of a normal processing. There are persons who, in spite of complaints which can be traced back to a traumatic experience, continue to function well socially. Only a limited number of people who encountered a traumatic experience show reactions afterwards that indicate an incomplete or stagnated processing. In these cases, psychiatric symptoms and complaints are presented which are currently labelled as post-traumatic stress disorder (PTSD).

## 2.2 STAGNATED PROCESSING AS PSYCHIATRIC DISORDER

The stagnated processing of a traumatic experience causes a diversity of symptoms and means of expression, all of which are coloured by the socio-cultural context. The two psychiatric disorders which are worldwide considered to be an expression of processing problems, are post-traumatic stress disorder (PTSD) and depression. However, the studies on the manifestation of psychiatric disorders within a refugee-population established in Western countries, often show a large variation in the frequency and occurrence of these disorders. For PTSD the prevalence varies from 3% up to 86%, and for depression from 3% up to 80%. This variation is mostly due to differences in research methods and the size of the population. After a selection based on the reliability of the studies, the prevalence is 9% with regard to PTSD and 5% for depression. This means that refugees have ten times more chance of developing PTSD than a similar population from a Western country.[12]

The majority of traumatized persons with mental problems shows an overlapping of psychological complaints. This also applies to asylum seekers and refugees. In a number of cases the complaints are too minor or insufficient to be considered as a psychiatric impairment, while in other cases the complaint pattern is so broad that several psychiatric diagnoses could be made.[13] In practice, the disorders frequently occur combined. Beside PTSD and depression it is possible to label the impairments as part of other psychiatric disorders such as dissociative disorders, somatoform disorders, anxiety disorders, addiction problems and personality disorders. Whether each psychiatric disorder can be distinguished is point of scientific debate. At the end, the disorders might come down to the combination of phenomena and symptoms, which are characteristic for the complex process of traumatization: a mix of fear, despair, vigilance, loss of control, autonomous physical reactions to stress and fear and characteriological changes.

The 'monopoly' of the psychiatric diagnosis PTSD as the sole manifestation of traumatization follows the structure of the psychiatric classification system of the American Psychiatric Association, the Diagnostic and Statistic Manual of Mental Disorders.[14] Therapists specialised in trauma treatment however, are very critical about the oversimplification of the complexity and multidimensionality that occurs with traumatization.[15] According to them, traumatization goes along with psychological, physical and socio-cultural processes. This view coincides with the broader diagnostic model that the British psychiatrists Turner and Gorst-Unworth use to describe the impact of torture on refugees.[16] They describe four different dimensions that usually manifest themselves at the same time and that should not be described as different syndromes, but rather as distinguishable expressions or forms of the same process, which is: a multi-faceted maladjustment as consequence of traumatization. These four dimensions are: incomplete processing (similar to with PTSD), depression, physical impairments as expression of the biological maladjustment and existential questions concerning giving meaning to what has happened, and concerning personality changes. This multidimensional model makes it possible to look into all different aspects and nuances that come along with traumatization and to categorise these aspects in one and the same phenomenon.

In spite of the restrictions mentioned above, it remains useful to briefly look at the psychiatric syndromes depression, dissociative disorders, post-traumatic stress disorder (PTSD) and its precursor at the first period after a traumatic experience: the acute stress disorder (ASD).[17] All of these syndromes can influence the capability of asylum seekers to speak about their dreadful experiences in the past.

**Depression**

A depression is characterised by a combination of a burdened mood and sad feelings, the reduction of interest and pleasure, loss of appetite and weight, sleep impairments, psychomotor inhibition, tiredness, feelings of worthlessness and guilt, a reduced attention and concentration, and suicidal ideas.

**Dissociative disorders**

To dissociate literally means 'to fall apart'. It is the opposite of to associate, which means 'to unite'. Dissociation is the psychological process by which the normal functions of thoughts, emotions, identity, memory or consciousness are set apart from the rest of the personality. It is a kind of coping; an effort to escape the frightening reality, which is, in a dissociated state, no longer experienced consciously. Someone who dissociates shuts off and hears, sees nor feels any longer what is going to happen to him. Dissociation occurs regularly as a normal phenomenon and does not need to be a symptom or the expression of disorder. Known examples of dissociation are: to daydream, to be busy without being focused on it, feelings of numbness after an accident or the death of someone dear, doing things accurately without being attached to the accompanying emotions. Afterwards the emotions can come loose while the person is not able to recall what has happened and what he did.

The dissociative disorders include the following disorders:[18] amnesia (not remembering important aspects of an event), fugue (to unexpectedly travel away without remembering doing this), dissociative identity disorder (the presence of two or more distinct identities), depersonalisation (feelings of unreality and estrangement), trance (diminished responsivity to stimuli, having another identity, accounted for by higher powers), dissociative situations after brainwashing or indoctrination, silence or loss of consciousness.
Research has shown that the cause of the majority of the dissociative disorders lies in traumatic experiences.[19] It is not clear though where 'normal dissociation' passes into pathological dissociation or whether both are distinct from each other.[20] Transcultural psychiatry shows that dissociation is a common phenomenon in non-Western cultures.[21] The psychological process of dissociation contributes to the mental health problems asylum seekers face after traumatic experiences in their country of origin or during the flight.[22] Some dissociative symptoms are of importance in the psychiatric syndromes of ASD and PTSD.

**Acute stress disorder (ASD) and post-traumatic stress disorder (PTSD)**
The syndromes ASD and PTSD have been linked to traumatic experiences. The prerequisite for ASD and PTSD is that the person concerned has been exposed to a traumatic experience. This means that the event in combination with the individually coloured traumatic experience is a necessary condition in order to be labeled with one of both psychiatric diagnoses according to the classification system of the DSM. The traumatic event is in both ASD and PTSD described as an event that involved actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others, and the person's response must have involved intense fear, helplessness, or horror.
Acute stress disorder (ASD) is characterized by a combination of the following symptoms: dissociative symptoms (numbing, detachment, absence of emotions, reduction of awareness of surroundings, derealization, depersonalization, dissociative amnesia), re-experiencing of the traumatic event (images, thoughts, nightmares, flashback), distress on exposure to reminders of the traumatic event, avoidance of stimuli that arouse recollections of the traumatic event, symptoms of anxiety and increased arousal (difficulty sleeping, poor concentration, irritability, restlessness). These symptoms make functioning difficult or impossible. ASD lasts for a minimum of two days and a maximum of four weeks and occurs within four weeks after the event. The question remains to what extent the symptoms belonging to ASD should not be considered as normal responses to a traumatic event. Many traumatized persons recognise elements of the ASD in their reactions shortly after the traumatic experience without considering themselves ill.
The diagnosis of ASD is limited to the first period after a traumatic event and never holds longer than four weeks. Since most asylum seekers need more than 4 weeks time to be able to flee to Europe and apply for asylum, ASD will often not be diagnosed in asylum seekers. The syndrome is nevertheless important in the sense that it shows which disturbances and impairments are suffered in the first period after a traumatic experience. These complaints can be of influence on the memories concerning the events, which lie at the root of the flight. The acute stress disorder can develop into a post-traumatic stress disorder (PTSD) when the symptoms and complaints remain for longer than four weeks.

Post-traumatic stress disorder (PTSD) is characterized by a combination of the following symptoms: re-experiencing the traumatic event (images, thoughts, perceptions, nightmares, flashbacks, acting or feeling as if the traumatic event is current, distress at exposure symbolizing the traumatric event), numbing and avoidance of stimuli associated with the traumatic experience (avoidance of thoughts, feelings, conversations, activities, places or people, inability to recall important aspects of the event, diminished interest and activity, feeling of detachment or estragement from others, restricted range of feelings, sense of a foreshortened future), increased arousal (difficulty falling or staying asleep, irritability or outbursts of anger, difficulty concentrating, hypervigilance, exaggerated startle respons). These symptoms makes functioning difficult or impossible. The duration of the symptoms is more than one month. The PTSD is acute if the duration is less than three months, chronic if the duration is three months or more, and with delayed onset if the onset is at least six months after the traumatic event.
PTSD is a complex of interrelated complaints, which are linked at the psychological level. A stressful and painful flashback triggers an attempt to avoid all situations in which similar cues are present and which could lead to another flashback. The heightened irritability and hypervigilance incites the need for numbness and blunting in order to reach a condition in which there are as little triggers as possible.[23]

Mental health specialists on trauma suggested that the concept of PTSD captures only a limited aspect of the mental health reactions on traumatic experiences. Specially for (chronic) interpersonal traumatization – such as being hostage, prisoners of war, concentration-camp survivors, childhood physical or sexual abused and victims of organised violence and torture – the concept of PTSD is criticized as being too limited. Some authors in that case speak of complex PTSD or disorder of extreme stress not otherwise specified (DESNOS).[24] This category has another constellation of symptoms that is not captured by the PTSD. Because DESNOS is not (yet) included within de DSM classification system, it is not officially accepted as a specific diagnosis. The DESNOS includes problems with (a) regulation of affect and impulses, (b) memory and attention, (c) self-perception, (d) interpersonal relations, (e) somatization, and (f) systems of meaning.[25] The post traumatic mental health problems of asylum seekers often go beyond PTSD symptomatology and resemble DESNOS.

The above mentioned psychiatric disorders – all of which are an expression of problems in the processing of traumatic experiences – can have a negative influence on the storing and retrieving of traumatic memories. This also applies to traumatised asylum seekers who must give account of the context of their asylum application. When examining these memory obstructing factors, it is important to consider the different symptoms of these disorders. In the next part the following factors and symptoms will be discussed: memory, shame and silence, distrust, concentration, and physical problems.

## 3 MEMORY

Memory is active in the present but represents the past. This representation is extraordinary complex; it is not a simple remake but more a matter of interpretation.[26] Memories are transformed into life histories about which people want to tell. They are positioned within the socio-cultural context of their lives. They are also a consequence of complex functions of the body and particularly of the brain. Memories are in no way simple recordings of the past, but complicated reconstructions of it, molded and transformed by several factors. Remembering and forgetting continuously takes place in the memory system. Traumatization influences the rules for storing and retrieving memories.

Being able to rely on information from memory is important for asylum seekers when giving account during the asylum interview. The story the asylum seeker tells to the authorities during the asylum procedure is pivotal for the appraisal of the application. It means, in principle, the difference between the right to a residence permitand expulsion.

In this part focus is on the functioning of the memory and how traumatization can obstruct it. The majority of research in this area has been conducted in the West.

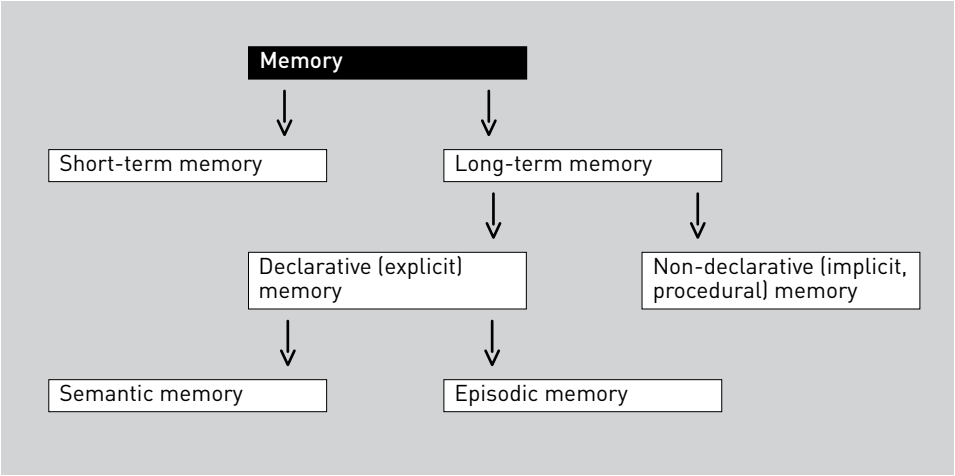
Because of the psychological processes and psychiatric disorders that are linked to traumatization, obstructions can give cause to the fact that asylum seekers are not able to recall their traumatic experiences accurately. The asylum seeker then does not succeed in making a good reconstruction of those experiences. This is scientifically understandable. Obstruction is unavoidable when we consider the psychological and medical problems coupled to traumatization. For the inability to make an adequate reconstruction of such experiences, an asylum seeker should not be blamed.

### 3.1 NORMAL FUNCTIONING OF THE AUTOBIOGRAPHICAL MEMORY

The memory of people is a complex and dynamic system that contains several components. The next diagram provides an overview.[27]

The memory consists of the short-term memory and the long-term memory.

- The short-term memory, also called working memory, is the part of the memory system where all stimuli from the senses come in. Only those items to which much attention is given, in the sense of meaning and emotions, are stored in the long term memory.
- The long-term memory is subdivided in two components: the declarative and the non-declarative memory.
  - The non-declarative memory, also called implicit or procedural memory, characterises itself by the unawareness about the knowledge stored there.




The memory of all the unconscious and automatic acts (like cycling or writing) is stored in this part of the memory system.

- The declarative memory contains those stored memories an individual can talk about. The declarative memory consists of an episodic and a semantic memory.
  - The semantic memory consists of general knowledge of the world, facts and meanings.
  - The episodic memory is the memory part where the autobiographical memory is found. Storing, remembering and recalling autobiographical memories take place in the episodic memory. These personal and unique memories are place and time bound.

Autobiographical memories can be classified according to certain aspects of human life, such as time periods (period of school, after a certain age), general social events and specific knowledge of an event.[28]

General events are frequently grouped in clusters or categories on the basis of time or resemblance. The memories concerning similar events that are stored over and over again can resemble a lot. The details of this type of memories can blur and the distinct memories amalgamate. This leads to overgeneralized memories, of which people can not easily specify particular details.[29] It is also known that in order to normalize memories, an individual constructs the memory by combining elements of new material with existing knowledge (semantic memory). Such knowledge influences what we 'make up' of the new material.

A memory concerning a specific event exists of information, which is unique for that situation. This type of autobiographical memory is a combined mix of information coming from all senses (seeing, hearing, smelling, tasting and feeling, but also the sense of time and space). These memories are also called multimodal memories. Many other factors contribute to the content of the auto-

biographical memory, such as age, nature of the event, context, location, emotional cargo and personal relevance. All of these factors determine the unique character of this type of memory. Furthermore, unique personal memories can be complemented with general memories in the form of knowledge from the semantic memory.

There are three ways of storing information: by rehearsal, organization and imagery.

Rehearsal is a deliberate recycling or practicing of the content of the short-term store. Organization means the structuring or restructuring of information as it is being stored in memory. Imagery is the making of a mental picture of a stimulus that affects later recall or recognition.

People do not store exact copies of an event in their memory. Frequently unique information gets lost. With repeating events less information will be lost. Contrary to what is often thought, each unique event is not stored in a separate box of the human brain. Instead, all events are dynamically stored.

Retrieving is the process of recalling and remembering the information which was previously stored in the episodic memory. The retrieving of a memory depends on 'cues' which one gets at the time that the event is experienced. A cue is a kind of mnemonic device, a 'search term' in computer language.

Autobiographical memories are formed by the interaction between the character and the individual knowledge. Cognitive factors, socialization, attention, sympathy, anticipation, motivation and emotional cargo contribute to the quality of memory. And these aspects also make memories changeable during the entire lifetime. The information which is picked up will therefore never correspond exactly to the 'real' event.

Because memories are organised in different ways it is possible that so-called cues trigger different memories. Imagined elements could therefore be (and often are) added to a memory, as if they really happened. Almost all of our memories contain fictitious elements.[30] An event which was once stored in the memory can be forgotten or be difficult to retrieve. There are gradations in forgetting, and it is not always easy to determine to what extent something is really forgotten. Memories can decay in time. By ageing there is a breakdown of biological processes that also involve substances and parts of the brain that are vital to the memory. The normal process of forgetting is reinforced if a memory is not needed regularly or if only a few cues are available. The search process can sometimes with some effort and after considerable time nevertheless produce a result. Something can seem to be forgotten, but might suddenly surface under the influence of a situation or context resembling the original event.

This corresponds with a more recent view on forgetting, that of the retrieval failure (loss in memory). There is always information (the availability), but the information does not always have to be present or accessible. In the latter case the retrieval cues are at that moment not availlable. By creating the original con-

text in which the cues were learned, the retrieving of it will be enhanced. Such affective cues serve as a useful prompt or reminder for the information to be retrieved.[31]

Recent neurobiological research and neuro-imaging techniques offer more information concerning the parts and processes of the brain that are important for the memory function. The processes which have to do with the autobiographical memory are located in the thalamus, hippocampus and the prefontal cortex. Another part of the brain, the amygdala, links emotion to memory. As such the amygdala is of great importance because an emotion like fear is connected to the signifying of meaning to memory as well as the emotional cargo of memory.

## 3.2 QUALITATIVE ASPECTS OF TRAUMATIC MEMORIES

How can the quality of the functioning of the autobiographical memory be measured: when, how and under which conditions do traumatic memories not correspond with what really happened?

When assessing the quality of recollection as a function of the memory itself, a number of terms are important to consider. Central within the asylum procedure are the terms consistency, accuracy and completeness – terms which are frequently muddled together. In order to prevent confusion when debating the quality of traumatic memories, it is important that the terminology be defined briefly:[32]

- Accurate: agreement between a memory and the objective, actual event.
- Inaccurate: lack of agreement between a memory and the objective, actual event.
- Complete: all details of an event are correctly reminded.
- Incomplete: some details of an event are not reminded correctly:
  - Omission: some details have disappeared from the memory.
  - Commission: new details have been added to the memory.
  - Distortion: some details of the memory have been changed.
  - Consistent: to give the same information at different moments.
- Inconsistency: changing the given information throughout time:
  - Omission: a decrease of information in the course of time.
  - Commission: an increase of information in the course of time.

With regard to accuracy, a distinction is made between technical accuracy, where the focus is on the recall or recognition of exactly what was experienced, and content accuracy, where the focus is on the recall or recognition of the meaning or content of what was experienced.

The term 'accurate' shows overlap with the term 'complete'. Accuracy how-

ever does not guarantee completeness. The terms 'omission', 'commission' and 'distortion' can be used within the framework of the alterations in completeness. But they are also used under the term inconsistency to point at the change of the recollection throughout time.

Traumatic memories frequently lack external evidence and it is often not possible to stipulate with certainty to what extent a memory really reflects the events. This certainly also applies to the memories of asylum seekers. There are generally no other witnesses available to confirm the facts that the asylum seeker tells in order to substantiate his asylum application. To be able to judge the quality of a memory, one frequently falls back on the consistency of what is told during the interview as an indication for the accuracy, quality and credibility of the story.

It is clear that consistency is hardly related to the correctness of a memory. Untrue statements that are told over and over again, are after all in themselves consistent. Research shows inconsistency in reporting about potentially traumatic events with an intermediary period of 6 years is significant (63%).[33] Other research shows that precisely with respect to traumatic experiences, repeated interrogations can gradually facilitate an increase of more correct details and thus for an increase of completeness of the memory, at least under the condition that the timespan between the interrogations is short. This so-called 'hypermnesia' however leads to a lack of consistency but also to qualitatively better and more correct information.[34]

Contrary to accuracy and completeness, consistency is measurable and is therefore – wrongly – considered as a parameter for accuracy. This wrong assumption is to be found in research papers on traumatic memory in general and also in the assessment of the quality of memory during asylum procedures.

The age at the time of a traumatic experience influences the consistency of memory too. Events from early youth are later on in life often remembered vaguely, or very fragmentarily. The younger a person is during traumatization, the more inconsistent the memories. This has to do, among other things, with personality factors and with the immaturity of the memory functions, as well as with the coinciding protection- and copingmechanisms, the incapacity to put in words or interpret the memories, and the amount of time (frequently long) between the event and the recounting of memories.[35]

Memories of traumatic events can be incomplete and deformed by omissions. The phenomenon 'boundary restriction' applies here: the failure to remember information which is on the visual of acoustic periphery of the shocking image. When experiencing a traumatic event the attention focuses on the most threatening element, which then becomes the central element. This has its consequences for the memory of that event later on. The memory of the central details of the event is reasonably good, while the peripheral details, such as

space, time, place and the number of people present, are poorly remembered. There is however, still another explanation for the good memory of the central details. The inclination of many people after a traumatic experience to be engaged with what has happened, to talk and think about it recurrently, each time leads to the digging up of central information. As a consequence, the information from the perceptual periphery remains in default. This phenomenon is called 'tunnel memory'.[36] In the course of time however, the memory for the peripheral details can improve. This is thought to be due to the decrease of the arousal.[37]

Asylum authorities often question asylum seekers about peripheral details of traumatic events. The memory for these peripheral details can be poor or even absent because of the boundary restriction and the tunnel memory for traumatic memories, mental health symptoms, fear about the outcome of the asylum procedure and the high level of arousal. Failure to remember such details (e.g. description of uniforms, number of people present during torture, duration of an event) during the asylum interview, often leads to the asylum account being rejected on the basis that it is not credible. Moreover, when during several (repeated) hearings the information concerning the peripheral details is deemed inconsistent, the qualification incredible becomes the predominant opinion of the interviewers and assessors. Research for example has shown that judges and lawyers are quick to consider inconsistenties in the testimonies of key witnesses in criminal cases as an indication of inaccurateness.[38]

In the asylum procedure the authorities too qualify inconsistencies in an asylum account as a sign of incoherence, unreliability and incredibility, and on that basis frequently see reason to reject the asylum application.[39] According to scientific research however the degree of consistency has a restricted value for determining the accuracy or completeness of the story. Consistency can therefore not be an effective or accurate measurement of the degree of truth, reliability and credibility of statements during the interview. In the asylum procedure the degree of inconsistency as qualification frequently carries too much weight. Judgement of the testimonies of asylum seekers in such a way is not consistent with the scientific knowledge concerning traumatic memories.

The term 'coherence' means 'interrelatedness'. A whole range of factors other than problems of memory can as such be the cause of an incoherent story. Coherence is also related to intelligence, clarity in thinking and expression, to language skills, personality, trust, shame, concentration and strong emotions. Much of these factors have to do with mental health aspects which will be discussed later on in this article.

The way in which someone is questioned, affects in part the coherence of the answers. There are indications that the way in which asylum seekers are interviewed concerning the motives of their asylum application plays a role in the outcome of this interview. It concerns matters such as the interview technique, the circumstances, environment and attitude, the reaction to emotional out-

bursts and the use of open, closed or suggestive questions.[40] The accuracy of a memory can be influenced by what is called 'free recall' and 'cued recall'. A free recall means that a person can freely speak about his experiences. With cued recall, the questions being asked are closed and the answers need to be short and specific. Open questions can lead to less details being remembered, however without any indication of reduced accuracy. If closed questions are posed, on the other hand, concrete facts can be ascertained. But often these questions are more suggestive, as a result of which the accuracy of the memory can be diminished and answers can be incomplete and inaccurate.[41]

Moreover, problems regarding intercultural communication may lead to the assumptions that the story told is incoherent. Many asylum seekers stem from cultures where other means of expression are custom when telling about an event. This is all the more the case if the account concerns sensitive, painful or emotional information. An expressive use of language or the use of metaphors can easily end up in confusion and in a distorted way of communication. The ordeal of incoherency then proves in fact the incapacity to bridge this communication problem. We should not expect from asylum seekers who have recently arrived in Europe, that their asylum account immediately fits into our Western 'format' of how to express and speak about traumatic experiences. The pressure of the interview and the negative reactions at the failure of giving clear answers, sometimes causes asylum seekers to give a random answer, which is not fed by any memory. Their fear that having no answers can negatively influence the procedure, can thus lead to unfounded answers. In many cultures it is more acceptable to lie than to say nothing at all. Such answering frequently leads then, at repeated questioning, to inconsistenties because the first answer is not remembered and one can not fall back on a real memory.

These insights from memory science clarify some of the complexity of the relation between traumatic events and what an asylum seeker can tell about it. The same goes for the relation between the used terms and qualifications such as consistency and credibility, terms which are at issue at the eventual judging of an asylum account.

## 3.3 PSYCHIATRIC DISORDERS AND TRAUMATIC MEMORIES

Many events that asylum seekers experienced were stressful or traumatic. Scientific research on memory for traumatic experiences shows that under severe stress both the storing of information into the memory and the retrieving of such information, can improve, deform or deteriorate. Research also shows these contrasts. Traumatic memory combines an apparent contrast of complete amnesia and intense reminiscence with total recall. This contrast makes it difficult to understand completely how traumatic memory functions,

but results of research help to clarify some of the dynamics of the different processes.

Some people have no memories of the traumatic experiences, or the memories have changed or are deformed. It occurs too that memories are retrieved after a long time in which nothing at all was remembered. When dealing with traumatized asylum seekers, besides the normal process of forgetting, other processes in the memory also play a role.[42] Mood and emotions are important, both at the moment of the event and at the time of the storing of the memory. As discussed before, the memory processes are also influenced by the psychiatric symptoms and disorders.

Several changes in the autobiographical memory have been shown in people with a depression or with a PTSD.[43] This also applies to the acute stress disorder (ASD).[44] The fact that memory changes and is vulnerable to damage under the influence of post-traumatic stress, has also been examined more lately at neurobiological level.[45] It is clear that the hippocampus, an important locus of the autobiographical memory, incurs changes through traumatization and diminishes in volume. This causes a reduction of the short term memory.[46] With depression this is the same case.[47] Particularly when suffering from chronic PTSD, levels of hormones and neurotransmitters undergo changes that are of influence on the functioning of the hippocampus and the amygdala.[48] The question remains to what extent changes in neural structures precede or are a consequence of PTSD.[49] The answer to the question why certain individuals develop a PTSD after a traumatic experience and others do not, is also sought on the neurobiological level.[50]

PTSD can cause the following changes of the memory function: intrusive memories of the traumatic experience, a decrease in recall of neutral information, fragmentation and (partial) amnesia of the trauma related information. On the other hand, at the level of the implicit, non-verbal accessible memory, it appears that trauma related information is fixed and that there is an increase of extreme conditioned responses to emotional events.[51]

In general, we can say that traumatic experiences, because of the emotional impact and involved stress, are rather more of a constant reminder than other experiences. The intrusive memories in the form of nightmares and flasbacks testify of this. Many traumatized individuals suffer from intrusive memories during their entire life. There is a close relation between the degree of direct involvement at the time of the event and the severity of the traumatizing effect of the experience. In case of severe traumatization this leads to permanent reminders or to an increase in the number of memories throughout time.[52]

It has been shown that extreme fear can change the interplay between the memory processes, as a result of which the explicit memory (a part of the declarative memory) is disturbed, whereas the implicit memory (a part of the non-declarative memory) remains intact. The declarative memory of the experience,

which is verbally accessible, falls short and is not accesible. The non-declarative memory however still functions, but because it is by nature purely physical and cannot be communicated about, remains probing the body with physical indicators and symptoms of stress and fear. These symptoms impede the capicity to retrieve information and speak about the memory. Only physical reminiscences are present in the form of visual pictures (nightmares and flashbacks), or smell and hearing sensations and as intense bodily reactions (such as sweat, suffocation or heartbeats). These symptoms correspond with feelings of fear, but without a memory in the form of a verbal account of the fearful experience.[53]

It is known that PTSD and depression can cause overgeneralized memory, as a result of which specific autobiographical memories cannot be well retrieved. The overgeneralisation of the memory would appear as a kind of defence mechanism to regulate the negative emotions. The traumatization and psychiatric problems created a vulnerability for these negative emotions. After traumatic experiences the development of a specific retrieving mechanism could become disturbed.[54] According to others the overgeneralized memory can be explained as an occasional side-effect of the constant emerging intrusive memories.[55] This corresponds with research that shows that the short-term memory of persons with PTSD is impaired. Because of the disturbances caused by the traumatic experience, the memory seems fixed to the traumatic event. To hold on to these memories, others are being suppressed.[56] For traumatised asylum seekers this could lead to impairments of the memory system for new information and to diminished cognitive functioning.

Repeated questioning of traumatized asylum seekers leads to more information and a more complete picture of what has happened.[57] It should be taken into account that a lot of research is based on retrospective reports, whereby victims can look back, making a judgement concerning the intensity of the traumatic experience. This may lead to an exaggeration of the traumatic memory. In these cases the fact should be considered that victims may want to explain for themselves and to others why they still suffer from the PTSD impairments.[58]

## 3.4 MEMORY AND DISSOCIATION

Dissociation deserves separate attention. Dissociation is a psychological phenomenon by which a traumatic experience is lived through and stored in the memory in a fragmented way. Anxiety and arousal frequently are at the cause of the dissociation and could hinder the normal memory process and storing of information into the explicit memory.[59]

At the time of the event, dissociation serves temporarily as an adaptive protection against the extreme pain, humiliation, helplessness and fearful reality. It results at first in a restricted impact of the traumatic experience. This may

cause some or all of the before-mentioned symptoms and phenomena that go along with dissociation. Over a long period the invalid integration of traumatic memories contributes to the development of disorders such as ASD, PTSD and dissociation disorders.[60]

Most of the research on dissociation shows a strong correlation between traumatic experiences in youth and dissociative symptoms. In a lot of these cases there seems to be repeated traumatization.[61] It also appears that someone who has learned to dissociate during and after a traumatic experience (as a coping strategy), will do so more easily in other stressful situations. Furthermore there are indications that persons with 'fantasy proneness', the inclination to engage in fantasizing and imagination, show more dissociative phenomena after traumatic experiences.[62]

Dissociative phenomena which are experienced during or shortly after a traumatic experience, the so-called peritraumatic dissociation, would be of predicting value for the later development of PTSD.[63] More recent research however states that after the traumatic experience the persisting dissociative symptoms are more important as a predictor of later psychiatric problems than peritraumatic dissociation. This functions as a protection for the fearful situation. Long-term persistant dissociation on the other hand, would maintain post-traumatic reactions because of the obstructed access to the traumatic memories, thereby making it impossible to reduce them. It is this constant dissociation which is an important feature of the ASD, that can develop in PTSD.[64]

The shock which people experience during or shortly after a traumatic event, and the speechlessness that goes along with it, has to be considered as a peritraumatic dissociative reaction. This is accompanied by a changed notion of the surroundings and the self, leading to different as well as missing memories in distinct states of consciousness. Elements of a traumatic experience are stored separately from each other and they can pop up as loose elements from the memory. They do so as a sensorial perception, a strong emotion or a disproportional behavioural pattern (isolation, agressiveness). These expressions frequently have neither consistency nor internal relation, both for the person involved and for the outside world. The particular experience also lacks a story because of the absence of a verbally accessible memory, as a result of which there are no words to describe it.[65]

The dissociative amnesia needs special attention. This amnesia is selective, since the victims cannot remember the traumatic experience, but do remember other things. This loss of memory is too extended to be explained by an ordinary aptness to forget. Dissociative (also called traumatic) amnesia depends on the age and gravity of the traumatic experience: the younger at the time of it and the longer and more intrusive the experience, the greater the chances of developing considerable amnesia. Such an amnesia can last for hours, weeks or sometimes even years.[66]

It is known that also asylum seekers who encountered traumatic experiences

can have dissociative symptoms and disorders which contribute to a poor memory function, and that they suffer difficulties when retrieving memories.[67] Particularly in the asylum procedure of children and asylum seeking adolescents, more alertness with regard to the above mentioned phenomena must be present. The phenomena can serve as an explanation for the incomplete or absent flight story. Child soldiers and little girls who were confronted with sexual violence run a serious risk to develop dissociative phenomena and incapacity to explain about their experiences.

## 3.5 CONSEQUENCES FOR THE ASYLUM PROCEDURE

The scientific research into the memory for traumatic memories takes place against the background of a slowly growing insight in the mechanisms and processes which play a role. By means of research hypotheses are reviewed and adjusted. This increase of knowledge should also be practically applied within the working methods in the asylum procedure. Given the great importance, for both the authorities and the asylum seekers, of a careful and thorough handling of the asylum application, this knowledge cannot be ignored.

In this sense, some reserve and restraint is necessary when using consistency as a reliable indicator for reliability and credibility in the asylum procedure. This certainly applies to traumatised asylum seekers. As we saw, granting a lot of weight to inconsistenties is not being supported by scientific research.

If an asylum seeker has trouble remembering certain things, it is recommended to try and discuss the issues later, after some time has passed. Scientific research shows that then there is a better chance to get accurate memories of the experiences. It is of crucial importance to avoid suggestive questions. The use of standard and non-suggestive questionnaires will increase the consistency of memories.

Emotional and psychological responses play an important role in memory processes, both at the moment of the event and at the time of retrieving the memory. At that last moment asylum seekers are within the structured setting of the asylum procedure. With regard to interviewing asylum seekers with post-traumatic mental health problems like PTSD and depression, this means that it is significant to document the psychological and psychiatric symptoms. This way an impression can be formed on the factors which obstruct the retrieving of memories. These symptoms also serve as an explanation for gaps in the memory.

The interview by the authorities within the framework of an asylum application is possibly a stressful and emotional experience for the asylum seeker. This can hinder him or her remembering other events. To minimize this kind of impact, it is of great importance to invest in matters such as a good and safe environment, a personal treatment and an empathetic attitude. Such an approach can reduce the stress and with that the arousal and fear. And it will enhance the chance of qualitatively better memories.

In this perspective, it should be clear that an accelerated asylum procedure works counterproductive. Time pressures and less attention for conducting a stress reductive approach will most likely contribute to a decreased capacity of asylum seekers to consult their memory. This applies all the more if there appears to be multiple traumatic symptoms. From a psychological and qualitative point of view it is advisable in that case to stop and abandon the accelerated procedure.

## 4 SHAME AND SILENCE

Shame is an everyday emotion. An emotion that can be very embarrassing, even up to the point of, as the English expression goes,'dying of shame'. Shame derives from feelings of powerlessness and not being capable of preventing an event. Except that one can blush of shame, it has no strong perceptible expression, such as tears at sorrow or aggression when angry. Shame is one of our basic emotions which play an important role within the education and socialisation of an individual. It helps us to remain 'on the straight and narrow path' and has a socially regulating function and guards for danger. Shameless behaviour frequently evokes social exclusion.

Shame is a social emotion, strongly dependent on the cultural context. Almost all asylum seekers in Europe come from cultures were honour and shame are prominent and strict features in the relations between persons. In these cultures, shame goes along with the roles and rules between men and women. Feelings of shame coincide with and reinforce the continuation of these roles and rules. Shame is powerful through the non-spoken agreements which are implicit among families and communities. The roles and rules eventually become self-evident to them. It frequently concerns matters such as sexuality, relations, respect and honour. By not keeping oneself to the agreements and morals, the group or social category is mocked, which leads to loss of honour and face. Men are generally the keepers of this honour.

Cultures in which shame plays a vital part are also frequently cultures of silence. Being silent protects the family and the community against shameful events and their consequences for social life.[68] In such societies between certain social categories, notably between men and women, there is little conversation on matters of sexuality. Men talk to men about these things, and women to women. The questions 'who is to blame' and 'who am I to talk to', are social matters, coloured by community conceptions and norms. Often issues as virginity and sexuality are at play. By deviating from or surpassing (even unwillingly) the sexual norms and rules, women bring shame to the family. This is considered a great offence. Every deviation can trigger a chain of reactions: shame, revenge, fury and expulsion. Men can transform shame into anger and revenge. Women are touched by deep shame.

The same applies to mistreatment, sexual abuse and rape. Women are often not allowed to speak of it, so they conceal it. As with an idiom of distress – a cul-

ture-bound way of expressing unease – it can be that suffering is something that has to be endured and not talked about. From clinical practice there are cases known in which the traumatherapist is eventually informed about a female refugee-client having been raped, while the husband of the client is still ignorant of his wife's experience. But the husband might also feign that he does not know. Denial is at work here since, if the husband knows what happened, he would be confronted with a moral and emotional dilemma. When the truth is said and known, the husband has to accept the fact that shame is now on the whole family and further actions are needed. Actions which could include revenge and the expulsion of his spouse from his family...

Feelings of shame and guilt influence the perception of a traumatic event. In societies with rigid conceptions of sexuality the perception of sexual violence is a breeding ground for shame and guilt. Feelings of shame and guilt can lead to the development of dissociative coping styles at the time of the traumatic experience. For women with an experience of sexual violence in youth there is a correlation between an inclination to feelings of shame (shame-proneness) and dissociative impairments.[69] These impairments can lead to psychiatric disorders related to traumatization.[70]

Feelings of shame originate from a negative evaluation of the own personality.There has been a discrepancy between the ideal self and the observed self in reality. Shame has a high correlation with low self-confidence and low self-esteem.

Shame is frequently mentioned in one breath with guilt. In spite of the overlap between the emotions, they are nevertheless distinguishable. Guilt concerns a judgement of a specific action or behaviour and only in a lesser degree the identity as a whole. Guilt can be made up for and forgiven. Shame concerns the whole identity of a person and refers to shortcomings and imperfection. It points to having done something wrong, both in the own eyes as in those of others. With shame, the condemnation of self-image is at issue. People who are ashamed of themselves, want to withdraw themselves from that social context and with that try to avoid a new threat of shame.[71]

Shame is an emotion which is frequently observed within persons who suffer from traumatization. Albeit the occurrance, shame is not appointed as a symptom of PTSD or depression within the DSM-IV.[72] It nevertheless contributes by means of its included psychological processes to the development of symptoms belonging to PTSD.[73]

Shame is often felt by asylum seekers who are victims of torture, rape and other ill-treatment. It is known that in war a lot of women are sexually molested and that the rape rate is very high. And it is right here, with sexual violence, that shame provokes a prominent reaction: silence. Shame is difficult to recognise from the outside, because feelings and thoughts concerning the sexual atrocity have to be hidden and remain that way. This hiding and silence concerning the shame itself is an important manifestation of shame.[74]

A central question is whether not talking has to be considered as a symptom of shame. Or could it be a psychiatric impairment or even a coping strategy which contributes to the processing of the experience? We have to consider that being silent sometimes is a means to avoid thinking about and thus trying not to be confronted with powerful emotional constraints and painful memories. This kind of silence can be considered an expression of the avoidance symptom with occurs in PTSD.[75]

Silence is also present at a collective level. This being so, it contributes to processing. It makes it possible not to be swallowed by the pain from the past but instead to be focused on the future and the construction of a new existence.[76]

In general in order to speak about a traumatic experience, the social surroundings in which the memory has to be recalled and told, is of importance. If a community as a whole or a society shares the traumatic experience and is unanimous about the perpetrators, a collective group memory arises within which memories to one's individual experience can find its place. In that case there is room to speak about it. If however the bystanders, family or community deny such an event has taken place, the individual memory will be influenced in a negative way. Retrieval of that memory will be hampered because it then finds no support in a collective memory.[77]

The silence can be regarded as a means to protect oneself against the danger which goes along with contact with people in general, and against the threat by specific persons in the direct context of the traumatic experience in particular. If the traumatization was 'man-made' this frequently causes a damaged confidence in people. It often leads to a hypervigilance with respect to contacts with others. Being silent concerning the events and personal experiences is then considered to ensure a reduced vulnerability.[78]

From this perspective, to be silent concerning a traumatic memory has a function. It can help to protect one and one's beloved against the pain the memory might cause. It adds to the feeling to be in control over the situation and one does not burden the others with horrifying stories. Not telling about it also means there will be no consequences. Frequently the conviction lives that talking about conflicting emotions is sickening, provoking even more bad feelings. It all adds to the function silence has in these cases: the active (but not necessary conscious) forgetting about what happened is an important coping strategy in dealing with painful memories.[79] As is seen in refugees, it is possible that after a while, words cannot be found anymore. The only way of expressing the emotions about what has happened in these cases, is through the body. Physical impairments then serve as an expression of the painful emotions and the suffering for which no words can be found.[80] Metaphorically, the pain which once was experienced has been embodied and became body language. We will go deeper into the relation between pain and recalling memories later on in this article.

To forget is often considered to be the best way to tackle painful memories.

Sharing memories is often almost impossible because of the silent agreement not to talk about them. In some communities this can also include other emotionally charged issues which may not be discussed (e.g. taboos). Some languages/communities even lack the words and terms related to certain painful emotions. In a litteral sense no words can be found then.[81] Furthermore, the pressure to keep silent about what happened can be enhanced if the situation is such that one must focus with total attention on practical, physical and social survival. To be silent can be a necessity, a matter of staying alive. When perpetrators and victims live together closely, as in refugee camps, the situation can be that unsafe, that holding back information about past events is the only practical option.[82] This pattern of being silent for your own sake, has exhaustively been described within families of Jewish victims of war who survived the holocaust. Within these families, across generations, the general aspects of the war can be discussed while the conversation would seldom be about personal experiences.[83]

These findings show that shame and silence are powerful influences. When considering asylum seekers, this means that the requirements of the asylum authorities to tell immediately everything concerning traumatic experiences are not compatible with a culturebound custom (or taboo) to remain silent concerning painful and shameful matters. It is important to realize that the strength of this influence goes beyond the free and conscious will. Asylum authorities consider the silence of asylum seekers as a simple choice. This approach ignores the weight and complexity of the psychological processes involved. The asylum seeker will choose at moments to remain silent, that is, when he realises that it would be the safest thing to do for his future within the family or community. Or the choice is made to do so out of fear to lose respect or self-control. At that moment the asylum seeker lacks the notion that refusing to speak can have a negative influence on the asylum application. Sometimes even other, untrue facts are mentioned or actions of sexual violence are denied, suppressed or minimised. Can we expect a woman to talk with a complete stranger about the rape that occurred, when she dare not speak of it with her husband?

Being asked or being forced to focus mentally on those painful experiences can give a sudden increase of symptoms. Consequently, such an increase has a negative impact on memory processes, including the recalling of traumatic experiences. Changes and corrections within the statements of the asylum account, made at a later stage due to new and other facts, lead inevitably to inconsistenties, which makes the declaration incredible for the asylum authorities. Sometimes more time and attention is needed in order to be able to discuss these delicate issues. It's also needed to make clear what is at stake and why it is better for the asylum seeker to talk about certain things instead of being silent. It occurs regularly that the silence can only be broken when in a safe environment, in the presence of trusted caregivers. Generally these declarations, brought in in a later stage, or a medical explanation concerning the context of

the asylum seeker, may no longer play a role in the assessment of the asylum application. This certainly does not do right to the complexity of the field of force which is at play.[84]

## 5 DISTRUST

Trust is a pillar of social functioning. The development of 'basic trust' commences soon after birth and it remains necessary for a healthy condition, social functioning and interhuman contact. Trust is accompanied by feelings of security. A lack or loss of trust leads to distrust and suspicion, whereby other people are considered unreliable.[85]

Distrust is one of the consequences of traumatization. After a traumatic experience – the more so if it has been caused or carried out by other persons – a victim is easily convinced that nothing and nobody can be trusted anymore. Feelings of insecurity with respect to other people and social situations develop. The self-perception and ideas concerning the own existence and future change, as a result of which trust in others is obstructed.[86] Distrust is noted in publications about traumatization as a consequence of hypervigilance and alertness. It is often seen as an accompanying symptom of psychiatric syndromes associated with traumatization, such as PTSD and depression, without being incorporated into the criteria of the symptoms of DSM-IV. Chronic distrust is described, however, as one of the core symptoms of the formerly mentioned chronic PTSD or disorder of extreme stress not otherwise specified (DESNOS).[87]

Distrust is an important factor which can obstruct asylum seekers to talk about their traumatic experiences. Especially if there are symptoms related to traumatization, distrust can play a significant role in the asylum procedure. Feelings of fear and vigilance at first often provoke distrust and suspicion. Decreased self-confidence, moreover, does not add to having trust in other people.

The asylum interview being held by a representative of the government reinforces the distrust of many asylum seekers. If the government in the country of origin was at the cause of the traumatic experience, this can lead to strong feelings of suspicion against governmental authority in general.[88] This reinforces the already present vigilance so much, that an asylum seeker does not find it safe enough to speak about certain subjects. In the perception of the asylum seeker, he is not capable of doing otherwise. The feeling of suspicion is so strong that it outweighs the pressure and requirement to tell everything. This way mistrust and suspicion can contribute to silence. Distrust definitely influences the interview with the representative of the asylum authority.[89]

Intrusive events are not easily told spontaneously. Talking about it demands time and it needs a secure environment. The first thing an asylum seeker wants to know is whether the interviewer 'can be trusted' and 'how safe it is to discuss everything'. Many asylum seekers complain of having too little time during the

interview. Also they complain that too few efforts are made to improve the atmosphere in such a way that they can reduce their suspicion. The fact that the asylum authorities are focused in first instance on having the whole asylum story told as soon as possible, correlates in a negative way to the issues which keep the asylum seeker busy. The more an asylum seeker suffers from severe post traumatic impairments and problems, the stronger this negative correlation.[90]

Distrust is also part of the policy of asylum authorities. An attitude of sound suspicion concerning the stories of asylum seekers is supposed to help the authorities discover these asylum seekers who, according to them, are not telling the truth. Such a basic rule of conduct influences the atmosphere as well as the approach of the officials during the interview. It will contribute to suggestive questions, miscommunication (interculturally) and non-verbal expressions of scepticism and doubt concerning the declarations of the asylum seeker. As we have seen, asylum seekers are in general very sensitive to this kind of signals.They feed and reinforce the already present mistrust and confirm the picture that authorities in Europe can not be trusted either. This can trigger associations with previous traumatic experiences and will in part contribute to a strong increase of the current stress – an effect which is called retraumatization. The physical and mental responses in reaction to this enlarge the risk of having difficulties in talking about the traumatic experiences.[91]

## 6 CONCENTRATION

Concentration has a close connection with attention. Concentration is needed in order to focus attention to something or someone. If the attention is unconsciously aimed at a particular thing, the level of concentration is of lesser importance, while for consciously targeted tasks, the level of concentration is important in the process of giving attention. A reduction of concentration causes distraction so that tasks are no longer carried out properly, or not carried out at all. This reduction in concentration can be assessed easily: by asking to complete specific tasks while the response time is being measured. This ought to give an impression of the level of concentration. There are all kinds of limited as well as extended psychological tests and tools to look at the level of concentration.[92]

A lot of psychological and psychiatric disorders go together with a reduced capacity to concentrate. This means that concentrations problems are non-specific for certain disorders. With PTSD and depression, concentration problems are explicitly mentioned as symptom. From studies is known that 80% of the persons who suffer from a depression have concentration problems.[93] Within the PTSD diagnosis according to the DSM IV, concentration problems are categorised under hypervigilance as being an expression of it.

Research shows that persons with PTSD score significantly low on concentra-

tion and attention.[94] There is, however, little research on concentration problems as an isolated symptom of traumatization. This means that concentration problems are impairments that pre-eminently should be examined at its symptom level by means of the existing psychological tests, such as the Bourdon-Vos test[95] or the Wechsler Memory Scale.[96]

In studies on the psychological and psychiatric impairments of asylum seekers and refugees, concentration problems are defined as one of the consequences of traumatization on the cognitive functioning.[97] The presence of PTSD and depression are of importance here.[98] The restrictions in concentration are also related to levels of stress which apparently coincide with (the lenght of) the asylum procedure or other long lasting psychosocial stress.[99] Torture-induced PTSD can restrict cognitive functioning and the capacity to concentrate.[100]

Research makes clear that the reduced concentration adds to psychological problems which asylum seekers experience when asked to talk about and explain traumatic events.

## 7 PHYSICAL PROBLEMS

Traumatization leads, besides to mental and psychiatric impairments, also to physical complaints. The physical complaints are caused by means of several mechanisms. The interrelations and connections between these diverse factors and mechanisms are legio and complex. Below, we discuss the physical factors relevant for this article since they contribute to the difficulties which asylum seekers can experience when retrieving and telling their asylum story.

### 7.1 PHYSICAL EXPRESSIONS OF FEAR AND STRESS

A life-threatening situation where fear and powerlessness are at issue, instantly causes physical reactions, such as alertness, activation of the breathing and blood circulation, an increase of muscle tension, transpiration and the emptying of bowel and bladder. These are unvoluntary reactions from the autonomous nervous system that function outside of our own will. In case of chronic stress and traumatization we speak of an over-excitement and maladjustment of the autonomous nervous system. Memories are then laid down by the autonomous nervous system into what is called the somatic memory (in muscles, synapses, nerves). As such, stress and fear can be observed in unconscious and involuntary physical reactions such as uncontrolable shaking, sweating and tics or bodily sensations such as pain, nausea and shortage of breath.

A stressful event (for example an asylum interview) sometimes comes along with a maladjustment, which causes a strong physical reaction of which the origin lies in the somatically stored memories.[101] Mostly these forms of 'bodily remembrance' are observed, when traumatic memories are difficult to recall or

verbalize. Many scientists and psychiatrists working with traumatized clients agree on the fact that traumatic memories can be available as isolated, nonverbal, sensory-motoric and emotional fragments. In such a case it is difficult to retrieve and recall traumatic memories as coherent, verbal narratives.[102] It happens that someone can not recall a traumatic experience in words while the body does remember – be it unconsciously.[103] In these cases traumatization is by times considered a complex but incomplete biological respons to threat, a residue of primitive reactions. The impulsive bodily reaction at the time of a traumatic experience monitored by the evolutionary older part of the brain – the part which we share with other mammals – generates activities which are needed to safe our life or overcome our losses. As a consequence there is a tendency to impulsively run, fight, duck, flee, stiffen or retract. But when there was no escape, part of that pattern is still stored inside the body. Some traumatized persons need treatment focused on the somatic level before they are capable of remembering everything that happened.[104]

Physical complaints frequently occur together with symptoms of before mentioned post-traumatic psychiatric disorders such as PTSD and depression. With post-traumatic impairments, as with PTSD, the autonomous nervous system keeps the body alert. This alertness can eventually lead to physical expressions of fear and hypervigilance: sudden heartbeats, pressure on the chest, suffocation, vomiting and diarrhoea, tremors, transpiration and painful muscles. Even fainting occurs and phenomena resembling to epilepsy. Depression is also known to have physical expressions of which the most common are: tiredness, exhaustion, a dry mouth, lack of appetite and obstipation.[105]

Transcultural psychiatry has made clear that expressing personal and social stress by means of somatic complaints is quite standard among most cultures. Somatic illnesses and impairments are less threatening and stigmatizing; they are considered socially secure and more acceptable than showing psychological impairments. Members of the same culture or community understand this pattern and so do the local medical doctors and caregivers.[106] Such a somatic presentation of complaints is seen on a worldwide scale and is regarded as common response to (extreme) stress among most cultures. Therefore somatic complaints ought to be considered one of the traumatization specific consequences.[107]

## 7.2 PAIN

Pain is a common physical complaint. Nevertheless it's a complex phenomenon, related to all sorts of problems. Pain has also psychological effects, while mental problems can cause pain; there is inter-connectedness. Personal characteristics and coping strategies (see 3.2) are of great influence on the tolerance for and endurance of pain. Physical pain can get worse because of anxiety, negative ideas and being nervous. And pain can be hold on to when it is rewarded

through behaviour from others. It is also possible that pain stands at the root of mental complaints and psychiatric disorders. Chronic pain for which no proper medical explanation can be given is often misunderstood and has posed a major problem to the medical science since a long time. Also within psychiatry there is a dispute on terms and classifications, because pain is an accompanying phenomenon of several psychiatric disorders.[108]

This certainly applies to the impact of traumatic experiences. Traumatization leads to fear and hypervigilance, and this chronic vigilance causes a raised tension of the muscles. This in turn frequently causes myalgia, particularly in the upper half of the body: head, neck, back and shoulders. Pain is one of the most frequently reported symptoms among patients with PTSD. This might be due to the fact that the pain that was felt during the traumatic experience became part of the 'somatic memory'. This happens especially when the traumatic experience includes physical violence, severe pain and wounds, as is the case with torture. Then the pain is a somatic reminder, similar to visual flashbacks during nightmares. Pain is in that case a cue that triggers the memory of the traumatic event, which in turn will maintain the fear as well as the hypervigilance.[109]

Chronic pain and PTSD reinforce each other regarding the psychosocial functioning and the 'perceived life control'. This means that in individuals suffering from PTSD, pain causes reduced feelings of control concerning their own living conditions and a decrease in social functioning (as in interaction, behaviour, activities).[110] People with chronic pain also suffer serious difficulties in their intellectual functioning. They have less attention and concentration and poor memory functions.[111] In short, there is a system of *mutual maintenance* between PTSD and chronic pain.[112] A number of mechanisms are relevant here. The heightened attention to threats of pain and emotions related to pain are of considerable importance. In these cases, pain is a reminder of the trauma, which reinforces the hypervigilance and triggers the bodily memory, and in turn the pain too. The attempts to avoid these stimuli can lead to even more inactivity and physical weakening (e.g. muscle atrophy). Among refugees, many complaints of pain are observed, notably of the musculoskeletal level. Neck- and backpain and painful joints are frequently indicated.[113] Pain is observed among refugees on a worldwide scale.[114] Among refugees in Europe who were victim of torture, pains occur, which have both a relation with the physical violence undergone previously as with psychiatric problems.[115] Studies amongst refugee populations in developing countries show the same results.[116]

## 7.3 SLEEPING PROBLEMS AND EXHAUSTION

A serious, persistant or lasting lack of sleep can lead to all kinds of complaints, such as memory impairments, excitability, concentration problems and hallucinations. It also leads to suggestibility. These consequences decrease the cognitive functioning.[117] Sleeping problems are a common symptom of

traumatization and part of the psychiatric disorders depression and PTSD. Exhaustion can appear at the end of an extended period of lack of sleep. Sleep has a function in the convalescence of the body and on the level of energy. And sleep is needed for a proper functioning of the memory system.

Sleeping problems are frequently observed among asylum seekers. It is possible that the sleeping problems victims of torture experience originate from the methods of torture that were used on them. Particularly when sleep deprivation was one of the methods. Many traumatised asylum seekers have difficulties falling asleep, or suffering early awakening or nightmares due to their psychiatric disorders. Traumatic experiences that took place before the flight as well as the stressful arrival in Europe can contribute to a maladjustment of the sleeping pattern. Having to stay in a reception centre with overcrowded and restless dormitories can exacerbate the sleeping problems even further. During an accelerated asylum procedure or interviews the asylum seeker's suffering from sleeping problems will add to the already existing difficulties with remembering and giving information. An asylum seeker can get that tired that he will give any answer in order to be released from the situation. Or the increased suggestibility of the asylum seeker leads to giving incorrect answers to suggestive questions. At a next interview these 'quick' incorrect answers may contribute to even more inconsistenties.

## 7.4 BRAIN INJURY

Injuries to the head can lead to brain damage. These injuries often include blows to the head, contusion, loss of conscience, and serious head wounds. Brain injuries can lead to brain concussion with long-term loss of consciousness. Such injuries may cause loss of memory because of the insufficient storing and imaging of events which occurred at the time before the loss of conscience (retrograde amnesia), or those which took place briefly afterwards (anterograde amnesia). As a consequence sometimes post-concussional symptoms are observed, such as: headache, tiredness, problems with concentration and memory, sleeping problems, anxiety, anger, fear, depression, emotionality, apathy and personality change. Within the DSM-IV this syndrome has been described as postconcussional disorder.[118] Neuro-imaging techniques and neuro-psychological research may help confirm the organic origins of these complaints.

Most of the complaints from brain injuries disappear after some months. Among a minority, however, they persist for many years. It is important to consider that also smaller kinds of brain injuries can cause this type of phenomena, albeit most often in a milder form.[119]

Asylum seekers might have brain injuries due to the violence endured during torture or war. They can suffer from the impairments mentioned above. During the period of the asylum procedure these impairments can be the rea-

son for not remembering an event or providing a chaotic presentation of what has happened. Asylum seekers do not often give a notion of their brain injuries spontaneously, but only if it is asked explicitly. The cognitive problems as a consequence of head wounds or brain injuries (e.g. forgetting, telling incoherent stories, lessened learning capacities) can contribute to the incorrect interpretation of their asylum story. Such an interpretation is moreover easily attributed to (deliberate) psychological factors, whereas the origin is in fact organic. Neurological research and cognitive tests can make the possible obstructions concrete and visible.[120]

## 7.5 MALNUTRITION

Malnutrition and loss of weight can influence the memory negatively. This is mainly due to a lack of vitamins, particularly the vitamins B. Vitamin deficiencies do occur slowly. Initially they cause few health problems. A shortage of vitamin B12 and foliumacid has a bad influence on the memory functions. Restoring the sufficient amount leads to better cognitive functioning. A serious lack of vitamin B1 (thiamine) causes Wernicke's disease with goes along with confusion and extended amnesia. The impairments are reversible only after treatment with thiamine.[121]

Malnutrition among asylum seekers can be caused by, among other things, the bad conditions in prisons, hunger strikes in captivity and a lack of food during the long flight to Europe by boat or truck. Recent severe loss of weight can point to a current condition of malnutrition and be an indication of the suffered shortages.

Malnutrition can also occur during the asylum process. Due to grief, fear and psychiatric symptoms, asylum seekers often do not take proper care of their well being. It happens that an asylum seeker will eat the same almost every day, while not knowing how to prepare or cook food or even what to buy.

## 7.6 MEANING FOR THE ASYLUM PROCEDURE

Physical reactions to fear and stress, and physical problems such as chronic pain, anxiety and hypervigilance, exhaustion, brain injuries and malnutrition do most probably influence the capacity to speak out concerning the asylum context. The asylum procedure as such can increase the level of complaints, because of the stress during the interview, the fear not to be admitted and the living conditions in the reception centre. Physical impairments are not always clearly visible and asylum seekers often do not talk about it because they do not understand the complaints themselves. It is crucial that asylum authorities realise the importance of these physical phenomena and processes, and be alert on this type of impairments. It is justifiable to accept that physical problems can

limit asylum seekers in telling their story.[122] In criminal law brain injury with amnesia is accepted as a factor that can impede the ability to testify.[123] For asylum seekers this should also be the case.

## 8 FROM TRAUMATIC REFUGEE EXPERIENCE TO ASYLUM SEEKER NARRATIVE

In general, when people experience something, the incoming information is most of the times synthesized into a chronological form of narrative. Research shows that traumatic experiences however are often stored in the memory as sensations or emotional states, and that they are not immediately transcribed into personal narratives. This difficulty in information processing and in the logical, verbal reconstruction and description of the memory is at the very core of trauma reactions and PTSD.

This article has clarified the importance of the consequences of a traumatic event, and the reactions that occur at the time of the event and shortly thereafter. Doctors and therapists working with traumatized clients agree to the fact that traumatic memories have a tendency to be available as isolated, nonverbal, sensory, motor, and emotional fragments.[124] Certainly in combination with mental problems this can make the memories difficult to retrieve as coherent, verbal narratives.[125] Primarily traumatic memories lack verbal narrative and context, because they exist in first instance mainly as static, but vivid sensations and images, difficult to verbalize.[126] As this article makes clear, traumatic memory can be absent, badly stored, difficult to retrieve and therefore sometimes impossible to put into words.

It is important to realise that traumatized asylum seekers face difficulties to rationally understand the horror that they have gone through and to give meaning to it. The suppressed, fragmented character of the memories, the fact they are too terrible to express aloud and with feelings of intense humiliation, make it almost impossible for a victim of torture to talk about the experience in a clear and understandable way. To provide a good narrative, that is to tell a story in a coherent and credible manner, it needs a beginning and an end. Also logic, visual clues and explanations help a lot. What if an asylum seeker still feels he cannot figure out where the overwhelming pain exactly comes from, what precisely happened next and what it all means to him? It should be considered and taken into account during the asylum procedure that 'speaking of the unspeakable' for some asylum seekers is not an obvious, not even a optional thing to do.

**Case**

A 36 year old man from a Middle Eastern country told in the asylum interview about his experiences in prison with beatings and electrical torture. Before a decision was made about his asylum request he tried to commit suicide. This suicide attempt failed and he was hospitalized in a psychiatric hospital. There he talked to a psychologist. Only after

some time he could tell that prison guards raped him, and that they told him he could never be a man. During therapy it became clear that his feelings of shame and worthlessness were making him silent about this experience, and that he felt suicide was the only solution. Together with the psychologist he managed to write down his complete prison account. This testimony would serve as his narrative document to be used in the continuation of his asylum procedure. But the asylum authorities refused to look at this testimony because he had not mentioned it all in his first interview.

Differences in language are an important disturbing factor during the construction of a narrative. That should be taken into consideration by the asylum authorities. Due to the fact that asylum seekers often do not speak the language (sufficiently) in which the procedure takes place, translators need to be used. The asylum seeker will not easily trust this extra person present during the asylum interview. This can create a barrier to speak out.[127] The language the asylum seeker uses also needs to be understood as a product of socio-cultural conventions and codes of conduct concerning how ego-experiences in general, and the degrading and painful ones in particular, have to be told. Such a convention can even be that painful narratives have to stress the importance of the group and that they need a communal perspective. This means that the group dimension is stronger than the individual dimension. In Afghanistan for instance, they use the word *Gham* to denote grief and severe emotional suffering, but it also means poverty, bad living conditions and even, nowadays, destroyed houses and bad weather.[128] Such an expression of the communal view on what happens to an individual may be difficult to an asylum seeker to combine with the demands of an asylum application that focuses on the details of individual experiences. This frequently contributes to a situation in which the applicant does not fully understand how the story should be told. Words can have different meanings when individually meant questions are answered in a general way, or through a more collectively intended expression. This can easily lead to miscommunication.

It is commonly known that asylum seekers talk among each other about the asylum procedure. Some, including the travel agent, who is often indispensable for the asylum seeker leaving his country, give the advice to use a certain story. Due to uncertainty about memories, difficulties to remember properly, shame and other psychological problems asylum seekers are sometimes inclined to tell these invented and advised stories. They may at first think that it will help them getting a (provisional) residence permit. It can seem better to have a complete story than a chaotic compilation of vague memories. Furthermore, reflection upon their past experiences can make them feel worse or trigger (more) pain, as is been discussed before. The fact that traumatization may contribute to this act should be taken into consideration by the asylum authorities.

Aside from the psychological and psychiatric aspects that make it difficult to construct a logical and complete story, there are also socio-cultural factors of

influence. According to certain scientists this influence is very much underestimated. Each memory is based in and constructed by its cultural context. The story about the memory too must be considered as a construction, a combination of the individual and the historical memory. A verbalized memory has its roots in part in the context in which the experience took place, and is in part formed by the new context in which that memory is told at that moment. Because of this intrinsic bond every verbal memory, every narrative is culture bound. One could say that the narrative of a memory can never be complete because each time the perspective and context change.[129]

An experience is understood according to culturally defined conventions. These cultural conventions can however constrain the narrative in the sense that certain issues are focused or touched upon while others are neglected or denied (e.g. sexual assaults). In the case of refugees applying for a refugee status, the trauma narratives told are not only based and constructed within the local cultural discourse for talking about grief, tragedy, struggle and displacement, but also in relation to the legal and bureaucratic cultures of the asylum authorities.[130]

Other contexts of culturally defined conventions concerning narrative also have to be considered, such as the therapy room, the courtroom and the asylum interview room. Generalizing: in the therapy room, when treating traumatized asylum seekers and refugees, (almost) everything goes as long as it serves the purpose of healing; the narrative is like a flow: evolving, accepting, transforming. While in courtroom, within the juridical domain, narratives are about valid proof and objective signs. These narratives have an evidentiary, eyewitness dimension.[131] These differences generate in turn different conventions on how the story needs to be told (performance) and they lead also to differences in the product of the narrative (the story itself).

**Case**

A 21 year old woman from a western African country talks in her asylum interview about her experiences in a rather general and vague way: 'those military beat my family, killed my father and took me with them to the bush. There I had to do all kind of bad work for them…'. Questions about names, locations and details of what happened she answered with 'I don't know' or 'I don't remember'. Her asylum request was rejected. Because of depression and anxiety she received treatment in mental health care. There she could tell more about her experiences of being raped by groups of military and about being treated as a slave. Due to her strong emotions she could only talk about this in small parts. Only after several sessions it was possible to make a more complete picture of her traumatic experiences. Only then she could tell properly about her experiences.

Since truth can be more easily revealed in the therapy room, it is useful to look into what makes this room a better place for recalling memories. Apparently, treatment can help to reconstruct the blurred memories and strong emotions

into a more complete narrative. Essentially, in therapy, time is given to *rediscover* what happened. By working through the physical sensations, emotions and cognitions and with the help of a treatment program, a client can gradually become aware of painful memories and start being capable to reconstruct what happened. Time, the therapeutic relationship and reduction of post-traumatic symptoms will help to retrieve in more detail what happened, and enable the client to review and assemble the experiences within its context of human rights abuses or war. This will lead to a more complete and accurate narrative.

Just as important is the atmosphere and the way the communication goes. As is discussed earlier, asylum seekers experience the atmosphere of the procedures and interviews in the asylum process often as not comforting or safe enough to make them feel at ease to talk about traumatic experiences. In the therapy room they experience more understanding and trust. This helps to diminish the level of agitation and the burden of mental symptoms. It becomes less difficult to talk and more easy to retrieve traumatic memories. The therapeutic alliance can help to overcome shame, guilt and silence.

Therapy therefore can be a source of complementary information and can certainly be of help to construct a more complete narrative about traumatic experiences. The above-discussed dynamics of gathering more information do require more time. This is very clear from the perspective of psychological mechanisms. However, in asylum procedures there is a high possibility this 'new' information will not be taken into account by the asylum authorities. Most of the time, they won't accept this later introduced information.

Can we expect all asylum seekers to produce a correct and understandable narrative while many of them do not even understand what happened themselves? We'd like to point out that Nietzsche had serious doubts on whether language-as-such was capable of expressing all 'truths'– the historical, the scientific as well as the emotional. If Nietzsche considers language a 'falsifier' of truth in normal situations – because things (included experiences) and the naming of things never correspond – then what about the truth concerning traumatic experiences? This article has made clear that many obstacles can prevent an asylum seeker from remembering, reconstructing and talking about his dreadful experiences. In case of torture and violence, talking about these experiences must first of all be regarded as an attempt to 'make a story' of something that at the end can never be completed. In these cases in-depth and proper investigation, reconstruction and registration of facts is only possible with professional aid.

## 9 CONCLUSIONS

Medical, psychological and psychiatric research on trauma, post-traumatic psychological and psychiatric problems like PTSD and depression, is extensive. This scientific knowledge makes clear that these mental problems can interfere with

asylum seekers recalling a traumatic experience such as torture, rape and other experiences of violence.

Post-traumatic mental health problems can easily be missed or misunderstood by asylum authorities. When this happens, it interferes with the asylum assessment leading to wrong conclusions regarding the experiences of the asylum seeker and his need for protection.

An important factor for impediment is the memory system, in which post-traumatic symptoms can interfere negatively with the storing and retrieval of traumatic memories, and make memory troubles quite common. Research makes clear that inconsistencies in asylum seekers' reports of their experiences should in principle not be explained as a sign of incredibility, surely not if these inconsistencies can be linked to post-traumatic problems.

Psychological problems such as shame, silence, diminished concentration and distrust, as well as divers physical complaints, can also contribute to asylum seekers having problems recalling and reporting their experiences. This can prevent them from telling a clear narrative about what has happened to them and what has made them flee their country. Socio-cultural factors frequently influence and add to strong feelings of inappropriateness concerning the talking about shameful experiences.

It is important that decisions in asylum cases are based on scientific knowledge. This article shows that this knowledge necessarily needs to have implications for the assessment of asylum seekers. It is clear that the complex mental condition of asylum seekers can have an adverse impact upon the ability of asylum authorities to assess the need of protection of asylum seekers. Rarely however, do asylum authorities ask advice from (mental) health care experts. Legal representatives often also fail to notice the mental disturbances that interfere with the asylum procedure. Asylum seekers with traumatic experiences therefore need to be considered as 'at risk' of having their mental health problems being overlooked, which may hamper the proper recounting of the asylum background.

This article shows the importance of mental health assessment when there are signs of psychological or psychiatric disturbances. This assessment by mental health specialists helps the asylum seeker to document and make feasible that his (mental) health problems interfere with the capabilities to tell a complete and logic story. The conclusions of these health findings can also serve as an aid to the asylum authorities since it enables them to make conclusions on a broader basis, qualitatively better and based on scientific knowledge. Such an assessment can help to understand the mental problems of traumatised refugees as well as to avoid misunderstanding their difficulties in retrieving memories and providing for an appropriate testimony. Since the Istanbul Protocol describes the guidelines for proper assessment of the mental health problems after torture and ill-treatment, this assessment should be included as a necessary step in the decision-making process in asylum requests throughout Europe.

## NOTES

1 Bloemen, E. (2005). *Een briefje van de dokter... Medische zaken in de asielprocedure*. Utrecht: Pharos.

2 Bremner, J. (1999) Does Stress damage the brain? *BiologicalPsychiatry*, 45, p. 797-805.

3 Vloeberghs, E. & Bloemen, E. (2005). *Uit lijfsbehoud. Lichaamsgericht werken met vluchtelingen in de GGZ*. Utrecht: Pharos.

4 Herman, J. (1992). *Trauma and recovery: the aftermath from violence – from domestic abuse to political terror*. New York: Basic Books.

5 See note 4.

6 Gorst-Unworth, C. & Goldenberg, E. (1998). Psychological sequelae of torture and organised violence suffered by refugees from Iraq. Trauma related factors compared with social factors in exile. *British Journal of Psychiatry*, 172, p. 90-94.

7 Sadock, B. & Sadock, V. (2003). *Synopsis of psychiatry. Behavioral sciences/clinical psychiatry*. Philadelphia: Lippincott Williams & Wilkins.

8 Summerfield, D. (1998). The social experience of war and some issues for the humanitarian field. In P. Bracken & C. Petty (Eds.), *Rethinking the trauma of war* (p. 9-37). London: Free Association Books.

9 Lazarus, R. & Folkman, S. (1984). *Stress, appraisal and coping*. New York: Springer.

10 Vries, S. de (2002). *Psychosociale hulpverlening en vluchtelingen*. Utrecht: Pharos.

11 Barlow, D. & Durand, V. (2005). *Abnormal psychology. An integrative approach*. Belmont: Wadsworth.

12 Fazel, M., Wheeler, J. & Danesh, J. (2005). Prevalence of serious mental disorders in 7000 refugees resettled in western countries; a systematic review. *Lancet*, 365, p. 1309-1314.

13 See note 7.

14 American Psychiatric Association (2000). Diagnostic and Statistical Manual of Mental disorders. Fourth Edition, Text revision ed. Washington DC: American Psychiatric Association.

15 Summerfield, D. (2001). The invention of post-traumatic stress disorder and the social influences of a psychiatric catogery. *British Medical journal*, 322, p. 95-98.

16 Turner, S. & Gorst-Unworth, C. (1990). Psychological Sequelae of torture: a descriptive model. *British Journal of Psychiatry*, 157, p. 475-480.

17 See note 14.

18 See note 14.

19 Foa, E. & Hearst-Ikeda, P. (1996). Emotional dissociation in response to trauma; an information-processing approach. In L. Michelson & W. Ray (Eds.), *Handbook of dissociation; theoretical and clinical perspective* (p. 207-222). New York: Plenum.

20 Putnam, F., Carlson, E. et al (1996). Patterns of dissociation in clinical and non clinical samples. *Journal of Nervous and Mental Diseases*, 184 (1), p. 673-679.

21 Escobar, J. (2004). Transcultural aspects of dissociative and somatoform disorders. *Psychiatric Times*, 21 (5).

22 Apitzsch, H. (1996). Trauma and dissociation in refugee patients. *Nordic Jornal of psychiatry*, 50, p. 333-336.

23 Feuer, C., Nishith, P. & Resick, P. (2005). Prediction of numbing and effortful avoidance in female rape survivors with chronic PTSD. *Journal of Traumatic Stress*, 18, p. 165-170.
24 See note 4.
25 Van der Kolk, B., Roth, S. et al (2005) Disorders of extreme stress: The empirical foundation of a complex adaptation to trauma. *Journal of traumatic stress*, 18 (5), p. 389-399.
26 Antze, P. & Lambek, M. (1996). Introduction. In P. Antze & M. Lambek (Eds.), *Tense Past: Cultural essays in trauma and memory*. New York: Routledge.
27 Ashcraft, M. (2002). *Cognition*. New Jersey: Prentice-Hall.
28 Neath, I. & Surprenant, A.M. (2003). *Human Memory, 2nd Edition*. Belmont: Wadsworth.
29 Hauer, B., Wessel, I. & Merckelbach, H. (2005). Over algemene herinneringen bij depressie en bij de posttraumatische stressstoornis: de rol van intrusieve herinneringen *Tijdschrift voor Psychiatrie*, 47 (5), p. 299-308.
30 Gezondheidsraad / Health Council of the Netherlands (2004). *Omstreden herinneringen / Disputed memories*. Den Haag / The Hague: Gezondheidsraad / Health Council of the Netherlands.
31 See note 7.
32 Smeets, T., Candel, I. & Merckelbach, H. (2004). Accuracy, completeness, and consistency of emotional memories. *American Journal of psychology*, 117 (4), p. 595-609.
33 Hepp, U., Gamma, A. et al (2006). Inconsistency in reporting potentially traumatic events. *British Journal of Psychiatry*, 188, p. 278-283.
34 Krinsly, K., Gallagher, J. et al (2003). Consistency of retrospective reporting about exposure to traumatic events. *Journal of Traumatic Stress*,16 (4), p. 399-409.
35 Ghetti, S., Goodman, G. et al (2002). Consistency in reports of sexual and physical abuse. *Child Abuse and Neglect*, 26, p. 977-995.
36 Safer, M., Christianso, S. et al (1998). Tunnel memory for traumatic events. *Applied Cognitive Psychology*, 12, p. 99-117.
37 Candel, I. & Merckelbach, H. (2002). Het geheugen voor negatieve gebeurtenissen. *Nederlands Tijdschrift voor de psychologie*, 57, p,. 1-9.
38 Fisher, R. & Cutler, B. (1995). The relation between consistency and accuracy of eyewitness testimony. In G. Davies, S. Lloyd-Bostock, M. McMurran & C. Wilson (Eds), *Law and Criminal Justice: International developments in research and practice*. Berlin: De Gruyter.
39 Herlihy, J. & Turner, S. (2006). Should discrepant accounts given by asylum seekers be taken as proof of deceit. *Torture*, 16 (2), p. 81-91.
40 Doornbos, N. (2005). On being heard in asylum cases – Evidentiary assessment through asylum interviews. In G. Noll (Ed). *Proof, evidentiary assessment and credibility in asylum procedures*. Leiden: Martinus Nijhoff.
41 Cohen, J. (2002). Questions of credibility: omissions, discrepancies and errors in the testimony of asylum seekers. *International Journal of Refugee Law*, 3, p. 293-309.
42 Porter, S. & Birt, A. (2001). Is traumatic memory special? A comparison of traumatic memory characteristics with memory for other emotional life experiences. *Applied*

*Cognitive psychology*, 15, p. 101-117.

43 McNally, R. (2003). *Remembering trauma*. Cambridge: Harvard University Press.

44 Moulds, M. & Bryant, R. (2005) An investigation of retrieval inhibition in Acute Stress Disorder. *Journal of Traumatic Stress*, 18 (3), p. 233-236.

45 Bremner, J. (2002). Neuroimaging studies in posttraumatic stress disorder. *Current Psychiatry Reports*, 4, p. 254-263.

46 Pederson, C., Maurer, S. et al (2004). Hippocampal volume and memory performance in a community-based sample of women with posttraumatic stress disorder secondary to child abuse. *Journal of Traumatic Stress*, volume 17 (1), p. 37-40.

47 Hickie, I., Naismith, S. et al (2005). Reduced hippocampal volumes and memory loss in patients with early and late-onset depression. *British Journal of psychiatry*, 186, p. 197-202.

48 Nemeroff, C., Bremner, J. et al. (2006). Posttraumatic stress disorder: a state of the science review. *Journal of Psychiatric Research*, 40, p. 1-21.

49 Yehuda, R. (2004). Risk and resilience in posttraumatic stress disorder. *Journal of Clinical Psychiatry*, 65 (suppl. 1), p. 29-36.

50 Freeman, T., Kimbrell, T. et al (2006). *Evidence of resilience: neuroimaging in former prisoners of war*. Psychiatry Research: Neuroimaging, volume 146, p. 59-64.

51 Elzinga, B., Bremner, J. (2002). Are the neural substrates of memory the final common pathway in posttraumatic stress disorder (PTSD)? *Journal of Affective Disorders*, 70, p. 1-17.

52 Giezen, A. van, Arensman, E. et al (2005). Consistency of memory for emotionally arousing events: A review of prospective and experimental studies. *Clinical Psychology Review*, 25, p. 935-953.

53 Van der Kolk, B., Hopper, J. & Osterman, J. (2001). Exploring the nature of traumatic memories: Combining clinical knowledge with laboratory methods. *Journal of Agression, Maltreatment and Trauma*, 4, p. 9-31.

54 Williams, J. (1996). Depression and the specificity of autobiographical memory. In D.C. Rubin (Ed.), *Remembering our past: studies in autobiographical memory* (p. 244-267). New York: Cambridge University Press.

55 Hauer, B., Wessel, I. & Merckelbach, H. (2005). Over algemene herinneringen bij depressie en bij de posttraumatische stressstoornis: de rol van intrusieve herinneringen. *Tijdschrift voor Psychiatrie*, 47 (5), p. 299-308.

56 Cottencin, O., Vaiva, G. et al (2006). Directed forgetting in PTSD: a comparative study versus normal controls. *Journal of Psychiatric Research*, 40, p. 70-80.

57 Herlihy, J., Scragg, P. & Turner, S. (2002). Discrepancies in autobiographical memories – implications for the assessment of asylum seekers: repeated interview study. *British Medical Journal*, 324, p. 324-327.

58 Candel, I. & Merckelbach, H. (2004). Peritraumatic dissociation as a predictor of Post Traumatic Stress Disorder: a critical review. *Comprehensive Psychiatry*, 45, p. 44-50.

59 Van der Kolk, B. & Fisler, R. (1995). Dissociation and the fragmentary nature of traumatic memories: overview and exploratory study. *Journal of Traumatic Stress*, 8 (4), p. 505-525.

60 Foa, E. & Hearst-Ikeda, P. (1996). Emotional dissociation in response to trauma; an

information-processing approach. In L.K. Michelson & W.J. Ray (Eds.), *Handbook of dissociation: theoretical, empirical, and clinical perspectives* (p. 207-222). New York: Plenum.

61 Nijenhuis, E., Van Dyck, R. et al (1998). Degree of somatoform and psychological dissociation in dissociative disorders is correlated with reported trauma. *Journal of Traumatic Stress*, 11 (4), p. 711-730.

62 Candel, I. & Merckelbach, H. (2004). Peritraumatic dissociation as a predictor of Post Traumatic Stress Disorder: a critical review. *Comprehensive Psychiatry*, 45, p. 44-50.

63 Spiegel, D., Koopman, C. et al (1996). Dissociative symptoms in the diagnosis of acute stress disorder. In L.K. Michelson & W.J. Ray (Eds.), *Handbook of dissociation: theoretical, empirical, and clinical perspectives* (p. 367-380). New York: Plenum.

64 Panasetis, P. & Bryant, R.A. (2003). Peritraumatic versus persistent dissociation in Acute Stress Disorder. *Journal of traumatic Stress*, 16 (6), p. 563-566.

65 See note 58.

66 Van der Hart, O. & Nijenhuis, E. (2001) Generalized dissociative amnesia: Episodic, semantic and procedural memories lost and found. *Australian and New Zealand Journal of Psychiatry*, 35 (5), p. 589-600.

67 Laban, C., Gernaat, H. et al (2004). Impact of long asylum procedure on the prevalence of psychiatric disorders in Iraqi asylum seekers in the Netherlands. *Journal of Nervous and Mental Disease*, 192, p. 843-851.

68 Groen, M. (2003). De samenhang van schaamte en geweld. *Tijdschrift voor Psychotherapie*, 29, p. 255-269.

69 Talbot, J., Talbot, N. & Tu, X. (2004). Shame-proneness as a diathesis for dissociation in women with histories of childhood sexual abuse. *Journal of Traumatic Stress*, 17 (5), p. 445-448.

70 Irwin, H. (1998). Affective predictors of dissociation. II. Shame and guilt. *Journal of Clinical Psychology*, 54, p. 237-245.

71 Tangney, J. & Dearing, R. (2002). *Shame and guilt*. New York: Guildford Press.

72 Andrews, B. (1995). Bodily shame as a mediator between abusive experiences and depression. *Journal of Anormal Psychology*, 104, p. 272-285.

73 Wong, M. & Cook, D. (1992). Shame and its contribution to PTSD. *Journal of Traumatic Stress*, 5 (4), p. 557-562.

74 Hynes, M. & Cardozo, B. (2000). Sexual violence against refugee women. *Journal of Women's Health & Gender Based Medicine*, 9 (8), p. 819-823.

75 Ventevogel, P. (2000). Ver-zwijgen en ver-werken. Niet praten als symptoom of als copingstrategie. *Medische Antropologie*, 12 (2), p. 237-242.

76 Bracken, P., Giller, J. & Summerfield, D. (1995). Psychological responses to war and atrocity: the limitations of current concepts. *Social Sciences and Medicine*, 40, p. 1073-1082.

77 Kirmayer, L. (1996). Landscapes of memory: trauma, narrative and dissociation. In P. Antze & M. Lambek (Eds.), *Tense Past: cultural essays in trauma and memory* (p. 173-198). New York: Routledge.

78 Tankink, M. (2000). Zwijgen. Het omgaan met oorlogsherinneringen in Zuidwest-Oeganda. *Medische Antropologie*, 12 (2), p. 207-224.

79 Tankink, M. (2004). Not talking about traumatic experiences: harmful or healing?

Coping with war memories in born-again churches in southwest Uganda. *Intervention. International Journal of Mental Health, Psychosocial work and Counselling in Areas of Armed conflict*, 2 (1), p. 3-17.

80 Coker, E. (2004). Travelling pains: embodied methaphors of suffering among Southern Sudanese rerefugees. *Culture, Medicine & Psychiatry*, 28 (1), p. 15-39.

81 Vloeberghs, E. & Rohlof, H. (2000). Praten of zwijgen over oorlogsherinneringen. *Medische Antropologie*, 12 (2), p. 243-246.

82 Vloeberghs, E. & Groot, I. de (1996). Nous sommes tous traumatisés. Kanttekeningen bij PTSS en cultuur in een Ruandees vluchtelingenkamp. *Medische Antropologie*, 8 (1), p. 129-142.

83 Bar-on, D., Eland, J. et al (1998). Multigenerational perspectives on coping with the holocaust experience: an attachment perspective for understanding the developmental sequelae of trauma across generations. *International Journal of Behavioral Development*. 22 (2), p. 315-338.

84 Rousseau, C., Crépeau, F. et al (2002). The complexity of determining refugeehood: a multidisciplinary analysis of the decision-making process of the Canadian Immigration and Refugee Board. *Journal of Refugee Studies*, 15 (1), p. 43-70.

85 See note 7.

86 See note 4.

87 See note 25.

88 See note 78.

89 Bloemen, E. (2003). Hippocrates in het aanmeldcentrum. De AC-procedure vanuit medisch perspectief. In A. Terlouw, *Binnen 48 uur. Zorgvuldige behandeling van asielverzoeken?* (p. 103-115). Nijmegen: Wolf.

90 Cohen, J. (2001). Errors of recall and credibility: can omissions and discrepancies in successive statements reasonably be said to undermine credibility of testimony? *Medico-Legal Journal*, 69 (1), p. 25-34.

91 Silove, D., Steel, Z. & Watters, C. (2000). Policies of deterrence and the mental health of asylum seekers in western countries. *Journal of the American Medical Association*, 284, p. 604-611.

92 See note 27.

93 See note 7.

94 Matsuo, K., Taneichi, K. et al (2003). Hypoactivation of the prefontal cortex during verbal fluency test in PTSD: a near-infrared spectroscopy study. *Psychiatry Research: Neuroimaging*, 124, p. 1-10.

95 Vos, P. (1988). *Bourdon-Vos. Test manual*. Lisse: Swets-Zeitlinger.

96 Wechsler, D. (1987). *Wechsler Memory Scale – Revised (WMS-R)*. San Antonio: Psychological Corporation.

97 Burnett, A. & Peel, M. (2001). Asylum seekers and refugees in Britain: The health of survivors of torture and organised violence. British Medical Journal, 322, p. 606-609.

98 Turner, S., Bowie, C. et al (2003). Mental health of Kosovan Albanian refugees in the UK. *British Journal of Psychiatry*, 182, p. 444-448.

99 See note 67.

100 Fernandez, M., Pissiota, A. et al (2001). Brain functioning in a patient with torture

related posttraumatic stress disorder before and after fluoxitine treatment: a positron emission tomography vocation study. *Neuroscience Letters*, 297, p. 101-104.

101 Hordijk-Dekker, M. (2003). Langdurige pijnklachten bij vluchtelingen. *Handboek Interculturele Zorg, II* 3.3.1. Maarssen: Elsevier/ De Tijdstroom.

102 Terr, L. (1994). *Unchained memories: True stories of traumatic memories, lost and found*. New York: Basic Books.

103 Rothschild, B. (2000). *The body remembers. The psychophysiology of trauma and traumatreatment*. New York: Norton.

104 Levine, P. (2006). *Memory, Trauma and healing*. www.traumahealing.com/art_memory.html.

105 Van der Kolk, B. (1994). The body keeps the score: memory and the evolving psychobiology of post traumatic stress. *Harvard Review of Psychiatry*, 1, p. 253-265.

106 Kleinman, A. (1987). Anthropology and Psychiatry. The role of culture in crosscultural research on illness. *British Journal of Psychiatry*, 151, p. 447-454.

107 See note 21.

108 Mayou, R., Kirmayer, L., et al (2005). Somatoform disorders: Time for a new approach in DSM-V. *American Journal of Psychiatry*, 162, p. 847-855.

109 Asmundson, G., Coons, M., et al.(2002). PTSD and the experience of pain: research and clinical implications of shared vulnerability and mutual maintenance models. *Canadian Journal of Psychiatry*, 47, p. 930-937.

110 Palyo, S., & Beck, J. (2005). Posttraumatic stress disorder symptoms, pain, and perceived life control: associations with psychosocial and physical functioning. *Pain*, 117, p. 121-127.

111 Iezzi, T., Archibald, Y., et al (1999). Neurocognitive performance and emotional status in chronic pain patients. *Journal of Behavioural Medicine*, 22, p. 205-216.

112 Sharp, T. & Harvey, A. (2001). Chronic Pain and posttraumatic stress disorder: mutual maintenance. *Clinical Psychology Review*, 21, p. 857-877.

113 Hondius, A., Van Willigen, L. et al (2000). Health problems among Latin-American and Middle-Eastern refugees in the Netherlands: relations with violence exposure and ongoing sociopsychological strain. *Journal of Traumatic Stress*, 13 (4), p. 619-634.

114 Marsella, A., Bornemann, T. et al (Eds). (1998). *Amidst Peril and Pain*. Washington DC: American Psychological Association.

115 Van Velsen, C., Gorst-Unsworth, C. & Turner, S. (1996). Survivors of torture and organised violence: Demography and Diagnosis. *Journal of Traumatic Stress*, 9, p. 181-193.

116 Van Ommeren, M., Sharma, B., et al (2002). The relationship between somatic and PTSD symptoms among Bhutanese refugee torture survivors: Examination of comorbidity with anxiety and depression. *Journal of Traumatic Stress*, 15, p. 415-421.

117 Blagrove, M., Alexander, C. & Horne, J. (1995). The effects of chronic sleep reduction on the performance of cognitive tasks sensitive to sleep deprivation. *Applied Cognitive Psychology*, 9, p. 21-40.

118 See note 14.

119 See note 7.

120 MacDonald, B., Mummery, C. & Heaney, D. (2001). Health needs of asylum seek-

ers and refugees. Head injury needs to be taken into consideration in survivors of torture (letter). *British Medical Journal*, 323, p. 230.

121 See note 90.

122 Herlihy, J., Ferstman, C. & Turner, S. (2003). Legal Issues in Work with Asylum Seekers. In J. Wilson & B. Drozdek (Eds), *Broken Spirits: the Treatment of Traumatized Asylum Seekers, Refugees, War and Torture Victims*. New York: Brunner Routledge.

123 Norfolk, G. (1999). Physical illnesses and their potential influence. In A. Heaton-Armstrong, E. Shepherd & D. Wolchover, *Analysing Witness Testimony*. London: Blackstone.

124 See note 105.

125 Terr, L. (1994). *Unchained memories: True stories of traumatic memories, lost and found*. New York: Basic Books.

126 See note 4.

127 See note 40.

128 Mehta, K. & Vankar, G. (2005). On the validity of the construct of posttraumatic stress disorder in a low-income country. *British journal of Psychiatry*, 187, p. 585-586. And: *Assessing Afghan children's psychosocial well-being: a multi-modal study of intervention outcomes* (2005). Christian Children's Fund, University of Oxford, and Queen Margaret University College, Edinburgh (www.forcedmigration.org/psychosocial/papers/afghan_report_ccf_ox_qmuc.pdf).

129 See note 77.

130 Shuman, A. (2004). Representing trauma: political asylum narrative. *Journal of American Folklore*, 117, p. 394-414.

131 See note 36.