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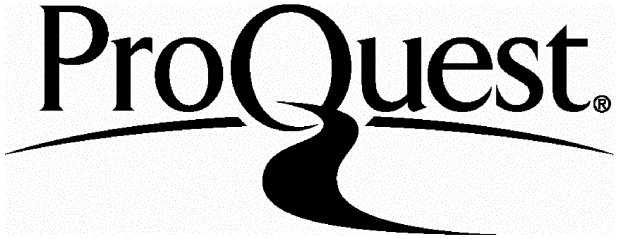

Discrepancies in Autobiographical Memories : Informing the Asylum Seeking Process

JANE HERLIHY

D.Clin.Psy 2000

University College London

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Abstract

Memory is known to be affected by trauma. High levels of emotion can have the effect of fixing highly vivid recollections of key moments of the traumatic experience (e.g. van der Kolk, 1996a). Similarly, 'flashbulb memories' may be retained of major news events (Larsen, 1992). High emotion has also been shown to cause a preferential recall of central, key events of a narrative, with an associated difficulty in recalling peripheral details of the same narrative (Christianson, 1992). However, laboratory testing shows a robust effect of inconsistency over time: most people remember different details if tested more than once (Roediger, McDermott, & Goff, 1997). Very few studies have investigated the processes involved in the inconsistency of recall in applied settings.

The effects of traumatic experience on memory processing is critical to many of the refugees who claim asylum in this country (Turner 1996). By definition, refugees have undergone life-threatening experiences - many in situations of war or torture, and a number of surveys have shown high levels of anxiety disorders in this population (eg. Silove, Sinnerbrink, Field, Manicavasagar, & Steel, 1997). The process of seeking asylum in this country is dependent on the individual giving an accurate and consistent account of her experiences. If such an individual is interviewed more than once, when submitting an appeal, for example, she may be rejected if there are discrepancies between the two accounts. The discrepancies are seen as detrimental to the credibility of the claimant.

The current study aims to replicate a part of the asylum process and investigate relationships between trauma and the consistency of recall. Participants were interviewed twice - on each occasion they were asked to recall a traumatic event and a happy event, and a standard set of details were elicited for each one. They were asked to rate each detail as central to their experience, or peripheral. This was repeated at the second interview, with the exception of the ratings. Participants also completed measures of Post-Traumatic Stress Disorder (Foa, Cashman, Jaycox, & Perry, 1997), Depression (BDI

: Beck, 1967), Dissociation (DES-8: Waller, Putnam, & Carlson, 1996) and Overgeneral Memory (ABMT: Williams & Dritschel, 1988).

The number of discrepancies was counted for each participant. Discrepancies are defined as details which contradict each other, whether within the same account, or between the first and second accounts. Significant new information, added at the second interview, was also added to the discrepancy count. This mirrors Immigration Office procedures (Home Office, 1998). These counts were second-rated by a trainee immigration lawyer to provide reliability data and an informal indication of validity.

There were discrepancies between individuals' first and second accounts. Quantitative analyses showed that discrepancies were associated with the length of the delay between interviews and with the severity of PTSD symptomatology. Discrepancies were more likely in details rated as peripheral than central details. The findings of the overgeneral memory literature were partially replicated in this sample: higher levels of depressive symptomatology were associated with more overgeneral memory.

The findings are considered in the light of current theoretical approaches to memory, and implications for the asylum process are outlined. It would seem that the assumption that genuine asylum seekers' memories are consistent may be an invalid basis for immigration decisions.

Note on language and reference to ethnic groups :

Serbo-Croat has long been the language of the Balkan states. Since the Bosnian war rapid changes have been perceived in the language spoken in Bosnia, Croatia and other regions of the former Yugoslavia.

Following the advice of Bosnian ex-patriates in this country, the language used in this study will be referred to as Bosnian.

All of the Kosovan group in the study were Kosovan Albanians. I have referred to these participants as Kosovans throughout the thesis. This is for the sake of ease alone, but its inaccuracy should be recognised, as it fails to acknowledge inhabitants of that region from different ethnic backgrounds.

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1 Introduction

1.1 Introduction to the thesis

The way in which an asylum seeker recalls information can seriously jeopardise their chances of asylum in this country (Turner, 1998). This study aims to bring findings regarding memory to bear on the process of seeking asylum in the United Kingdom.

This first chapter will briefly describe the process of seeking asylum in the United Kingdom and present some evidence that delays in this process may be detrimental to applicants' mental health. It will then present a review of areas of memory research within the psychology literature and discuss how they might be applied in order to help inform the decision-making involved in the asylum process. Finally, the recorded incidence of trauma in refugees will be examined, before outlining the hypotheses of this study.

The Method chapter will describe the measurement instruments used, discussing their reliability and validity by drawing on previous studies in which they have been employed. The procedure followed for the recruitment and interviewing of participants will be detailed, and clinical and ethical considerations arising from this contact will be discussed.

In the Results chapter, the quantitative data collected will be presented and statistical tests will be described showing where significant findings have been made.

Finally, the results of the study will be considered in the light of the clinical and academic literature on memory. Careful examination will be made of the pertinence of the findings to the process of asylum interviewing in this country.

1.2 Claiming asylum

1.2.1 Description of the asylum process

If it is established that an individual is a refugee, then they are eligible for asylum (United Nations High Commission for Refugees, 1992). In order to gain refugee status the individual has to establish that they have a well-founded fear of persecution in their home country, on the grounds of race, religion, nationality, membership of a particular social group or political opinion (Home Office, 1998). This claim is established on the basis of an interview, and may be supported by a written statement. Discrepancies can arise in the applicant's account, as differences between the written statement and the information given at interview or as failures to remember details of events and the facts surrounding. These discrepancies can significantly jeopardise the credibility of the claimant and increase the likelihood of their application being refused. At the appeal stage, further written statements and documentation may be submitted in support of the appeal. Details which appear to contradict the applicants' initial account can similarly lead to refusal on the grounds of credibility.

The following is taken from the Home Office guidelines on how to inform an asylum applicant that they have not been granted refugee status.

"The Secretary of State noted that there were significant differences between your various accounts, and that these cast doubt on the credibility of your claim. He considered that, had the events in your later account occurred as you claimed, it was reasonable to expect that you would have mentioned them at the earliest opportunity."

(Home Office, 1998 : Chapter 11, Section 1 The Reasons for Refusal Letter)

1.2.2 Examples of discrepancies from asylum/appeal reports

Asylum Aid are a group with charitable status, who offer legal representation and personal support to asylum seekers. Their report, first published in 1995 and updated in 1999, outlines some of the problems with the reasons for refusal given to asylum applicants. In particular they give some examples of discrepancies in accounts which have been part of the reasons for refusal of actual asylum applicants. It should be noted that Asylum Aid were satisfied that all of the individuals cited had evidence of persecution in their country of origin, and a genuine fear of imprisonment, torture or death if they returned (Asylum Aid, 1999:4).

"a Kurd was cross-questioned during his appeal: Why had he told the interviewing officer that he left his country in June, when he later said it was July?"

(Asylum Aid, 1999:28)

"one Kurd ... was refused asylum partly on the basis of discrepancies in certain dates he had mentioned. These included that he had said that the military coup in Turkey occurred in 1979, rather than 1980"

(Asylum Aid, 1999:28)

" A member of the Algerian FIS (Front Islamique de Salut) had his credibility queried because he got the year of the banning of FIS right (1992) but the month wrong." (Asylum Aid, 1999:28)

These examples clearly illustrate that the Immigration Service decision-making may often rely on an assumption that memory is consistent and reliable.

The following example is taken from a refusal letter to an asylum seeker. It concerns the accuracy of memory, rather than merely consistency:

"You then stated that you remained at a friend's house until 30 October, 1995, when your parents telephoned to let you know that sentence had been passed on Ken Saro-Wiwa. [The Secretary of State] is aware that sentence was passed on Ken Saro-Wiwa ... on 31 October, 1995. [He] is of the opinion that these discrepancies must cast doubt on the credibility of your claim"

(Asylum Aid, 1999:1)

The last example illustrates a different aspect of the assumptions made about the disclosure of difficult material.

> "One woman failed to reveal in an initial statement that she had been raped by soldiers who had arrested her... She only revealed this later, at an interview with the Home Office. [They] stated that this was a discrepancy which showed she was lying."
>
> (Asylum Aid, 1999:29)

A report by Turner (1998) proposes a number of areas which need to be explored when assessing the significance of such discrepancies between accounts. Communication and interview skills on the part of immigration officials are crucial to the quality of the information obtained. There are also particular issues in the interviewing of asylum seekers who may have significant difficulties with trust of state representatives, due to their experiences in their own country. Cultural differences and gender may also be significant in the disclosure of difficult material, such as sexual assault. Sexual torture in particular carries with it a high likelihood of shame, making disclosure difficult, subject to delay and, in some cases effectively impossible for the individual concerned.

Turner (1998) also highlights the role of mental illness in the asylum seeker's capacity for consistent recall. He identifies both concentration and memory as areas which are impaired by various psychological disorders and which are likely to have a significant impact on asylum seekers' ability to describe their experiences. Following this report,

the current study will focus on memory. Firstly I will briefly explore links between mental health and seeking asylum.

1.2.3 The asylum process and mental health - a vicious circle?

There is some evidence that the very process of applying for asylum in a host country can be inimical to mental health. Silove et al. (1993) describe the 'risk of re-traumatization'. They argue that detention, uncertainty and the fear of being returned to the country of origin may compound existing mental health problems. In a survey of 36 asylum seekers in Australia (Silove et al., 1997), all participants indicated that fear of being repatriated was a problem and 29 (81%) rated this as 'serious' or 'very serious' on a five point scale. Being unable to return home in an emergency, another consequence of having no legal status, was endorsed by 26 participants (72%), and 20 (56%) rated this as a serious/very serious problem.

That the specific features of the asylum seeking procedure are responsible for mental health problems is contested by Rodenburg et al. (Rodenburg, Hovens, & Kleijn, 1997). They compared refugees (who have been granted legal status) with asylum seekers (who are awaiting the granting of refugee status) at a centre for trauma in The Netherlands. Their survey data showed equally high levels of trauma symptomatology in both groups. They argue that both refugees and asylum seekers suffer difficult social circumstances, which will affect their mental health. However, given their statement that they see 'the most severe cases' of both groups, they do not consider the possibility of a ceiling effect

in their measures of psychopathology. If both refugees and asylum seekers score very highly, it may be difficult to distinguish them on the basis of these data.

Notwithstanding this argument, Silove et al. (1997) raise the question of whether the asylum process exacerbates mental illness, or whether there is a more complex, perhaps circular process at work. It is possible that the symptoms of anxiety disorders, for example, heightened irritability, may cause individuals to 'interact in a conflictual manner'. Interacting in a conflictual manner may in turn adversely affect the treatment they receive within their host state. Thus drawn-out decision making in the asylum process may adversely affect the individual's mental health, but at the same time, the individual's disturbed mental functioning in turn adversely affects his interactions with those considering the asylum application. Consider the fictitious example of an asylum seeker, made increasingly anxious by the long delays, who believes his case is not being considered and absconds from a detention centre. The claim is consequently refused. An appeal, which takes a further two years to process, may then cause more anxiety.

The current study will investigate another mechanism by which mental health has a direct impact on the ability of asylum seekers to successfully present their case to the Immigration Office. If memory is impaired due to trauma, such individuals may find it difficult to give a consistent account of their experiences. Further weight is thus added to the importance of the mental health of the asylum seeker in determining the outcome of their asylum application.

1.3 Memory

1.3.1 Introduction

In this section, a broad range of evidence concerning memory will be considered. A very brief outline will be given of the theoretical stances taken to autobiographical memory. Brewer (1986) distinguishes 'copy theories' from 'reconstructive theories' of memory. I will briefly consider each of these accounts of autobiographical memory, which will provide a framework for considering the literature reviewed in the rest of the section. I will then address what has been described as the 'raging debate' (Southwick, Morgan, Nicolaou, & Charney, 1997) concerning the consistency of memory. Firstly I will examine the evidence for the assertion that memory is consistent, particularly in the case of memory for traumatic events. Secondly I will review evidence that memory is, on the contrary, inconsistent. Finally, three areas of applied psychology literature will be reviewed: studies of memory in emotional disorder; the eye-witness testimony literature and studies of overgeneral memory. Each of these bodies of work suggest that memory is not simply poorer under different conditions, but that there are qualitative differences in the types of material recalled.

In all of the following sections, the focus will be on explicit memory, which is tested by recall tasks. Explicit memory is the material that is available to conscious awareness, as opposed to implicit memory, where the individual is not consciously aware of knowing the material. Explicit memory is known to be more susceptible to bias in certain emotional disorders (Williams, Watts, MacLeod, & Mathews, 1997) and seems to be

disrupted in extreme trauma (see below: e.g. van der Kolk, 1996a). It is also the type of memory that is needed in order to give information during the course of an asylum claim.

1.3.2 Models of autobiographical memory - a framework

1.3.2.1 Copy models of memory (Brewer)

What Brewer terms 'copy theories' of memory have long provided the most powerful analogy of memory (Brewer, 1986; Brewer, 1996). According to this approach, what we perceive in the present is stored in memory as a copy of those perceptions. This copy may then, over the course of time and influenced by interference from new experiences, decay. Decay in the copy explains the phenomenon of forgetting.

Two of the bodies of work presented below draw on the copy model of memory. Firstly, van der Kolk subscribes to this view of memory in his discussion of the 'memory trace' that is laid down to record an experience. He argues that the memory trace is stronger under conditions of extreme stress. (See below in section 1.3.3.1 - Traumatic memories). Secondly, the phenomenon of flashbulb memory is concordant with the copy model. Brown and Kulik (1977) describe memory processing at times of heightened arousal as a moment when the memory is instructed : "Now print!" This is discussed more fully below (section 1.3.3.2 - Flashbulb memory).

1.3.2.2 Reconstructive models

The broad alternative to 'copy theories' is that each retrieval of a memory is a reconstruction. The origin of this approach seems to have been in the description of a memory that is vividly recalled, and thus seems to be a 'copy' memory, but is then shown to be inaccurate (Brewer, 1996). This is the predominant view in the literature on eye-witness testimony, where it has been shown that the testimony of witnesses may be distorted by later misinformation about what they saw (Belli & Loftus, 1995). This effect is taken as a demonstration that memory is reconstructed, not fixed. It also has implications for the debate on recovered and false memories, a debate which is beyond the scope of the current discussion, but which is explored in Conway (1997).

The current study will attempt to investigate whether individuals give different answers to the same questions on two different occasions. If this is found to be the case, then explanations as to why are likely to come from reconstructive theories of memory.

1.3.3 Evidence that memory is consistent

Researchers who argue that traumatic memory is consistent draw on a number of bodies of research. Firstly, clinical research into the nature of flashbacks in sufferers of Post-Traumatic Stress Disorder (PTSD) suggests immutable memories of traumatic events. Secondly, flashbulb memory has been described as a fixed memory of public, emotional events. Thirdly, investigation into the quality of eye-witness testimony has shown how

the central gist of emotional events are well retained. These three bodies of research are briefly reviewed below.

1.3.3.1 Traumatic memories

Clinical researchers claim that individuals who have suffered traumatic experiences have a highly fixed, reliable memory of the event (e.g. van der Kolk, 1999). Flashbacks experienced by sufferers of PTSD are taken to be illustrations of this - and as such are one of the diagnostic criteria of PTSD (American Psychiatric Association, 1994). Flashbacks are highly vivid, clear images (they may be visual, olfactory, auditory or kinaesthetic) of the traumatic event.

Van der Kolk (van Der Kolk, 1996a) reviews studies showing that reports of personally significant events are likely to remain stable over time, and would seem to be on the side of the debate that sees traumatic memory as indelible. In the case of individuals diagnosed with PTSD, he found

> "no published accounts in the scientific literature of intrusive traumatic recollections of traumatic events in patients suffering from PTSD that had become distorted over time."
>
> (van der Kolk, 1996a:282)

Van der Kolk also proposes a physiological mechanism by which traumatic memories can become unusually fixed. He refers to the same processes considered by Southwick

et al. (Southwick et al., 1997) to explain flashbulb memories. At times of high stress, higher levels of norepinephrine are secreted, which has the effect of strengthening the memory trace which is laid down at that time. Such memories, stored at times of high arousal, are also more easily accessible at times of high arousal. The accessing of traumatic memories then, in turn, triggers physiological arousal :

> "it is likely that the frequent reliving of a traumatic event in flashbacks or nightmares causes a re-release of stress hormones, and that this further strengthens the memory trace"
>
> (van der Kolk, 1996a).

However, according to this body of work, the quality of those memories is quite distinct from that of non-traumatic memories. Traumatic memories tend to be perceptual and emotional rather than declarative. They are often only in the form of what seems to be physical re-enactment of the traumatic event, without any conscious narrative. The unintegrated nature of the memories into consciousness is made worse by dissociation (a discussion beyond the scope of the current thesis) (see van der Kolk, 1996a).

Such a view is compatible with the literature on eye-witness testimony (see below) where it is proposed that, at times of high emotional arousal, the attention is narrowed. Van der Kolk suggests (following Pierre Janet) that attention can narrow to the extent that there is complete amnesia for the event at a conscious level (van der Kolk, 1996a). Since such a

memory cannot be integrated into a meaningful narrative, it remains unprocessed and fixed.

Another proposed form of memory, which supports the proposition that memory is consistent over time is the *flashbulb memory.*

1.3.3.2 Flashbulb memory

This term has been used in the memory literature to describe vivid memories of traumatic events, in which hearing news of an upsetting event seems to produce not only good memory of the news itself, but also of the circumstances in which the news was heard. The flashbulb effect has been shown many times (Christianson & Safer, 1996), originating with the classic example of people knowing what they were doing when they heard that J.F. Kennedy had been shot (e.g. Brown & Kulik, 1977).

One of the frameworks used to explain the flashbulb memory effect is that heightened arousal facilitates the memory of events experienced in that state (LeDoux, 1992). Southwick et al. (Southwick et al., 1997) cite studies proposing that 'highly arousing events cause an overstimulation of endogenous stress hormones, resulting in an overconsolidation of memory'. The relationship between arousal and memory is described as an inverted U relationship (Revelle & Loftus, 1992). Low arousal has little effect on memory processing; as arousal increases, memory processing is facilitated, but very high levels of arousal are inhibitory. So it may be that flashbulb memories are due to ideal levels of arousal.

However, it is not clear that this evidence can be applied to individuals exposed to traumatic experiences for two reasons. Firstly, it cannot be claimed that hearing that a president has been shot has the same salience to the individual as being held at gunpoint or raped (van der Kolk & Fisler, 1995). Secondly, most of the events used to study flashbulb memory have been national events, highly socially shared. In the minutes following such news, it can be expected that people will talk to those around them, elaborating the experience and fixing the immediate situation in their memory. In contrast, many people experiencing traumatic events find themselves intensely isolated (Joseph, Williams, & Yule, 1997).

1.3.3.3 Eye-witness testimony

This literature will be considered in more detail in a later section. One of the main findings in this area is that, for events which have a high level of emotional impact, the central details of the event will be well remembered by witnesses. It is included here as it is often cited as evidence that memory is consistent for traumatic experiences.

Wagenaar and Groeneweg's (1990) study of concentration camp survivors is also often cited in support of the proposition that memory for traumatic events is reliable. They compared responses over two interviews with survivors of a Nazi concentration camp in The Netherlands. The first set of interviews took place between 1943 and 1948, the second set between 1984 and 1987. They found that certain 'basic facts' about life in the camp were mentioned spontaneously by between 36 and 42 of the 55 interviewees

Wagenaar & Groeneweg, 1990. However, they also outline a considerable number of inconsistencies, which will be examined in later sections (see section 1.3.4.3 - Studies outside of the laboratory).

In summary, van der Kolk (van der Kolk, 1996a; van der Kolk, 1999) does propose enduring memories, but of a highly specific type. Furthermore, Christianson and Safer (Christianson & Safer, 1996) conclude that the 'flashbulb memory' effect, together with eye-witness testimony studies demonstrate that traumatic events are well-remembered. However, this would seem to be too sweeping a generalisation, given the implied inclusion of some very different types of events within the same conclusion: van der Kolk refers to memories for experiences such as rape; flashbulb memories are typically of political events and the events used in eye-witness studies range from witnessed armed robberies to constructed videos of violent events.

1.3.4 Evidence that memory is inconsistent

In this section, I will firstly review studies of normal (non-traumatic) memory. It will be seen that repeated attempts to remember the same material in laboratory conditions can result in inconsistency in the details recalled. I will then consider a small number of studies which have examined repeated recall under more life-like conditions.

1.3.4.1 The effects of repeated recall

Conway states that, in laboratory studies of free recall, using non-traumatised participants,

> "when the same memory is recalled on subsequent occasions the content of the memory varies. Only about 60 per cent of the content is the same from one recall to the next, demonstrating an instability in the content of memories."
>
> (Conway, 1997)

There are four long-established mechanisms by which the content and amount of recalled material will change from one instance of testing to the next.

The most intuitively obvious mechanism is *forgetting*. A full discussion of the mechanisms proposed to explain the decreasing availability or accessibility of learned material is beyond the scope of the current discussion. However, the effects of forgetting are in contrast to three mechanisms by which new material may become available for recall over successive trials.

The first mechanism is known as the *testing effect* and is well recognised in all areas of psychology research. Put simply, the more often an individual is shown and asked to recall the same material, the more of the material she or he will retrieve each time. This picture is complicated by methods of testing and the use of cues, but the overall effect is robust (Roediger et al., 1997).

The second mechanism is *reminiscence*, which was first identified by Ballard (Ballard, 1913). In his study children were taught a poem and then tested periodically for one week. He found that they frequently recalled new lines on later tests. The children may have been forgetting some information, but they were also retrieving information on later trials that they had failed to retrieve earlier.

The third mechanism at work is *hypermnesia*, when more material overall (having been presented only once) is remembered over repeated recall tests. Studies reviewed by Roediger et al. (Roediger et al., 1997) show a steady increase in the amount of material recalled over repeated testing episodes. This will happen when the amount of reminiscence is outweighing the amount of forgetting.

In a review of experimental work on memory, Roediger et al. (Roediger et al., 1997) conclude both that "intertest recovery is observed in virtually all experiments [of] more than one free recall test" [p.122] (*reminiscence*) and that "improvement in overall recall over repeated free or forced recall tests is now a well-established ... phenomenon" [p.123] (*hypermnesia*).

1.3.4.2 Limitations

Although these phenomena have proved to be robust in the laboratory, there are three major limitations. The first is that studies are needed to show that the laboratory findings do generalise to more natural conditions. The second important limitation of the

laboratory studies of repeated recall is that the retention periods are generally very short – a matter of minutes or hours. In the case of the autobiographical memories which are the focus of the current study, the events to be recalled have happened years ago. Thirdly, this literature has nothing to say about the effects of emotional states on repeated recall.

1.3.4.3 Studies outside of the laboratory

The limitations of the laboratory studies of repeated recall are addressed by a small number of more ecologically valid studies.

One of these is a suggestive study by Williams and Hollon (Williams & Hollon, 1981). They asked four adults to recall, over daily tests for two weeks, the names of people who had been in their classes at school. Although the overall number of names recalled increased, they were also able to show that this was largely due to erroneous names being produced. Clearly such a study would benefit from being replicated with a larger participant group.

Interestingly, the same effect has been shown robustly in experimental work by Roediger and McDermott using a 'false memory' inducing word list paradigm, where the more times recall is tested, the more likely individuals are to recall the material, but at the cost

of an increase in false recall (Roediger and McDermott, 1995, cited in Roediger et al., 1997).[1]

A study of repeated recall over a very long period of time is that by Wagenaar et al. (Wagenaar & Groeneweg, 1990). They compared interviews with survivors of a Nazi concentration camp in The Netherlands. The first set of interviews was conducted immediately following the war; the second forty years later. Although much of the life of the camp was remembered, they also present data that show that many details, such as dates, names and events had been forgotten over the intervening period. When reporting the date on which they had entered the camp, for example, 11 individuals were inaccurate, but mostly by less than one month. Forty years later, eighteen interviewees gave the wrong date, and eleven of these were wrong by more than one month. Three individuals are quoted as being six months out, reporting arriving in the winter when it had in fact been July (Wagenaar & Groeneweg, 1990:80,81).

Wagenaar and Groeneweg's findings seem to demonstrate the effects of simple forgetting. The pattern shown by Southwick, Morgan, Nicolaou and Charney (1997) is more complicated. Fifty-nine veterans of the Gulf War completed a 19-item inventory of traumatic experiences one month and two years after the war. A comparison of the

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[1] **Recovered or false memories?**
There is a highly prolific debate concerning the difference between recovered and false memories, with particular application to the recall of childhood sexual abuse. The issue in the current context is not the accuracy of the recall, as we are not in a position to judge the truth or falsity of any autobiographical information given by refugees. We are only concerned with consistency over repeated instances of recall. Clearly any new memories, whether 'recovered' or 'false' will make for discrepancies between accounts and it is this which is of concern in the context of the asylum process.

responses showed that eighty eight per cent of the participants had changed their answer (from 'no' to 'yes', or from 'yes' to 'no') in the intervening period. Sixty-one per cent of the participants changed their answers on two or more items. This study also suggested a link between traumatic experience and the consistency of memory. The number of responses changed from 'no' at one month to 'yes' at two years was significantly positively associated with PTSD symptoms, as measured on the Mississippi Scale for Combat-Related Posttraumatic Stress Disorder (Southwick et al., 1997).

1.3.5 Qualitative differences

So far in considering the debate on memory consistency, I have focused on studies examining the amount of material that individuals can remember under different conditions. The outcome variables of these studies have been the number of words recalled (in laboratory tests) or the quantity of detail about witnessed events (flashbulb memories, eye-witness testimony, traumatic personal experiences).

Recent work has suggested looking beyond quantity to the qualitative aspects of recalled material (Williams, 1992). Such an approach may provide answers that are a helpful contribution to the debate over the consistency or inconsistency of memory. It would also be constructive for the current study to show not only that there are inconsistencies between repeated accounts, but to be able to make some prediction about the type of material that could give rise to inconsistency.

In the next section, I will consider investigations into the quality or nature of the material that is remembered under different conditions. Firstly I will look at the clinical literature on the effects of emotional disorder on memory performance. Then I will consider two bodies of work, eye-witness testimony and overgeneral memory studies, which investigate the parameters that predict particular types of material that tend to be recalled.

1.3.5.1 Emotional disorder and memory

A great deal of experimental research has focused on investigating memory performance in interaction with emotional disorders, particularly clinical depression and clinical anxiety.

Williams et al. (Williams et al., 1997) describe and review this work to date in a comprehensive examination of the theoretical aspects of emotion and cognition. A thorough discussion of the work in this area is beyond the scope of the current study. However, there do seem to be some robust findings that may inform a broad understanding of the effects of emotional disorder on cognitive processing.

Experimental findings regarding emotional disorder and memory

One generalisation that may be made concerns the differences in the cognitive processes affected by anxiety and depression. It seems that anxiety mostly affects earlier stages of processing. This has been demonstrated by studies showing attentional biases favouring the selection of negative and threat-related stimuli (e.g. MacLeod, Mathews, & Tata,

1986; Mathews, Mogg, Kentish, & Eysenck, 1995). Depression, on the other hand, seems to have most impact on the storage of material and subsequent retrieval. Williams et al. (1997) state that a range of studies, comparing depressed patients with controls, comparing patients when depressed and recovered, and correlating the severity of depression with memory performance demonstrate conclusively that free recall is problematic for clinically depressed individuals (Williams et al., 1997:55; Williams, 1992).

Focusing on memory, since that is the area of the current study, there are two main processes which might be affected by impaired performance: encoding and retrieval.

At the encoding stage there is evidence that people with emotional disorders are disadvantaged. Normally, when people are given words to learn they will tend, where possible, to structure them into semantic categories and use these categories as cues to recall (Tulving & Pearlstone, 1966; Basden, Basden, Bryner, & Thomas, 1997). There is some evidence that both anxiety and depression affect people's ability to do this (Williams et al., 1997:59). We know that when material is less elaborately encoded, it is likely to be less well remembered (Tulving, 1974).

Another possibility, which is compatible in a broad sense with the limited capacity model of the information processing paradigm, is that the level of effort available for both encoding and retrieval is diminished by emotional disorder. In a study that suggests evidence for this hypothesis, depressed patients and controls were presented with word

lists, in which some words had been repeated. The authors argued that stating whether words had been heard once or twice was an automatic task, whereas recalling the words was effortful. The depressed patients were impaired only on the effortful task, (i.e. recalling the words), compared to the controls (Roy-Byrne, Weingartner, Bierer, Thompson, & Post, 1986). This study is important in that it is one of the few which used clinical patients, rather than inducing low mood, or selecting students who score high on the BDI (Williams et al., 1997). Their findings also offer support for the fairly robust finding that memory deficits associated with clinical groups are more likely to be found in explicit memory than implicit memory (Williams et al., 1997:62).

In terms of the nature of material recalled, it is generally found that depressed patients show bias in the content of remembered material. A meta-analysis by Matt et al. (Matt, Vazquez, & Campbell, 1992) found that, on average, depressed patients recall 10% more negative than positive material, in contrast to non-depressed controls, who tend to recall 8% more positive than negative. Once again, hypotheses to explain such a bias focus on the resources allocated to elaboration of the material. Williams et al. describe this as "bias in the encoding and retrieval of the relations *between* items, rather than the integration or priming of item-specific information [as seen in anxiety]" (Williams et al., 1997:148). In other words, depressed individuals do not show a bias in their attentional processing of material, but do show bias in the elaboration of material, tending to form more associations for negative items. Those negative items will thus be more readily accessible. Anxious individuals on the other hand, will tend to show bias according to

the meaning, or content of the stimulus material (e.g. threat), and this will influence what is encoded.

PTSD and memory performance

So far the literature reviewed concerning memory performance and emotional disorders has focused on anxiety and depression. There are a small number of studies conducting standard neuropsychological testing of individuals with PTSD, which have shown specific memory deficits in this group.

One such study, by Yehuda et al. (1995) tested twenty subjects with PTSD, excluding concomitant psychiatric disorders, illicit or psychotropic drug use, head injury and loss of consciousness. They used the California Verbal Learning Test, in which a word list is learned by being presented and tested five times, before an interference list is presented and tested. Subjects are then tested on the first list immediately, and after twenty minutes. Yehuda et al. found that the amount of interference produced by the second list was significantly greater for the PTSD group than for the twelve matched comparison subjects. A similar study by Bremner et al. (1993) also shows a variety of memory deficits in a similar group of 26 Vietnam veterans with combat-related PTSD (and the same exclusion criteria).

However, both of these studies had fairly small subject groups and, whilst they were very clear in their selection of pure PTSD diagnosis, this might be said to have limited ecological validity, since co-morbid diagnoses with PTSD are so common (Van-Velsen,

Gorst-Unsworth, & Turner, 1996). Barrett et al. (Barrett, Green, Morris, Giles, & Croft, 1996) studied 2,490 Vietnam veterans and examined the combinations of common co-morbid diagnoses. They compared four groups: those with no current diagnosis, those with PTSD but no other diagnosis, those with both PTSD and another diagnosis (depression, anxiety or substance abuse) and those with other diagnoses but without PTSD. They found that the group with both PTSD and another diagnosis had highly significantly lower scores than all other groups on a variety of standardised neuropsychological tests of learning and memory, but that this difference was not evident for the group with PTSD alone. They concluded that PTSD alone is not enough to account for most deficits in cognitive impairment. Nonetheless they did replicate Yehuda et al.'s finding of an increased interference effect on the California Verbal Learning Test in the PTSD group.

1.3.5.2 Overgeneralised Memory

An area of memory research which investigates the quality rather than quantity of recalled material is the work on overgeneral memory. Much of this work has been developed with depressed individuals (e.g. Williams & Dritschel, 1988), but there is some evidence of overgeneral memory applying also to people who have had traumatic experiences (McNally, Litz, Prassas, Shin, & Weathers, 1994). These two areas of study are reviewed below.

Review of the evidence

In a study of mood-congruent recall, Williams and Broadbent (Williams & Broadbent, 1986) found, as hypothesised, that parasuicidal patients took longer than controls to retrieve positive memories. However, on examining the explanations for their data, they found that the longer latencies were due to the experimental group tending, as a first response, to give memories which were inappropriately general - or overgeneral. They defined overgeneral as memories referring to people, places, or activities where a time period was not referred to or was greater than one day.

These findings were replicated in a later study of patients who had taken an overdose, showing a robust overgeneral memory effect (Williams & Dritschel, 1988). Examples of overgeneral and specific responses to cue words used in this study are given in Table 1-1.

Cue Word	Control	Patient
HAPPY	The day we left to go on holiday	When I'm playing squash
SORRY	When I dropped something and my flatmates got annoyed	When I lie to my Mum
SAFE	In London last week getting off the bus at 4am.	When I'm at home in my house
ANGRY	With my supervisor on Monday	When I've had a row

Table 1-1 Examples of specific and overgeneral memories (Williams, 1995)

Williams and Dritschel's study compared a non-psychiatric control group with recent overdose patients and patients who had taken overdoses some months previously. They also measured current mood. This allowed them to show that overgenerality, whilst a robust phenomenon, was not due to current mood (there was no correlation between mood and tendency to overgeneral recall), nor recent events (since both overdose groups differed significantly from control groups, but were similar to each other). However, they also found that there were differences in the pattern of overgenerality. That is, current overdose patients were more overgeneral in their recall of positive memories, as found previously. However, ex-patients did not show this bias, leading the authors to conclude that

> "we need to distinguish between the overall tendency for memory to be overgeneral (for which a cognitive style explanation may be needed) and the relative tendency to be more over-general in positive than negative memories (for which an explanation in terms of recent life events may be more helpful)".
>
> (Williams & Dritschel, 1988)

In terms of the overall tendency to be overgeneral, two studies have suggested the development of a cognitive style in response to trauma. McNally et al. (McNally et al., 1994) compared overgeneral memory levels in Vietnam war veterans with PTSD and a matched group of "well adjusted combat veterans" (with no psychiatric diagnosis). They found that the PTSD group had higher levels of overgeneral memory. Given the high levels of comorbidity between PTSD and depression (20 out of 39 in their study), this might not be significantly different from the findings of Williams and colleagues.

However, they also found suggestive evidence that the underlying factor was combat exposure, since the levels of overgeneral memory in their well-adjusted veterans group was higher than those in the Williams and Dritschel's control group (they do not offer statistical significance levels). Williams and Dritschel's controls had overgeneral scores of 27% and 33% compared to 44% and 40% in McNally et al.'s control group (McNally et al., 1994). McNally et al.'s controls had had exposure to combat. However, they also had sub-clinical levels of PTSD, which could equally have accounted for their high scores.

Support for the proposition that exposure to distressing life events was implicated in overgeneral memory was provided by Kuyken and Brewin (1995). They found that higher levels of overgeneral memory were related to reported childhood sexual abuse, which they took to be an indication of a generally higher level of aversive life-events.

These two studies (Kuyken & Brewin, 1995; McNally et al., 1994) suggest a role for a history of trauma in the development of a pattern of overgeneral memory recall.

In a review of the evidence on overgeneral memory, Williams (Williams, 1995) summarised the findings as follows : -

1. overgeneral memory is found with a variety of cueing techniques (single word cues; adding more specific activity cues);
2. overgeneral memory is associated with both suicidal and depressed individuals;

3. overgeneral memory is not associated with all forms of emotional disorder; it is not found in generalised anxiety;
4. overgeneral memory is not state-dependent; when depressed mood is alleviated, the effect is still apparent.

Overgeneralised Memory - possible mechanisms

Williams (1995) proposes a mechanism by which memories might be organised in certain individuals which would account for their retrieval of overgeneral memories. Drawing on studies of child development, he suggests that the ability to suppress categorical memories in order to produce a specific instance of memory is something that has to be learned. For example, if asked to produce a happy memory, one would first think of 'things that make me happy', then perhaps 'playing squash, drinking beer'. These categories would then have to yield to the next level of search - the specific examples of squash games and beer drinking evenings. In certain individuals, Williams suggests, where the specific examples are too painful, they are avoided. So to the cue "unhappy", the thought 'I've always failed' is less painful than specific memories of failure, so the latter are not accessed. The mechanism by which this becomes a cognitive style may be shown diagrammatically. See Figure 1-1.

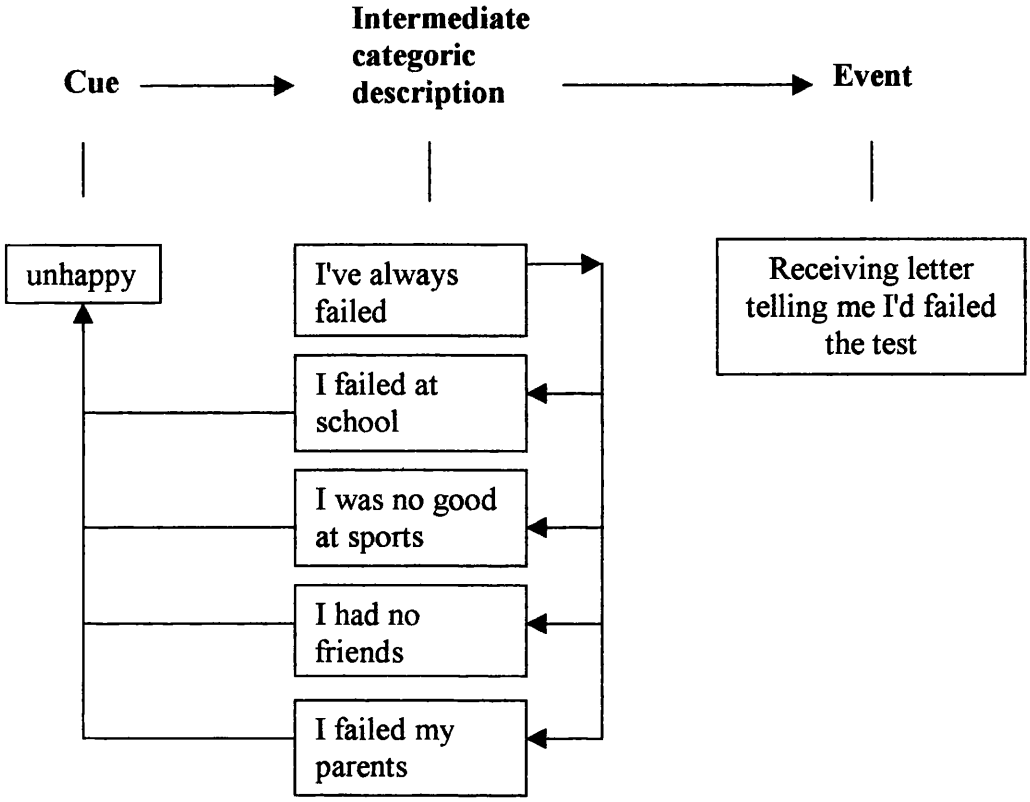

Figure 1-1 : Proposed mechanism of overgeneral memory adapted from Williams, 1995.

When a search for a specific memory is aborted, the retrieval mechanism attempts to search using another associative link - another categorical memory. When this too fails, a further iteration is attempted. An elaborated network of categorical memories is thus consolidated. Moreover, Williams (1992) suggests that it is at the categorical level that emotional, self-referential information is held, giving the result of "an over-elaboration of categories, encouraged by and itself encouraging ruminative self-focus". Williams cites evidence showing that asking participants to focus on memories that typified themselves in some way would exacerbate the overgeneral effect (Singer and Moffitt, 1992, cited in Williams, 1995)

What this explanation does not do is address the pattern of higher levels of overgeneralisation in response to positive cues. In a later review, Williams et al. (1997) suggest that this pattern is a function of recent life events. As McNally et al. (McNally et al., 1994) suggest, individuals who are ruminating about past negative events will have fewer positive cues available to them to help in the process of retrieval. Nonetheless, it is hard to understand how or why the preference for categorical memories described above would develop concerning positive events. These studies also leave open the question of whether it is possible to develop such retrieval strategies later in life.

Life events

The work on overgeneral memory does not target memories of trauma, but makes wider claims about the development of memory processing under the strain of continued traumatic experiences.

Williams' argument for the development of a categorical style of memory processing is based on an understanding of memory development in the child. What is less well understood is what happens in the adult, whose childhood was without trauma, who is then exposed to repeated, chronic trauma. Is it possible to develop this style later in life?

Vietnam war veterans with PTSD are known to report higher levels of childhood abuse, thus confounding McNally et al.'s PTSD group (McNally et al., 1994). In other words, this group are likely to have suffered trauma in their childhood as well as their adult lives. However, the higher levels of overgeneral memory in their well-adjusted veteran control group, compared to Williams and Dritschel's controls (Williams & Dritschel, 1988), do suggest that combat exposure might account for this.

Kuyken and Brewin (1995) suggest an alternative mechanism to Williams' developmental hypothesis. They found that overgeneral memory was associated with high levels of avoidance of abuse-related memories and quote McNally et al. (McNally et al., 1994) as also suggesting that overgenerality may be related to avoidance of trauma-related memory, rather than a result of childhood experiences. Williams (Williams, 1995; Williams et al., 1997) does also draw on studies in older adults and brain-damaged patients, suggesting that reduced working memory capacity can hinder the ability to inhibit categorical memories. If it is the case that adults who have experienced trauma in their adult lives show an overgeneral memory effect, then it may be as a result of the intrusion and avoidance seen following trauma.

1.3.5.3 Eye-witness testimony

I have examined some of the effects of emotion on memory functioning. Emotional disorder can not only affect the quantity of material recalled under various testing conditions, but the quality, or content of what is recalled. The following section examines the effects of distressing material on non-clinical groups. This area of work has focused on the experiences of witnesses in court who are asked to recall details of events. The events are often of a distressing nature. This literature has focused on the reliability and accuracy of the testimony given.

The eye-witness testimony literature is of interest to the current study, as it suggests that there are systematic differences between the types of details that are likely to be remembered following the witnessing of distressing events.

Experimental evidence

One of the classic studies in the eye-witness testimony literature was conducted by Loftus and Burns (1982). They showed individuals a film of a bank robbery with different endings. In both versions the bank robbers run away past a young boy wearing a sports shirt with a number on the back. In the neutral version the bank robbers turn, shoot the gun, not hitting anyone and run away. In the alternative ending, the robbers turn, shoot, hitting the boy in the face, which is shown in detail, and then run away. Recall of the story showed no difference in the memory of the central events and the gist of the story,

but participants shown the traumatic ending were significantly less likely to recall the number on the boy's back - a detail peripheral to the event depicted.

This effect has been found consistently over a number of experimental studies (Christianson & Safer, 1996). Central details are defined variously, but refer generally to the gist of the story - who did what to whom, as well as critical items, such as the presence of a gun. Indeed there is evidence of a specific 'weapon effect', whereby witnesses' attention is so drawn by the threatening weapon, that they are, it seems, less able to encode, or recall, other details of the situation (see Christianson & Safer, 1996). Peripheral details are defined as details which are not critical to the action of the event. In Christianson and Hubinette's study (Christianson & Hubinette, 1993 - see below), the date, the time and other people were used as examples of peripheral details.

In a real-life study, Christianson and Hubinette (1993) asked witnesses to a bank robbery, some of whom had been held at gunpoint, some of whom were bystanders, to report their emotions and the details that they could remember. The results reflected the findings from the experimental paradigms - namely that central details were recalled somewhat better than peripheral details. Furthermore, the memory of those held at gunpoint was more accurate, compared to security videos, than that of the bystanders. The researchers do not attribute this difference to emotional arousal, since they found no difference in reported emotional arousal between the two groups. However, it is not inconceivable that there would be a ceiling effect in the reporting of emotional reactions to such an event.

The debate on the retention of emotionally charged memories can in part be resolved by distinguishing in this way between central and peripheral details of a remembered event. The hypothesis that emotion facilitates memory seems to be supported for central details, or the gist of the event, whereas the hypothesis that emotion inhibits memory is supported for peripheral, unimportant (to the subject) details. Two statements clarify this position:

> "both autobiographical studies and laboratory studies suggest that highly negative emotional events are relatively well retained, both with respect to the emotional event itself and the central, critical detail information of the emotion-eliciting event" Christianson & Safer, 1996:220

and

> "memory for information *associated* with unpleasant emotional events, that is, information preceding and succeeding such events, or peripheral, noncentral information within an emotional scenario, seem to be less accurately retained." (my emphasis) (Christianson & Safer, 1996:220)

Limitations

The eye witness literature looks at the reliability of people's accounts of events they have seen. Experimental paradigms typically show a series of pictures, or a video. With the exception of a few studies, the participants are taken from general samples - often students - and the events they witness do not involve them personally, nor, as far as we

can be aware, do the events have any particular personal salience for them. We might call the scenes shown in these studies 'upsetting material' rather than trauma.

In order to explore what happens to memory processing when the individual is involved in a traumatic experience, autobiographical studies are needed. Christianson and Safer claim there is no qualitative difference between witnessing 'genuine trauma' and witnessing a simulated incident (Christianson & Safer, 1996:225). However, they do not provide evidence to support this view. A few studies do try to capture a salient emotion in the testing situation. Christianson and Nilsson (1984) tested recall of verbal information presented alongside forensic pathology photographs of disfigured faces, describing the pictures as "traumatic". It is highly unlikely, however, that the experience of looking at even these pictures captures the effects of a genuinely traumatic (life-threatening) experience, as described in the diagnostic criteria for Post-Traumatic Stress Disorder (American Psychiatric Association, 1994).

Yuille and Tollestrup (1992) argue that participants in eye-witness studies are typically 'uninvolved bystanders'. By this they mean that the experimental manipulations have low 'impact' in terms of personal consequences. High impact would mean personal threat and a major effect of high impact is increased arousal, or stress. Wessel and Merckelbach (1997) conducted a study using spider phobics in order to capture more closely the phenomena of 'high impact' emotion. They asked spider phobics to look at a jar containing a spider. In the room there were also a number of objects, such as a painted Chinese fan and toy animals. The spider phobics were less able to recall the

objects unconnected with the spider, compared to non-phobic controls. These results suggest that the findings of the eye-witness literature regarding central and peripheral details do generalise to more life-like stress provoking situations, and the researchers concluded that the use of phobic subjects might allow a more appropriate investigation of the predictions of this literature. Clearly more research in this area using clinical groups, as Wessel and Merckelbach (1997) suggest, would add to the quality of this literature.

1.3.5.4 Combining eye-witness testimony and overgeneral memory literature

The two literatures reviewed, on overgeneral memory and eye-witness testimony, focus on different aspects of exposure to trauma. Overgeneral memory studies are increasingly focused on individuals who have experienced long term or repeated trauma and these studies are finding explanations in the development of distinct memory processes. The eye-witness testimony field, and indeed much of the work on flashbulb memory and other instances of traumatic memory, focus on single traumatic witnessed events and the way in which these are represented in 'normal' memory.

People in the refugee population will often have been both witnesses to traumatic events *and* have been in life-threatening situations over a prolonged period. Thus we can expect both effects - i.e. eyewitness effects and overgeneralisation effects.

1.4 Refugees and trauma

Having reviewed the evidence for the effects of heightened emotion and traumatic experience on memory, the application of this literature to refugees will be examined. This section will review the evidence of trauma and mental disturbance in refugees and asylum seekers.

1.4.1 Incidence of trauma

A wide range of prevalence rates of mental illness has been reported in the literature on refugees. Silove et al. (1977), for example, reported that fifty percent of their sample of 40 asylum seekers in Australia had symptoms of mental illness. Approximately one quarter had clinically significant levels of anxiety; approximately one third had significant symptoms of depression and 14 (37%) of the 38 who reported a traumatic history met DSM-IV diagnostic criteria for PTSD. However, the most common diagnoses across studies are consistently Post-Traumatic Stress Disorder and the depressive disorders (Van-Velsen et al., 1996).

Ramsay (1993) conducted a retrospective survey of 100 refugees referred for psychiatric assessment at the Medical Foundation for the Care of Victims of Torture in London. Of this 100, who constituted refugees from a variety of regions, 42 (42%) were diagnosed with Major Depressive Disorder, 31 (31%) with PTSD, and 20 met diagnostic criteria for both disorders. Van-Velsen et al. (1996) reported a similar sample of 60 refugees, the majority of whom were asylum seekers referred to the Medical Foundation for the Care

of Victims of Torture. Of these, 31 (52%) met the diagnostic criteria for PTSD and 21 (35%) met the diagnostic criteria for Major Depressive Disorder.

In their review of the literature, Silove et al. (1997) found a range of reported prevalence of 42%-89% for depressive disorders and over 50% for PTSD across clinic based studies. In community based studies lower rates were found in some samples, but the higher levels found were very similar to the clinical samples – between 15% and 80% prevalence of depression and between 3.5% and 86% of PTSD. A similar review found studies primarily looking at South East Asians reporting rates of PTSD of between 10% and 86% (Thulesius & Hakansson, 1999). In a much larger survey, psychiatric interviews determined that 36% of 1,458 prisoners of war from Army camps in the former Yugoslavia met diagnostic criteria (DSM-III-R: American Psychiatric Association, 1987) for PTSD (de Zan, 1992).

In a small study of Bosnian refugees, Weine et al. (1995) reported that 15 of the 20 participants met the criteria (DSM-III-R) for at least one diagnosis. Thirteen met diagnostic criteria for PTSD and seven of them met the criteria for a depressive disorder (Dysthymia, Major Depressive Episode, Depressive Disorder Not Otherwise Specified).

A more exploratory study investigated the relationship between types of traumatic experience and prevalence and severity of PTSD in 209 women in Bosnia (Dahl, Mutapcic, & Schei, 1998). Of the whole group, 111 (53%) were classified as PTSD cases. When the women were grouped by trauma experience, the highest rate of PTSD

was 71%, in the group of women who had been in concentration camps and/or witnessed or experienced rape. This group was significantly distinct from the other trauma groups, all of whom had experienced incidents endangering their own lives or those of others close to them.

Only one study has been identified that specifically focuses on long term adjustment in refugees. This study compared the levels of psychopathology of 34 Bosnian refugees upon resettlement in the USA and twelve months later (Weine et al., 1998a). Weine et al. found that 25 individuals reported a decrease in severity of PTSD symptoms, eight an increase and one remained stable. Of the 25 cases of PTSD at the time of resettlement, 14 still met the diagnostic criteria and one new case arose.

1.4.1.1 Limitations

The main problem with this literature is that a large number of studies rely on clinical populations, thereby biasing the prevalence rates. The studies of Weine's group (Weine et al., 1995; Weine et al., 1998a; Weine, Kulenovic, Pavkovic, & Gibbons, 1998b; Weine et al., 1998c) in particular are confounded by their work with testimony therapy and suggest that suitable individuals are 'invited' to participate, suggesting a selection bias according to the needs of their work. Thulesius and Hakansson (1999) attempted to widen the base of their sample by approaching a large cohort of residents (206 took part) at an asylum centre. Unfortunately they used non-diagnostic self-report measures, which only enabled them to estimate caseness for each individual. Their estimated rates for PTSD

were between 18 and 33%, and for depression, 21%, somewhat lower than most of the clinic based studies.

There are also concerns with the use of the PTSD construct with certain groups. Van-Velsen et al (1996) recorded details of torture experience in a group of refugees in London, but failed to find significant statistical relationships between these and the diagnosis of PTSD. This counter-intuitive finding led them to explore the limitations of the PTSD diagnosis for this group. They found evidence that there are different patterns of post-traumatic symptomatology associated with different types of trauma (in particular sexual torture) which adds weight to their suggestion (in Turner & Gorst-Unsworth, 1990) that a dimensional model of post-traumatic stress would be more appropriate. Ramsay et al. (1993) found in particular that, although they score very highly on intrusion and arousal symptoms, torture survivors would typically score below the diagnostic threshold on avoidance.

Nonetheless, the consequence of this argument in terms of prevalence rates is that the sequelae of trauma in refugees are being under-represented by the use of the PTSD diagnosis. There is one study which suggests a process of over-reporting in two cases, referred to a clinic in The Netherlands for traumatised refugees (Rijnders, Hovens, & Rooijmans, 1998). The two individuals were subsequently diagnosed with psychotic disorders. The authors argue that the traumatic experiences of refugees and the increasing awareness of the experiences of refugees can bias the clinician to see trauma as the sole causal process.

The studies reviewed give varied prevalence rates, and some can be criticised on methodological grounds. Nevertheless, there would seem to be sufficient justification for applying the literature on emotional disorder and memory to this population.

1.5 The study

The main thesis of the current study is that there will be discrepancies between autobiographical memories recalled by refugees on different occasions. Critically, the sample used for the study will not have applied, nor be applying for refugee status. Consequently, if discrepancies are found to occur, then it will be possible to explore explanations for them, other than the explanation that refugees are fabricating their accounts for the sake of immigration status. Hypotheses relating to emotional disorder (depression and PTSD) and the type of details recalled (central or peripheral) will explore alternative explanations for discrepancies. The relation of emotional disorder (depression and PTSD) to overgeneral memory in this sample will also be explored.

1.5.1 Null hypothesis

That there will be no discrepancies within or between accounts in this sample

1.5.2 Hypotheses

I. that there will be discrepancies (including missing information subsequently recalled) within and between two accounts given by the same individual on two occasions

II. that individuals with higher levels of depression and PTSD symptomatology will have a higher number of discrepancies between their accounts (both non-traumatic and traumatic memories)

III. that in the recall of traumatic memories, there will be more discrepancies (including "don't know"s) in peripheral details than central details compared to recalling non-traumatic memories

IV. that there will be an interaction between PTSD symptomatology and the nature of the incident recalled (i.e. traumatic or non-traumatic) which predicts the number and type (i.e. central/peripheral) of discrepancies between accounts

V. that individuals with higher levels of depression and PTSD symptomatology will be more likely to have patterns of overgeneral memory

2 Method

2.1 Introduction

This chapter outlines the design of the study, the measures used and the selection of participants. It will describe the procedures followed throughout the study and, where appropriate, clarify the rationale for methodological decisions taken.

2.2 Aim

The main aim of the study is to investigate discrepancies in autobiographical accounts in refugees, through a simulation of one aspect of the asylum application process. The study will comprise a systematic analysis of the relationship between discrepancies in accounts and the psychopathology of the individuals involved.

2.3 Participants

All participants had entered this country as 'programme' refugees.

2.3.1 Definition of programme refugees

In exceptional circumstances, such as times of war or mass persecution, the United Nations High Commission for Refugees (UNHCR) may identify a group of people requiring protection outside their own country and will approach other governments to request asylum on their behalf. The Bosnia Project, funded by the UK government, was set up to provide for such a group. Individuals identified for the Bosnia Project were

granted Exceptional Leave to Remain in the United Kingdom. They did not have to apply individually for this status. Kosovan refugees, who entered the United Kingdom more recently, did so under the same procedure, and were also granted Exceptional Leave to Remain.

The refugees who came to the United Kingdom through the Bosnia Project tend to be ex-detainees from prison camps and medical evacuees. Most are Bosnian Muslims (McAfee, 1998). All of the Kosovan refugees interviewed had come to England from refugee camps outside of the former Yugoslavia. All were Kosovan Albanians.

2.3.2 Recruitment

Bosnian participants were recruited from various community groups in North London and Hertfordshire. The study was originally intended to include only Bosnian Muslim refugees, in order to focus on just one cultural group. Due to recruitment difficulties however, the study was extended to include the interviewing of Kosovan Albanians, who have a similar legal status in this country (see above : 2.3.1 - Definition of programme refugees).

The Kosovan participants were recruited from a refugee reception centre in the north of England. These participants were also taking part in a separate project, concerned with identifying the prevalence of mental health problems of refugees from Kosovo. This survey included standard measures of PTSD and depression.

The study was explained to various community leaders and organisers of community groups and, in the case of the Kosovans, the reception centre manager, who were asked to assist in recruiting individuals known to them. Individuals were contacted by letter and telephone, by community contacts, the project interpreter, or the researcher. They were told about the aims and procedure of the project and invited to volunteer. A copy of the information sheet shown or sent to potential participants may be found in Appendix A : Recruitment letters, along with translations into Bosnian and Kosovan Albanian.

2.3.3 Inclusion criteria

Bosnian and Kosovan refugees who were over eighteen and who had entered the United Kingdom as part of a UNHCR program (see above) were recruited.

2.3.4 Exclusion criteria

Refugees who had sought or were seeking asylum on an individual basis were excluded from the study.

2.4 Measures

In this section, the measures used in the study will be introduced. Firstly the approach taken to the translation of the measures will be described. Secondly, the memory tasks are explained, followed by a description of each of the standard measures of psychopathology employed in the study. Other information collected about participants will also be outlined.

All data were collected over the course of two interviews, conducted by the researcher and assisted by interpreters.

2.4.1 Translation of measures

All self-report instruments and interview schedules were translated into Bosnian or Kosovan Albanian. Kosovan Albanian is a dialect of standard Albanian and care was taken to ensure the appropriate forms were used.

Bosnian forms of the measures for PTSD and depression were obtained from previous studies. These were used without further translation work and are described below. The measures of PTSD and depression had been translated into Kosovan Albanian for a separate project. This had been undertaken by medically qualified native speakers. Back-translation had also been used in order to ensure faithful translation of the measures.

The remaining measures (Dissociative Experiences Scale, Autobiographical Memory Task - see below) were translated into Bosnian by a professional Bosnian translator and back-translated into English by a second translator. The back translation and the original were then compared to ensure faithful translation. Copies of each measure, their translations and back-translations are available in the appendices to this volume.

2.4.2 Summary of measures

Table 2-1 lists the measurement instruments administered at each of the two interviews. They will then be described in detail.

Interview One	Interview Two
Demographic questions	Autobiographical Memory Test (AMT)
Post-Traumatic Stress symptomatology (PDS)	Memory Task II - traumatic - non-traumatic
Memory task I - traumatic - non-traumatic	Depression symptomatology (BDI)
Dissociative Experiences Scale (DES-T)	
Head injury and early abuse questions	

Table 2-1 : Summary of measures

2.4.3 Memory Task - calculating discrepancy rates

This section will describe the memory task designed to assess discrepancies in recall.

2.4.3.1 Rationale - The Asylum Interview

When asylum applicants are interviewed by Home Office officials, both initially and at appeal, they are asked to recall details of events they have described, in order to establish the veracity of their account. For example, applicants are asked to name the date that a described event happened, or the number of people that were involved. Confusion over, for example, dates, suggests to the Home Office official that the applicant is not being honest. In this section a memory task is described that was designed to assess the rate of discrepancies in accounts given by participants in the current study.

2.4.3.2 The Experimental Task

The memory task was designed specifically for the study. In order to simulate the asylum interview in a manner which would allow systematic analysis, a set of questions was developed which, whilst similar to the above examples, could also be applied to any memory generated by participants.

2.4.3.3 Free recall and standard questions

Participants were asked to generate a memory, firstly of a time when they felt that their life was in danger (a traumatic memory), and secondly, an everyday event, not connected with the war or danger (a neutral, non-traumatic memory). Following each free recall, a standard set of questions was asked. Examples are "who was with you?" and "what was the weather that day?". The questions were modelled on questions found in transcripts of actual asylum interviews and examples given by a Home Office interviewer. They were supplemented by questions used in previous studies of central and peripheral information (e.g. Christianson & Hubinette, 1993). A copy of the whole task, including the 15 standard questions, in English, Bosnian and Kosovan Albanian, can be found in Appendix B : Memory Task.

2.4.3.4 Centrality

The memories elicited by the fifteen standard questions were rated by the participants as central or peripheral. A description of how this was done follows a brief discussion of definitions of central and peripheral memories.

Peterson and Bell (1996) describe how the concept of centrality has been interpreted in varying ways in the eye-witness literature, from relevance to the plot of a story to spatial proximity to central characters (Peterson & Bell, 1996). However, Christianson speaks of the 'gist of the event' or the 'gist of emotional events' (e.g. Christianson, 1992), and in later work defines central detail as

"the central, critical detail information about the emotion-laden event, that is, the information that elicits the emotional reaction"

(Christianson & Engelberg, 1997)

In accordance with this, Williams' definition of the concept is in terms of 'centrality to the action necessary' (Williams et al., 1997). Accordingly, this study adopts the definition of central detail as that which is critical to the action and emotion of the event.

This was operationalised by asking participants in the first interview to indicate whether each detail question was central or peripheral using the question : "Was this important to what happened or to how you felt?" Rating in this way by the subject of the event was felt to have more validity than independent rating, particularly when the events recalled were known by participants, but unknown and perhaps even alien to the researchers. The question of how to reliably define centrality is discussed by Heuer and Reisberg (1992) and by Christianson (1992), who notes that the centrality of details is difficult to determine in advance or outside controlled laboratory conditions.

2.4.3.5 Coding of discrepancies

In order to control for differences in personal speaking style (garrulous or taciturn), discrepancies were calculated as a function of the amount of information given in the first interview. This calculation is described in the following sections.

2.4.3.6 Count of units of information

The autobiographical memories elicited in the first interview were broken down into phrases, each containing one piece of information. For example : "/ I was sitting / in the garden / with my 3 / grandchildren. /" The total number of these units was recorded. The principle used was that each unit contained information that could be contradicted in the second interview - thus in the above example, both "3" and "grandchildren" are counted as units, so that, if the response in the second interview mentions "2 nieces", then two units of information will be involved rather than one. The number of units of information was counted, and recorded by central or peripheral rating.

This was repeated for both traumatic and non-traumatic memories.

The counting of units of information was done by two independent raters for 27 (70%) of the transcripts. See 2.4.3.11 for details of reliability calculations.

Thus for each individual, there were four 'unit of information' scores: traumatic central, traumatic peripheral, non-traumatic central and non-traumatic peripheral.

2.4.3.7 Count of discrepancies

For each participant, the transcripts from interviews one and two were then put side by side, and examined for differences. Firstly the traumatic memory was examined. Comparing each question across the two interviews, if any part of the answer in one interview contradicted the answer in the other interview, then a discrepancy was

recorded. If the answer to that question in the second interview contained any new information, not in the first, this was also rated as a discrepancy. Each of the 15 questions was rated in this way. This process was then repeated for the non-traumatic memory. A recording sheet was used to collate this information for each participant. Twenty-seven (70%) of the transcripts were also rated in this way by a second rater. See 2.4.3.11 for details on the calculation of reliability coefficients.

Thus four sets of discrepancies were counted per individual - discrepancies of central and peripheral details for traumatic accounts and discrepancies of central and peripheral details for non-traumatic accounts.

2.4.3.8 Discrepancy rates

In each category (central/peripheral; traumatic/non-traumatic), discrepancy rates were calculated by dividing the number of discrepancies (contradictory or new information) by the number of units in that category. Thus the number of traumatic central discrepancies was divided by the number of traumatic central units of information and the number of traumatic peripheral discrepancies was divided by the number of traumatic peripheral units of information. The number of non-traumatic central discrepancies was divided by the number of non-traumatic central units of information and the number of non-traumatic peripheral discrepancies was divided by the number of non-traumatic peripheral units of information.

2.4.3.9 Overall discrepancy rates

An overall discrepancy rate was calculated per person by adding the total counts of discrepancies across the four categories, adding the units of information across the four categories and dividing one by the other. A discrepancy score of 1 would mean that every piece of information given in one interview was contradicted by another piece of information in the other interview. A discrepancy score of more than one could be attained by complete contradiction and the addition of new material in the second interview. A discrepancy score of 0 would mean that no piece of information in either interview was contradictory, and no new information was given in the second interview.

2.4.3.10 Free recall

It was not possible to rate discrepancies between the free recall parts of the interviews. The free recall at the second interview was consistently much shorter than the first, perhaps because participants were referring to an account already told, rather than telling it for the first time.

2.4.3.11 Reliability

A second rater also performed the coding of 70% of the transcripts, recording both the total number of units of information, and the discrepancy count in order to test the reliability of the scoring.

The reliability rates for the four discrepancy rates are shown in Table 2-2.

Discrepancy rate	Intraclass correlation estimate
Traumatic central	0.72
Traumatic peripheral	0.81
Non-traumatic central	0.66
Non-traumatic peripheral	0.65

Table 2-2 : Reliability of discrepancy rates

An example of a set of transcripts may be seen in Appendix C : Example pair of transcripts.

2.4.4 Overgeneralized memory : AMT

The Autobiographical Memory Task (AMT) was developed by JMG Williams and colleagues (Williams & Broadbent, 1986) and used in subsequent studies with depressed patients (Williams & Dritschel, 1988) and Vietnam war veterans (McNally et al., 1994). Subjects are presented with cue words and asked to produce a specific, autobiographical memory in response. A standard prompt is used if the first memory presented is general (e.g. I used to enjoy going for walks when I was younger). Response latencies are recorded to the first response and to the first specific response. In some forms of the task 30 words were used, 10 positive, 10 negative and 10 neutral, and participants were given 60 seconds to respond (e.g.McNally et al., 1994) . More recent studies have found effects with only 10 words - 5 positive and 5 negative, and a time limit of 30 seconds (Williams, 1999).

A copy of the Instructions for the AMT may be found in Appendix H : Autobiographical Memory Task.

The current study used a selection of the words used in the AMT, which were translated into Bosnian, and then back-translated. Only words which translated unambiguously back to the same English word were used.

The same ten words were subsequently translated into Kosovan Albanian.

The five positive words were : *happy, proud, faithful, tender, friendly* (Bosnian translations : *sretan, ponosan, vijeran, njezan, prijateljski;* Kosovan Albanian translations : *gezuar, kremar, besnik, tendosun, shogrueshen*)

The five negative words were : *tired, ashamed, hopeless, sad, weakness* (Bosnian translation : *umoran, posramljen, beznadni, tuzan, slabost*; Kosovan Albanian translation : *lodhur, turperuan, pashpresi, pikellim, lige*).

The mean Kucera-Francis Frequency and emotionality ratings for each of these groups of words were calculated and compared to the range of frequencies and ratings in the word groups provided with the AMT.

The word groups chosen for the study are within the ranges of the groups suggested with the AMT. This is shown in Table 2-3.

		Word group for this study	Range of suggested groups for AMT
Positive words	Emotionality	4.78	4.73-5.04
	Frequency	35.8	18.8-39.8
Negative words	Emotionality	4.84	4.81 - 4.98
	Frequency	32.8	18.8 - 37.7

Table 2-3 Emotionality and Frequency of AMT cue words

2.4.4.1 AMT procedure

This task was administered with the assistance of the interpreter, who had been instructed in the purpose and nature of the task. Participants were instructed that they would be read ten words and that the researcher was interested in specific memories. They were told that the memories could be recent or distant, interesting or trivial. The need for specificity was repeated, and an example given (Williams, 1999).

Three practice words were presented, and further explanations given when necessary. The test did not proceed until the participant had given a specific memory for at least two of the practice items.

The cue words were presented singly on cards, and simultaneously read by the interpreter. Participants were given 30 seconds to retrieve a specific memory. A stopwatch was used to time the response latency. Timing started after the reading of the cue word and stopped at the beginning of the participant's first response (excluding phrases such as 'let me see now...'). If the first memory was not specific, a standard prompt was given - "can you remember a specific event?" and the timing restarted, giving a cumulative latency for subsequent retrieved memories. Where the participant was clearly struggling to understand the task at all, the standard prompt was only repeated once. In these cases, as in cases where time ran out, a latency of 30 seconds was recorded (following Williams & Dritschel, 1988; Kuyken & Brewin, 1995).

2.4.4.2 Rating reliability

Memories given were rated as to whether they were specific or general and negative memories were counted. Two raters completed this task for all participants. Intraclass correlation coefficients ranged from 0.83 to 0.92 for scoring of specific memories and latencies. These figures compare favourably with those of Williams and Broadbent's (1986) study. The coefficient for negative memories was 0.78.

2.4.5 Psychopathology

2.4.5.1 Dissociation

Dissociation is a phenomenon which is often associated with PTSD (van der Kolk, Hart, & Marmar, 1996). It has been thought of as a continuum, from the everyday lapses of awareness experienced by most people to extreme cases of Dissociative Identity Disorder. The widely used Dissociative Experiences Scale (DES: Bernstein-Carlson & Putnam, 1986) was developed on this basis, and has a range of items, from "Some people have the experience of driving a car and suddenly realising that they don't remember what has happened during all or part of the trip" to "Some people have the experience of finding new things among their belongings that they do not remember buying". However, in recent work, Waller et al. (1996) have argued that it is possible to distinguish two distinct constructs : pathological and non-pathological dissociation. Making use of taxometric methodology, they analysed the data from a subject base of

1,574 individuals in a number of clinical groups, including PTSD. The result was a subset of eight items from the DES which appear to distinguish pathological dissociation.

The rationale for measuring dissociation in the current study was in order to screen for individuals who might be highly dissociative. Hence the eight item Dissociative Experiences Scale-Taxon (DES-T) was used.

The DES-T was translated into Bosnian and back-translated to English. The English translation had only minimal differences from the original version. A copy of the eight item DES-T, the Bosnian translation and the back-translation may be found in Appendix D : DES.

2.4.5.2 Post-Traumatic Stress Disorder (PTSD)

The measure used was a translated form of the Posttraumatic Diagnostic Scale (PDS : Foa et al., 1997) used in studies by Weine and colleagues (Weine et al., 1998c). The original scale has been demonstrated by the developers to have high internal consistency, reliability and consistency with other recognised forms of measurement of PTSD, such as the Structured Clinical Interview (SCID : Spitzer, Williams, Gibbon, & First, 1992).

The measurement of PTSD in a group who have suffered prolonged and multiple traumata is problematic. Ramsay, Gorst-Unsworth and Turner (1993) argue that for torture victims, who are a subset of the refugees received into this country, a categorical

diagnosis can miss severe levels of symptomatology which may not fit the standard pattern of PTSD as defined in the Diagnostic and Statistics Manual (DSM-IV).

Accordingly, although a standardised measure of PTSD was used, allowing a diagnostic judgement to be made, the severity and frequency of each symptom was recorded in order to give a continuous measure of severity and thus a finer picture of each individual's trauma reactions (Foa et al., 1997).

2.4.5.3 Depression

Clinical depression was measured for two reasons. Firstly, it is implicated in impaired memory processing, and has been linked strongly with overgeneralized memory (Williams, 1995). Secondly, there is a high degree of co-morbidity with Post-Traumatic Stress Disorder (Blanchard, Buckley, Hickling, & Taylor, 1998).

The Beck Depression Inventory (BDI : Beck, Rush, Shaw, & Emery, 1979) is widely used as a measure of depression. Many studies, summarised by Beck (1996), have found that the BDI has high levels of validity and reliability.

A copy of the Beck Depression Inventory translated into Bosnian was acquired from the Institute of Psychiatry, London. The measure had already been translated and back translated. It has been found to perform similarly to the English version when compared with the General Health Questionnaire (GHQ 28: Goldberg & Hillier, 1979) (Perrin, 2000).

The Kosovan group were already involved in a study which included their filling in the BDI. However, in that study, the second version (BDI-II:Beck, 1996) was used. Rather than ask the Kosovan participants to fill in the BDI-I (Beck, 1967; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), a conversion table, supplied with the BDI-II was used, to convert the BDI-I scores of the Bosnian participants into BDI-II equivalent scores. Thus the reported scores are BDI-II scores for all participants.

A copy of the original BDI-I and the Bosnian translation may be found in Appendix F : BDI-I; the BDI-II and Kosovan Albanian translation may be found in Appendix G : BDI-II.

2.4.6 Childhood abuse

Participants were asked two questions regarding early experiences of violence at both interviews. There are cultural differences in the levels of physical violence that are considered normal and in the perceived acceptability of discussing sexual violence. Information gleaned from pilot interviews indicated that we should be direct in our questioning, and that we should raise the subject at both interviews. Accordingly, participants were asked firstly "In your childhood, were you ever beaten?" and, secondly "Did anyone ever force you to have sex when you were a child?"

2.4.7 Head Injury

It was not possible to carry out extensive neurological testing which would rule out the possibility of head injury as a cause of memory impairment. However, as the length of unconsciousness following head injury is often used as one rough indicator of the likelihood of brain damage (Lezak, 1995), the following two questions were asked:

Have you ever been knocked unconscious?

For how long were you unconscious?

Retrograde amnesia is another indicator of damage (Lindsay & Powell, 1994), but it was not felt that this could be assessed with any accuracy in the group under study.

2.4.8 Demographic Information

Participants were asked their age, their sex, the age when they left school (to indicate educational level) and their occupation prior to leaving their home country (to indicate socio-economic status).

2.5 Procedure

Participants who joined the project were visited at home or at community premises by the researcher and an appropriate interpreter. The core of the research interview took between one and two hours. However, some visits lasted up to seven hours.

For the list of measures administered in each interview, see Table 2-1 : Summary of measures. The second interview was at least four weeks after the first. On this second occasion, the memory task was repeated, with participants first being asked if they could remember the events they had related on the first occasion. If they could not, this was noted and they were reminded of the first recall, before being asked the set of fifteen standard questions from the memory task (described above in section 2.4.3.3). These questions are listed in Appendix B : Memory Task.

Written, translated forms of each of the measures were available and participants were encouraged to complete the standardised questionnaires. However, almost all of the participants preferred the interpreter to read and mark these forms on their behalf. The literacy levels of participants was not assessed, but seemed to vary widely, and in some cases was very low indeed. In these cases, the instructions for oral administration given in the BDI-II (Beck, 1996) were used as a guide.

In some cases the measures of psychopathology indicated clinical levels of depression or PTSD, and the participant was not known to be receiving psychiatric or psychological treatment. In these cases participants were sent a letter, addressed to their GP, which gave their symptom scores and outlined our concerns. Thus participants were able to choose whether they wanted to use this letter to request clinical help.

2.6 Pilot study

Two pilot interviews were conducted, in order to finalise the wording of the memory task and the ordering of tasks and questionnaires. The questions regarding early abuse were discussed with the pilot participant, who had been a social worker in Bosnia, in order to find a discreet but effective form of questioning about a subject which is less easily discussed than in this country.

2.7 Ethical approval and Consent

Ethical approval for the study was granted by the Local Research Ethics committee of Camden and Islington Community Health Services NHS Trust . For copies of correspondence, see Appendix I : Ethical approval - correspondence.

Signed consent was given by all participants, on a translated version of the consent form recommended by the Local Research and Ethics committee of Camden and Islington Community Health Services NHS Trust.

Copies of the consent form in English, Bosnian and Kosovan Albanian may be found in Appendix J : Consent forms.

2.8 Analysis

All data were analysed using the software package Statistical Package for the Social Sciences (SPSS), Version 7.5.1, running under Windows 95.

3 Results

3.1 Description of participants

3.1.1 Response rate

Table 3-1 shows the numbers of potential participants approached, the response rate (Interview 1) and the eventual figure for a complete data set (Interview 2).

Community group	Addressed	Interview 1	Interview 2
North London	80 (mailshot)	8	7
Hertfordshire	Community leader	3	1
West London	8 (support group)	3	2
Other community links	2	2	2
Shipley Reception Centre	70 (incl. children)	27	27
Total participants	160+	43	39

Table 3-1 : Recruitment of participants

3.1.2 Reasons given for refusal

This issue was not addressed formally within the study, but an impression was gained from participants and other members of the community. In the eight years that Bosnian refugees have been in this country they have been approached many times by media and research groups. Community workers and participants both believed that this was the reason for the very low initial response rate.

All of the individuals (4) who undertook the first interview but not the second said that it had been too distressing to revisit memories of their war experiences. They were not in the extreme ranges of PTSD symptomatology, nor showing the highest levels of dissociation. Depression scores were collected in the second interview and were thus unavailable for these individuals.

3.1.3 Demographic information

Demographic information is given for all participants who entered the study, including those who declined to give a second interview.

3.1.3.1 Age

The age of the participants ranged from 18 to 64 with a mean of 39.5 (s.d. 14.5)

3.1.3.2 Sex

The participant group consisted of 23 (53.5%) men and 20 (46.5%) women.

3.1.3.3 Occupation (previous)

None of the interviewees had a current occupation, largely due to their status as refugees.

The distribution of previous occupations is shown in Figure 3-1.

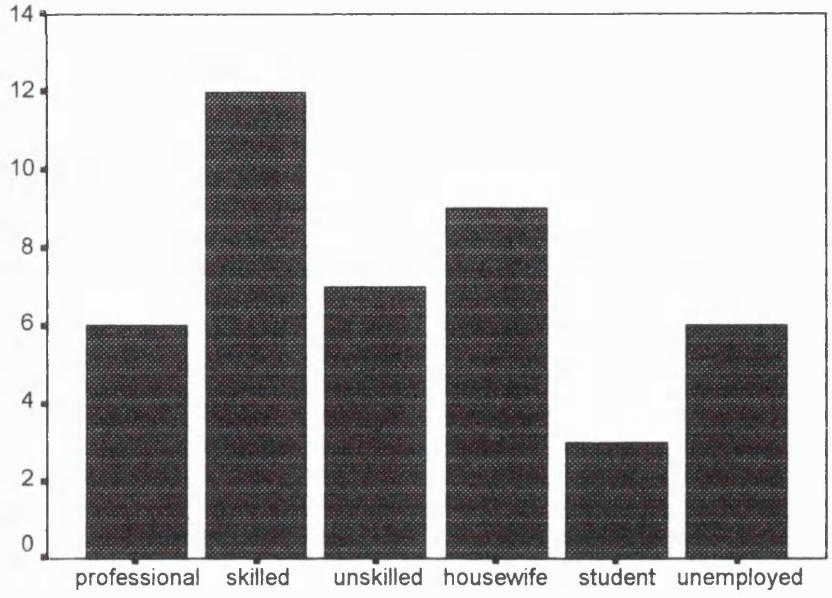

Figure 3-1 : Previous occupations of participants

3.1.4 Head injury

10 participants reported a loss of consciousness at some time in their lives. Of these, one (who also refused the second interview) reported having been unconscious for over 24 hours. A further four reported unconsciousness lasting between 1 and 24 hours.

3.1.5 Early abuse

No participant reported any sexual abuse in childhood. One participant reported being beaten at school.

3.1.6 Psychopathology

3.1.6.1 PTSD scores

The PTSD questionnaire consisted of questions pertaining to each of the DSM-IV diagnostic criteria for Post-Traumatic Stress Disorder. A presumptive diagnosis of PTSD may be made based on participants' responses to the measure. By totalling the scores on criteria B, C and D (re-experiencing, avoidance and hyper-arousal) a symptom severity score may also be calculated (Foa et al., 1997). All of the refugees were assumed to have experienced events adequate to meet criterion A as described in DSM-IV (American Psychiatric Association, 1994).

Three participants had missing variables for symptoms, so symptom severity scores could not be calculated. For two of these, the missing value was replaced with the mean of the scores within the symptom type. For example, if one of the re-experiencing symptoms

(criteria B) was missing, then the mean of the other re-experiencing symptoms (B1 - B5) was calculated and substituted for the missing value. One value was replaced in this way for one of the three participants with missing data, and two values (in different symptom types) for the other. In the third of these 3 participants, no substitutions were made as two of the five symptoms were missing, which makes it difficult to justify substituting on the basis of the remaining three (Bryman & Cramer, 1997). This participant was excluded from the analyses of symptom severity.

Continuous measure

Symptom severity scores ranged from 5 to 50, with a mean of 27.28 (s.d. 10.91). The maximum possible score on the scale is 51.

Categorical measure

Of the 43 participants measured, 37 had a presumptive diagnosis of PTSD according to their responses on the instrument used, leaving 4 not diagnosed (and 2 missing data). Consequently, where analyses required two groups, the sample was split by the median score, rather than on the basis of diagnosis. The median PTSD symptom severity score was 25. Individuals scoring 26 or more were grouped as high PTSD scorers, those with a score of 25 or lower as low scorers.

The symptom severity scores of those not meeting criteria for PTSD were 5, 9, 21 and 26. The scores of those diagnosed ranged from 6 to 50. There is a large overlap between the two methods of measuring psychopathology.

3.1.6.2 Depression scores

The Bosnian group were administered the BDI-IA (Beck et al., 1979). The Kosovan group, as part of a different study, had filled in the BDI-II (Beck, 1996). The manual for the BDI-II provides a conversion table, translating BDI-1A scores to equivalent BDI-II scores. This table was used to convert the BDI-1A scores obtained for Bosnian participants to BDI-II scores, in order to allow comparison with the Kosovan group. See section 2.4.5.3 for details about these two instruments.

One participant had 2 missing BDI-II responses. The mean of this participant's other 19 responses was calculated and substituted for these two items.

Two of the women did not answer question 21, (Loss of Interest in Sex). A third had originally left this question blank and, when asked to fill it in, replied that she wasn't married, so it didn't apply to her. She agreed to answer the item with 0 (no change). Of the two who haven't offered data, one is also a young, unmarried woman, and the other is a woman who stated elsewhere that she felt that sex was an inappropriate topic amongst strangers. Zero was entered as the response for both of these participants, in order not to exclude them from analysis.

Occasionally there were multiple responses to an item. In this case the highest rating was scored, following the instructions from the scoring manual (Beck, 1996).

Continuous measure

The mean of the BDI total scores was 24.24 (s.d. 11.62). Total scores ranged from 7 to 52 (the maximum possible on this measure is 63).

Categorical measure

Depression scores were categorised according to clinical caseness. The literature on emotional disorder suggests that psychiatric categories may be distinct in terms of memory processing (Williams et al., 1997).

The cut-off scores given in the BDI-II manual (Beck, 1996) give ranges for minimal, mild, moderate and severe depression as shown in Table 3-2.

Total Scores	Range
0-13	Minimal
14-19	Mild
20-28	Moderate
29-63	Severe

Table 3-2 : BDI-II cut-off scores

Table 3-3 shows the frequency of participants in this sample in each of the depression categories in Table **3-2**.

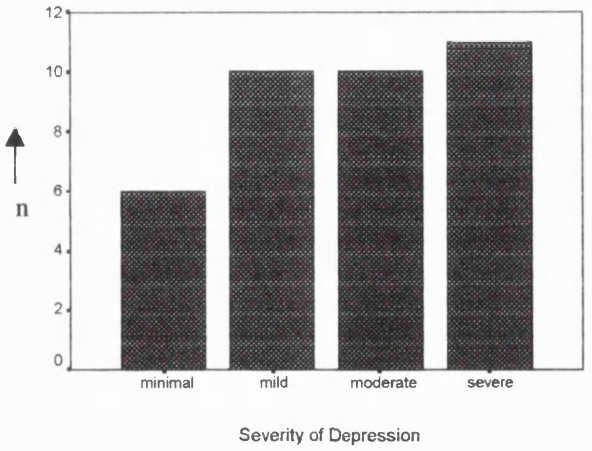

Table 3-3 : Depression categories

In accordance with the categories of the BDI-II, likely clinical cases of depression were defined as those with a score of 14 or more.

3.1.6.3 Comorbidity

It is known that PTSD and depression are highly co-morbid in the refugee population (e.g. Van-Velsen et al., 1996). As expected, a Pearson correlation shows a significant positive correlation ($r=0.72$, $p<0.001$) between BDI totals and PTSD symptom severity scores in this sample. Table 3-4 shows the numbers of clinical cases of PTSD and depression. Presumptive diagnoses of PTSD and BDI are strongly associated (phi=0.56, $p<0.01$).

	PTSD	Non-PTSD
Depressed (expected)	30 (27.6)	1 (3.4)
Non-depressed (expected)	3 (5.4)	3 (0.6)

Table 3-4 : Comorbidity of PTSD and Depression

3.1.6.4 Pathological dissociation

The DES-T, the eight item, taxonomic version of the Dissociative Experiences Scale, was administered in order to identify any individuals who might be exhibiting exceptionally high levels of dissociation. Total scale scores are calculated by averaging the eight item scores (Waller et al., 1996).

The mean total scale score for the sample was 2.00 (s.d. 3.60). Seventeen participants (39.5%) scored 0. The scores of those who endorsed any items ranged from 0.36 to 16.79.

These scores are low relative to the scores cited by Waller et al. in their testing of the measure (Waller et al., 1996). They cite mean scores per item. For ease of comparison their mean item scores are averaged and shown, per clinical group, in Table 3-5.

PTSD	16.38
Multiple Personality Disorder (MPD)	19.53
Dissociative Disorder other than MPD	39.24

Table 3-5 : Quoted means for DES-T

3.1.7 Differences between ethnic groups?

Due to difficulties in recruiting Bosnian refugees, the study was extended to include Kosovan refugees, as discussed in Section 2.3 - Participants. The two groups were compared by age, sex, school leaving age, PTSD diagnosis and BDI scores in order to identify any systematic differences between them. 16 Bosnians and 27 Kosovans made up the participant sample.

3.1.7.1 Age

The Bosnian group had a mean age of 46.19, whilst the mean age of the Kosovan group was 35.52. This difference was statistically significant ($t(41)=2.47$, $p<0.05$).

3.1.7.2 Sex

The Bosnian group was made up of 9 men and 7 women; the Kosovan group comprised 14 men and 13 women.

3.1.7.3 School leaving age

The Bosnian group had a higher level of education. The mean school leaving age for Bosnians was 19.94 (s.d. 4.45), whereas for the Kosovan group it was 16.15 (s.d. 5.86). This difference was statistically significant ($t(41)=2.23$, $p<0.05$).

Further analysis of differences between groups are given below, in relation to discrepancy rates.

3.1.7.4 Psychopathology

There were no significant differences in PTSD symptom severity between the two ethnic groups ($t(38)=0.99$, $p=0.33$).

There were no significant differences in mean BDI scores between the two ethnic groups ($t(35)=0.12$, $p=0.90$).

3.2 Hypothesis testing

The analyses reported have shown that there are no significant reasons to treat the Bosnian and Kosovan refugee groups separately. Nonetheless, there are differences between the groups that limit the conclusions that may be drawn from an analysis of the whole sample. The length of time between interviews, for example, was longer for Bosnian participants than it was for Kosovan participants, and statistically significant differences have been shown between the groups regarding age and age of leaving formal education. In order to reduce the limitations that these differences place on interpreting the results of testing, each of the hypotheses was tested on the whole sample, and then again on the subset of Kosovan participants. Whilst this raises the probability of Type I errors, if findings in the smaller group (n=27 in the Kosovan group) confirm the findings

of the larger group, we may be able to consider the significance of those results with more confidence.

Only findings which reach, or approach, statistical significance in the Kosovan-only group will be reported.

3.2.1 Hypothesis 1 : Discrepancies

The first hypothesis stated that

"there will be discrepancies (including missing information subsequently recalled) within and between two accounts given by the same individual on two occasions"

3.2.1.1 Count of discrepancies

The calculation of discrepancy rates is described in detail in section 2.4.3 - Memory Task - calculating discrepancy rates. In sum, discrepancy rates were calculated by dividing the number of discrepancies between answers at the two interviews (contradictions or pieces of new information) by the number of units of information in the first interview. Firstly an overall discrepancy rate per participant was calculated by totaling the number of discrepancies for both traumatic and non-traumatic memories and dividing this by the total number of units of information across both memories. Secondly, four rates were calculated per participant - discrepancies in traumatic-central details, in traumatic-

peripheral details, in non-traumatic-central details and in non-traumatic-peripheral details.

One individual, when prompted to re-recall his traumatic memory at the second interview replied that he could not, saying "there were so many times like that". His discrepancy rate was scored as 1.

An example of a set of transcripts may be seen in Appendix C : Example pair of transcripts.

3.2.1.2 Distribution of discrepancy rates

Whole sample

The highest discrepancy rate was .65 and the lowest was .01. The highest total number of discrepancies by any individual (not as a function of their total amount of information) was 36 and the lowest was 1. The overall discrepancy rates were normally distributed. The mean discrepancy rate was 0.32 (s.d. 0.14)

Kosovan sub-sample

The mean discrepancy rate in the Kosovan group was 0.28 (s.d. 0.12), ranging from 0.01 to 0.50 .

These findings are consistent with hypothesis one.

3.2.1.3 Comparisons of discrepancy rates between groups

Bosnian/Kosovan

The mean discrepancy rate in the Bosnian group was 0.41, as opposed to 0.28 in the Kosovan group; a significant difference ($t(37)=2.88$, $p<0.01$).

Correlation between time between interviews and number of discrepancies

Due to the organisation of the data collection, the time between interviews was also related to ethnic origin. The mean number of days between interviews was 158.5 (s.d. 52.6) for the Bosnian group, whereas the mean for the Kosovan group was 28.56 (s.d. 7.48). We would therefore expect a relationship which reflects the difference between the means of ethnic groups, reported above.

A Pearson correlation showed a significant association between the time between interviews and the overall discrepancy rate ($r=0.42$, $p<0.01$). The longer the time between the two interviews, the more likely it is that there will be inconsistency between the first and second responses.

3.2.1.4 Educational level and discrepancy rate

An additional, post-hoc test was performed following observation of the performance of participants. It revealed a negative correlation, albeit a weak one, between educational level and discrepancy rate ($r = -.31$, $p < 0.05$). That is, the fewer years of education the

individual has had, the more likely they are to have discrepancies in their autobiographical memories using the methods of this study.

Educational level was also associated with ethnic group, and thus may also be related to the time between interviews (see above). By repeating this analysis within the Kosovan-only sub-set these confounding variables are eliminated. Within the Kosovan-only sub-set the finding was replicated, with a higher r value ($r=-0.41$, $p<0.05$).

Same interpreter/different interpreter

As it was not possible to use the same interpreter across interviews within each participant, this was also checked as a source of variance in the number of discrepancies. The sample was split according to whether they had the same translater for both interviews, or had two different interpreters. A t test on the number of discrepancies compared across the two groups showed no significant difference ($t(37)=0.85$, $p=0.40$). However, when this test was repeated with the Kosovan group only, the effect of a change of interpreter approached statistical significance ($t(25)=1.78$, $p=0.09$).

3.2.2 Hypothesis 2 : the effect of psychopathology on discrepancies

The second hypothesis stated that

"individuals with higher levels of depression and PTSD symptomatology will have a higher number of discrepancies between their accounts (both non-traumatic and traumatic memories)"

3.2.2.1 The effect of PTSD on discrepancy rates

Mean discrepancy rates were compared across high and low scoring PTSD groups. Table 3-6 shows the mean discrepancy rates for each group.

	High PTSD scorers	**Low PTSD scorers**
Mean total discrepancy rates	0.37	0.28
(standard deviation)	(0.15)	(0.12)

Table 3-6 : Discrepancy rates by PTSD score

An independent samples t test showed the difference between the group means to be significant ($t(34) = 2.05$, $p<0.05$). Participants who had a high score on the measure of PTSD were more likely to have discrepancies between their accounts.

3.2.2.2 The effect of Depression on discrepancy rates

As with the PTSD scores, mean discrepancy rates were compared across depressed and non-depressed groups.

Table 3-7 shows the mean discrepancy rates in each group.

	Depressed	Non-depressed
Mean total discrepancy rates	0.33	0.26
(standard deviation)	(0.13)	(0.16)

Table 3-7 : Discrepancy rates by BDI score

The difference between these group means was not statistically significant ($t(35)=1.22$, $p=0.23$).

3.2.3 Hypothesis 3 : central/peripheral and traumatic/non-traumatic interactions

The third hypothesis stated that

> *"in the recall of traumatic memories, there will be more discrepancies in peripheral details than central details compared to recalling non-traumatic memories"*

Three of the four types of discrepancy rates were significantly skewed, and this was found to be largely due to outliers. One participant had an unusually high traumatic-peripheral discrepancy rate, as may be seen in Figure **3-2** below. A further two participants had unusually high non-traumatic peripheral discrepancy rates, as shown in

Figure **3-3**. These three participants were excluded from the analyses for hypothesis three.

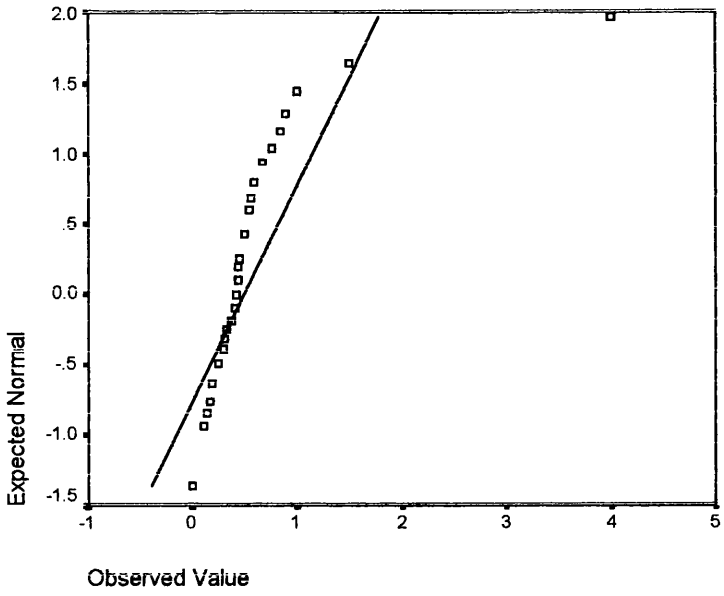

Figure 3-2 : Plot of traumatic peripheral discrepancy rates

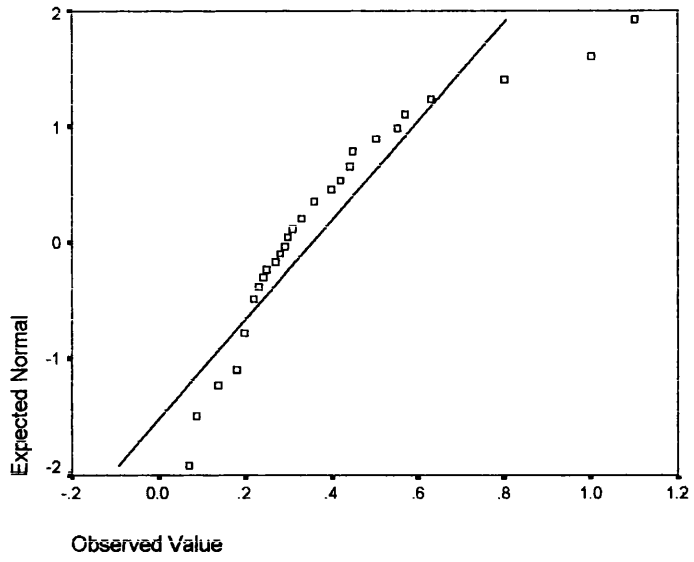

Figure 3-3 : Plot of non-traumatic peripheral discrepancy rates

The mean discrepancy rates for each category of discrepancy are shown below in Table 3-8.

	Traumatic memory		Non-traumatic memory	
	Central	**Peripheral**	**Central**	**Peripheral**
Discrepancy rate (standard deviation)	0.31 (0.21)	0.42 (0.33)	0.28 (0.19)	0.31 (0.16)

Table 3-8 : Discrepancy rates - estimated marginal means

Each of the categories of discrepancy rate were entered into a General Linear Model - Repeated Measures analysis. Two variables were defined - Traumatic-Non-traumatic and Central-Peripheral, each having two levels.

The interaction of these variables is shown graphically in Figure 3-4.

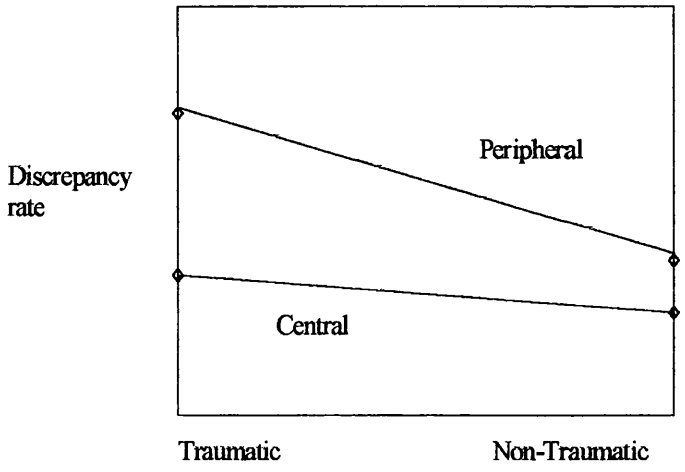

Figure 3-4 : Central and peripheral discrepancies for traumatic and non-traumatic memories (whole sample)

The analysis showed a main effect of type of detail showing that discrepancies in peripheral details were significantly more likely than discrepancies in central details ($F(1,32) = 5.06$, $p<0.05$). The effect of the nature of the memory (traumatic/non-traumatic) was not significant ($F(1,32)=2.83$, $p=0.10$) and the interaction of the central/peripheral and traumatic/non-traumatic discrepancy rates was not significant ($F(1,32)=1.68$, $p=0.20$). However, the trend was in the direction of the hypothesis. The non-significance of the result may have been due to insufficient power with a relatively small sample size. Following this reasoning, post hoc pairwise comparisons were run. These tests showed that the effect of type of detail (central/peripheral) was significant for traumatic memories ($F(1,32) = 4.42$, $p<0.05$), but not for non-traumatic memories ($F(1,32)=1.25$, $p=0.27$) suggesting further evidence, albeit less strong, for the hypothesis.

Kosovan sub-sample

The findings for the Kosovan group are shown graphically in Figure 3-5.

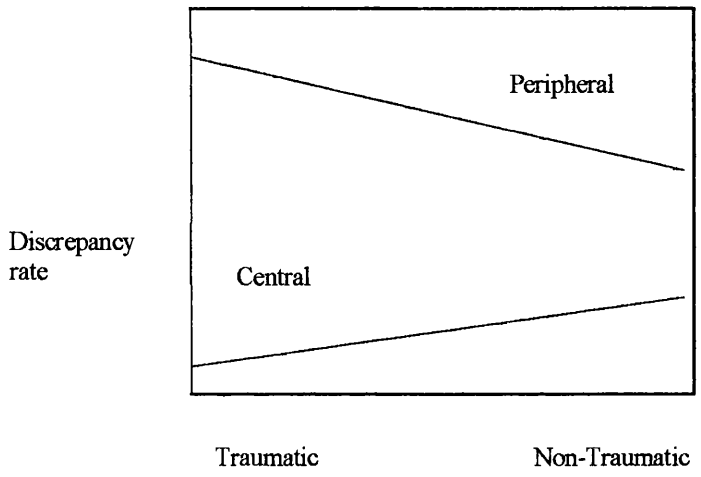

Figure 3-5 : Central and peripheral discrepancies for traumatic and non-traumatic memories (Kosovan participants only)

In a repetition of the General Linear Model analyses on the Kosovan sub-sample, the main effect of type of detail (central or peripheral) was replicated in a result which was significant at the 5% level ($F(1,24)=4.25$, $p=0.05$). Furthermore, the post-hoc pairwise comparisons also showed that the effect approached statistical significance for traumatic memories ($F(1,24)=3.26$, $p=0.08$) rather than for non-traumatic memories ($F(1,24)=1.48$, $p=0.24$).

These findings are consistent with the hypothesis that there are likely to be more discrepancies in details rated by participants as peripheral, when compared to details rated as central. They provide suggestive support for the hypothesis that the nature of the memory (traumatic or non-traumatic) is also important to the type of detail which gives rise to discrepancies.

3.2.4 Hypothesis 4 : the additional effect of psychopathology

This more exploratory hypothesis stated that

> *there will be an interaction between PTSD symptomatology and the nature of the incident recalled (i.e. traumatic or non-traumatic) which predicts the number and type (i.e. central/peripheral) of discrepancies between accounts*

The Repeated Measures test of Hypothesis 2 was repeated with PTSD symptom severity added as co-variate, but this had no significant interaction with the effect of central/peripheral details ($F(1,28)=0.15$, $p=0.70$).

3.2.5 Hypothesis 5 : overgeneral memory

The fifth hypothesis stated that

individuals with higher levels of depression and PTSD symptomatology will be more likely to have patterns of overgeneral memory

These data were collected using the Autobiographical Memory Test (Williams, 1999). Details of the administration of this test are given in section 2.4.4. In sum, participants were shown 10 cue words, five negative (e.g. hopeless) and five positive (e.g. happy) and asked to give a specific memory in response. The nature of the first response was recorded (specific or general), as were the latencies to the first response and to a specific response. The percentage of all responses that were negative was also calculated for each participant.

Table 3-9 shows the means and ranges for the number of first responses that were specific, the latency to a specific memory, and the percentage of all responses that were negative.

	Mean (SD)	Range
No. 1st memories specific (of 5 +ve cues)	1.82 (1.25)	0-5
No. 1st memories specific (of 5 -ve cues)	2.08 (1.46)	0-5
No. 1st memories specific (of all 10 cues)	3.90 (2.47)	0-10
Mean latency to 1st specific (+ve cues)	18.87 (4.96)	10.4 - 30
Mean latency to 1st specific (-ve cues)	16.71 (5.18)	8.8 - 28
Mean latency to 1st specific (all cues)	17.79 (4.10)	11.1 - 25.8
Percentage negative responses (all cues)	52.33 (14.13)	28.57 - 94.44

Table 3-9 : ABMT responses and latencies

Table 3-9 shows that the frequency of specific first responses to all cues was low. For 2 participants, none of their first responses to the 10 cue words was a specific response - that is, they needed further prompting for every item. By cue, 5 participants gave no first response that was specific to the positive cues, and 7 participants gave no specific first response to a negative cue.

Participants retrieved overgeneral memories to 68% of all cue words.

The latencies to first responses are correspondingly high. A score of 30 represents a failure to report any specific memory, and consequently a mean of 30 indicates that no specific memories were offered to any cue word. 11 of the 39 participants had a mean latency of more than 20 seconds.

A figure of 50% of all responses being negative corresponds to the proportion of positive and negative cue words. However, for 5 participants, over 70% of their responses were negative.

3.2.5.1 Analysis

The distributions of specific memory scores and latencies were skewed. Different methods of transformation had little effect, largely due to the small number of possible scale points in the specific memory scores. Accordingly, all tests were repeated using

non-parametric tests. The results obtained did not differ from the results given by the general linear model. General linear model results are reported below.

Clinical categories were entered as between-subjects factors in the general linear model analyses, rather than the continuous measures being entered as covariates. This is in accordance with previous studies which have analysed similar data on the basis of between group comparisons (e.g. Williams & Broadbent, 1986; Williams & Dritschel, 1988; McNally et al., 1994).

3.2.5.2 PTSD and over general memory

Nature of first response

Following previous studies (Williams & Dritschel, 1988; McNally et al., 1994), the number of first responses that were specific, by cue valence, was compared to PTSD scores. See Table 3-10.

	High PTSD	Low PTSD
Positive cues (standard deviation)	1.76 (1.35)	1.84 (1.26)
Negative cues (standard deviation)	1.82 (1.42)	2.21 (1.36)
All cues (standard deviation)	3.59 (2.48)	4.05 (2.41)

Table 3-10 : Specific first responses, by cue valence

The number of first responses to each cue type were entered into a General Linear Model, Repeated Measures test, with PTSD score category as the between-subjects factor. There was no main effect of PTSD score category ($F(1,34)=0.32$, $p=0.57$), nor any interaction of PTSD score category and positive or negative cues on the nature of the first response ($F(1,34)=0.67$, $p=0.42$).

Kosovan sub-sample

In the Kosovan-only group there was also no effect of PTSD score category. The within subjects effect of cue valence, however, approached significance ($F(1,22)=3.21$, $p=0.07$). There were more specific memories given in response to positive cues, compared to negative cues. The mean numbers of specific memories for this sub-group, by PTSD group and cue valence, are shown in Table 3-11.

	Positive cues	Negative cues
High PTSD (standard deviation)	1.42 (1.16)	1.83 (1.11)
Low PTSD (standard deviation)	1.42 (0.90)	1.92 (1.31)
Total (standard deviation)	1.42 (1.02)	1.88 (1.19)

Table 3-11 : Specific first responses, by cue valence

Kosovan sub-sample only

Latency to specific memory

Following McNally (1994), latencies to first specific response were recorded and compared across high and low PTSD scorers and by cue valence. See Table 3-12.

	High PTSD	Low PTSD
Positive cues	19.01	18.18
(standard deviation)	(4.66)	(5.17)
Negative cues	17.74	16.27
(standard deviation)	(5.77)	(4.48)
All cues	18.38	17.23
(standard deviation)	(4.34)	(3.92)

Table 3-12 : Mean latencies to first specific response

whole sample

The latencies to a specific response for each cue valence were entered into a General Linear Model, Repeated Measures test, with PTSD score category as the between-subjects factor. There was no main effect of PTSD score category ($F(1,34)=0.70$, $p=0.41$), nor any interaction effect of PTSD score category and positive or negative cues on the latencies ($F(1,34)=0.11$, $p=0.74$).

Kosovan sub-sample

In the Kosovan-only group there was also no effect of PTSD score category. The within subjects effect of cue valence, however, approached significance ($F(1,22)=3.36$, $p=0.08$). The latencies to specific memories given in response to positive cues were longer, compared to response latencies to negative cues. The mean numbers of specific memories for this sub-group, by PTSD group and cue valence, are shown in Table 3-13.

	Positive cues	Negative cues
High PTSD (standard deviation)	20.68 (5.24)	17.00 (5.42)
Low PTSD (standard deviation)	18.55 (4.71)	17.67 (4.55)
Total (standard deviation)	19.62 (4.99)	17.33 (4.91)

Table 3-13 : Mean latencies to first specific response

Kosovan only sub-sample

3.2.5.3 Depression and overgeneral memory

The same tests were repeated for the Depressed and Non-depressed groups.

Nature of first response

Table 3-14 shows the number of first responses that were specific, compared across the two groups, by cue valence.

	Depressed	Non-depressed
Positive cues (standard deviation)	1.48 (1.09)	3.33 (1.03)
Negative cues (standard deviation)	1.71 (1.27)	3.33 (1.37)
All cues (standard deviation)	3.19 (2.07)	6.67 (2.16)

Table 3-14 : Number of first responses which were specific

The numbers of specific responses for each cue valence, were entered into a General Linear Model, Repeated Measures test, with depression as the between-subjects factor. There was a main effect of group on the first responses ($F(1,35) = 13.95$, $p<0.01$). There was no interaction of cue valence with group ($F(1,35)=0.20$, $p=0.66$). Non-depressed individuals were significantly more likely to give a specific first response across both positive and negative cues.

Kosovan sub-sample

The same test was repeated for the Kosovan-only sub-group. There was no between subjects effect of depression. Mean scores of first specific responses, by cue valence and depression group are shown in **Table** 3-15. The scores are in the pattern that would by predicted by the general findings of the literature, in that there are fewer specific responses to positive cue words. The effect was not statistically significant ($F(1,23)=2.95$, $p=0.10$), but may be suggestive of a significant finding given a larger sample size.

	Positive cues	Negative cues
Depressed (standard deviation)	1.38 (0.96)	1.69 (1.32)
Non-depressed (standard deviation)	1.42 (1.08)	1.92 (1.16)
Total (standard deviation)	1.40 (1.00)	1.80 (1.22)

Table 3-15 : Nature of first responses that were specific

Kosovan-only sample

Latency to specific memory

Table 3-16 shows the mean response latencies to a specific memory, by cue valence.

	Depressed	**Non-depressed**
Positive cues (standard deviation)	19.28 (5.08)	16.20 (3.87)
Negative cues (standard deviation)	17.76 (5.02)	13.47 (3.88)
All cues (standard deviation)	18.52 (4.07)	14.83 (3.32)

Table 3-16 : Mean latencies to first specific response whole sample

The latencies to a specific response for each cue valence, were entered into a General Linear Model, Repeated Measures test, with depression as the between-subjects factor. There was a main effect of group ($F(1,35) = 4.34$, $p<0.05$), but no interaction with cue valence ($F(1,35)=0.22$, $p=0.64$). Individuals in the Depressed group took significantly longer to give a specific response to positive and negative cue words.

Kosovan sub-sample

The same test was repeated for the Kosovan-only sub-group. There was no between subjects effect of depression. However, the mean latencies did differ according to cue valence. Mean latencies to first specific responses, by cue valence and depression group are shown in Table 3-17. The effect approached statistical significance ($F(1,23)=4.01$, $p=0.06$).

	Positive cues	Negative cues
Depressed (standard deviation)	20.15 (5.43)	18.48 (5.53)
Non-depressed (standard deviation)	19.60 (4.88)	16.37 (3.92)
Total (standard deviation)	19.89 (5.07)	17.46 (4.85)

Table 3-17 : Mean latencies to first specific response

Kosovan sample

3.2.5.4 Nature of responses

McNally et al. (1994) reported a higher percentage of negative responses to all cues in high PTSD groups. In this sample there was no significant relationship between the proportion of negative responses and the level of either PTSD ($r=-0.17$, $p=0.34$) or depression ($r=-0.22$, $p=0.19$) symptomatology scores.

3.3 Summary of findings

❖ Differences between the Bosnian and Kosovan groups

- The mean age of the Bosnian group was higher than that of the Kosovan group
- Bosnian participants tended to have left formal education at a higher age

❖ Psychopathology

- There were high levels of PTSD and depression in the sample
- PTSD and depression are comorbid in this sample

❖ Discrepancies

- There were discrepancies between individuals' first and second interviews
- Individuals who had a high score on the measure of PTSD had more discrepancies between interviews than those with a low PTSD score
- A higher rate of discrepancies was associated with a longer delay between the first and second interviews (although this may be considered as confounded by ethnic group)

- Less formal education may be associated with more discrepancies

- Discrepancies were more likely in peripheral details than in central details

❖ Overgeneral memory

- The first response of depressed individuals to the cues of the Autobiographical Memory test were less likely to be specific compared to non-depressed individuals

- Depressed individuals tended to take longer to produce a specific response to the Autobiographical Memory test

4 Discussion

In this section I will firstly discuss the findings, exploring the implications for the psychological literature and for the asylum process. During the course of the study, a number of practical limitations arose, many of which have implications for the interpretation of the findings. These methodological limitations will be outlined, in order to assess the conclusions that may be drawn from the study. Finally, clinical implications and future directions of research arising from the current study are considered.

4.1 Hypotheses one and two - discrepancies and psychopathology

4.1.1 Discrepancies and asylum decisions

The findings of the study were consistent with the main hypothesis, that is, that there will be discrepancies (including missing information subsequently recalled) within and between two accounts given by the same individual on two occasions. There were inconsistencies between individuals' accounts of their experiences. In one example, eleven of the details given by the individual in the first interview were contradicted in his second interview. In the first interview, he told of a day when he and his cousin had been put in different groups and they knew that one group was to be killed, before the other group was transferred to another camp. In the second interview, he did not remember what specific event he had described in the first, he only remembered it was 'something that happened in the camp'. He was reminded of the account, and he then

said that he remembered telling it previously. Table 4-1 shows some of the answers he gave.

	Interview One	Interview Two
Where were you?	Outside in the yard	A room near the restaurant
What was the date?	6th August 1992	31st May 1992
What made you most afraid?	That one of us would be killed	I wasn't afraid - I thought it must be a joke
What day was it?	Don't know	Sunday
Who was with you?	Can't remember any specific people	My brother, my uncle
What time was it ?	9am when we were sorted out; 3pm when we were transported	10am
What were they doing?	Being efficient, putting us on the buses; then beating and killing	It was very busy - the journalists had arrived

Table 4-1 : Discrepant answers

It should be noted that his other answers were consistent, making it difficult to say with any certainty that he was describing two completely separate events.

These data have serious implications for the assumptions in the Home Office guidelines for asylum applications:-

> "Discrepancies, exaggerated accounts, and the addition of new claims of mistreatment may affect credibility. ... they may equally reflect a concern on the part of the applicant, or his advisers, to bolster a claim..."

Asylum Directorate Instructions : Chapter 1 Section 2 - Assessing the Claim (July 1998)

In the example quoted above, the individual had no ostensible reason to exaggerate nor bolster his story. In later sections some of the other possible explanations for these inconsistencies will be explored (see section 4.1.3).

4.1.2 Discrepancies and the psychology literature

In the psychology literature there are few studies of repeated recall with reasonable subject numbers and using real-life material. Much of the work demonstrating inconsistency of memory has relied on laboratory paradigms, such as the learning of word lists (Roediger et al., 1997). Williams and Hollon (1981) suggested that memory is also inconsistent in more life-like recall situations. They tested four participants each day for two weeks, on the names of people they had been at school with. More

information was recalled on each test, although Williams and Hollon were able to show that later information was more likely to be false. Notwithstanding its low number of participants, this study remains the main cited ecologically valid investigation into the consistency of memory over time. The current study differs somewhat in design and aim, since the validity of recall is not under investigation. Nonetheless, it provides a further ecologically valid study of repeated recall, with a larger subject group.

The current findings of inconsistencies in recall support Southwick et al's (1997) findings. They asked veterans of the Gulf War to report whether or not they had experienced a number of potentially traumatic events during the course of their combat. Between the first report (1 month post-combat) and the second (2 years post-combat), fifty-two (88%) of the fifty-nine participants had changed their answer to at least one of the items. They offer a number of explanations for their results: changes from yes to no on some items may have been due to normal forgetting, repression or media trivialisation; changes from no to yes may be explained by repressed material becoming conscious, exaggeration following repeating telling or the involuntary re-experiencing of PTSD.

In the following sections some of the possible explanations for the inconsistencies in the current study will be considered.

4.1.3 Possible explanations for the discrepancies?

4.1.3.1 Time interval between interviews

The length of time between interviews was strongly associated with the number of discrepancies between accounts. This finding is clearly important for the asylum process when there may be months and even years between the original interview and an appeal hearing.

However, in terms of understanding possible causes, there was a confounding factor of ethnic group. Due to the practicalities of data collection, the Kosovan group were seen over a short period of time (typically four weeks), whereas the Bosnian participants were interviewed over a longer period. Ethnic background alone is unlikely to account for differences in the numbers of discrepancies, however the age of the memories reported by the two groups may be important. The war in Bosnia took place between 1992 and 1995, whereas the Kosovan refugees arrived here during the course of 1999. Consequently the age of war memories differed by up to 7 years between the two groups. However, this would be to argue that there are more discrepancies in older memories. If age were the only factor, we might expect older memories to be more fixed through repetition (whether private or social), or to be showing signs of forgetting only. The findings of this study is that they were not more fixed - they were more inconsistent. An informal inspection of the discrepancies in the Bosnian group showed that this does not seem to be due to simple forgetting, which would most obviously be demonstrated by answers in the first interview being changed to 'don't know' in the second.

The other possible differences between the groups, however (and which would therefore confound the variable of the time between interviews) is that most Bosnian refugees suffered victimisation and brutalisation over a long period. Some were in concentration camps for many months. The terrors experienced by the Kosovan Albanians happened over a far shorter period. Thus discrepancies between the accounts of Bosnian participants may reflect the higher likelihood of confusion between repeated events such as beatings or arrests.

4.1.3.2 Different events?

One of the difficulties that was reported by participants (particularly Bosnians) in trying to repeatedly recall war time events is that when brutal events happened many times over a long period, it became difficult to distinguish separate instances. One participant gave an account of being beaten in prison as his traumatic memory. When prompted at the second interview to reconsider this memory, he replied that it was simply impossible for him to remember a specific instance of his having been beaten, since it had happened to him so many times. Other examples were less clear. One individual seemed to be recalling the same event both times, in that he gave the same date, although many of the other details changed. Another participant gave an account of military police coming to his house, taking him to the police station and beating him. When asked at the second research interview whether he remembered what he had described, he said he did, that it was about being picked up by the police from home. However, the details he then gave differed in many ways, such that it seems clear that he was relating a different event, or

possibly confusing two or more events. Brewer (1986) argues that strong (accurate) personal memories are facilitated not only by emotionality, consequentiality and unexpectedness, but also by uniqueness (p.44).

4.1.3.3 Reminiscence?

Reminiscence is a mechanism which has taken on a technical definition in laboratory based studies of memory. This was first demonstrated by Ballard (1913). In an experiment measuring memory performance over repeated trials, schoolchildren were taught a poem and tested periodically for one week. He found that they frequently recalled new lines on later tests. The children may have been forgetting some information, but they were also retrieving information on later trials that they had failed to retrieve earlier.

Many mechanisms have been proposed to explain this phenomenon (e.g. Wheeler & Roediger, 1992). One which seems to have received little attention is that, having initiated a search in memory, the search continues, although the subject may be unaware of it. Reminiscence would then arise from the fact that a search initiated during a recall phase continues after that phase has finished.

Hence in the current study, questions to which individuals responded 'don't know', later yielded a response as more information was retrieved. Of course, new information is not the only possible result of continuing to search for details of a memory. It is possible that a response is given in the first instance that seems to make sense in the context of the

account, and yet, on further reflection, contradictory details are recalled. For example, in one participant's first interview he described the driver of the police van which was taking him to the police station - 'he was young, wore a cap'. However in the second interview the same question yielded the response 'we couldn't see the driver - he was blocked from view'.

There were also examples in the current study of conscious reconstructions of the accounts offered. For example, one woman gave an account of her tenth birthday as her non-traumatic memory. At the second interview, when asked again for the date, she mentioned that she had enjoyed remembering the surprise party, and had talked about it with her parents after the interview. They told her that it had in fact been her sixth birthday. Consequently, she changed the year in response to that question, causing a discrepancy between the two answers.

4.1.3.4 Interviewer effects

One explanation for the discrepancies between accounts must focus on the interviewing situation - the interviewer, the fact of there being two interviews, the role of the interpreter.

On the one hand, participants may have been less anxious at the second interview, since they had met the interviewer and interpreter before. In some of the cases where a different interpreter was used, the second interpreter was better known to the

interviewees than the first. It might be, then, that participants felt more relaxed and offered more information on the second occasion.

On the other hand, of the 36 individuals who did not speak sufficient English for the interview, 15 of them (all of the Bosnians) already knew the interpreter and so would be unlikely to be significantly more relaxed with them in the second research interview compared to the first. In contrast to the suggestion that participants would be more relaxed, they may also have been less interested or motivated to be interviewed for a second fairly lengthy interview. Indeed, on recognising that they were being asked about exactly the same events as previously, many seemed not to see the point in giving the same details again. Lastly, in the case of the Kosovans, the level of uncertainty in their housing situation was considerably greater by the time of the second interview, as the centre in which they had been living was about to be closed.

Taken together, it is not possible, within the confines of the current study, to predict which of these factors might have had the most influence on the responses given in the interviews. However, although these may be confounding factors in the search for psychological mechanisms underlying the discrepancies, they may all be pertinent in the course of asylum applications.

4.1.3.5 Mood

One participant changed his description of how he was treated by military police from "we were slapped around" to "we were badly beaten". I will consider two ways that this change might have come about.

One of the explanations for inconsistent memory which is considered by Southwick et al. (1997) is that exposure to others' reactions can influence the retelling of experienced events. In their sample, for example, media accounts of the Gulf War which minimized the trauma experienced by military personnel may have led some veterans to downplay their own experiences. On the other hand, conversations with other traumatized veterans may lead some to exaggerate the extent of their own experiences. The example given above from the current study may have resulted from similar types of influences. Indeed the reaction of the researcher in the first interview may have motivated the participant, whether knowingly or not, to exaggerate the description of his suffering the second time.

Another explanation of this shift in the description of maltreatment may be mood. We know that in states of depressed mood, recall is biased towards negative memories (Williams et al., 1997). Furthermore, such biased recall may be affecting judgement. Schwarz and Clore (1989) propose that we use a 'how do I feel about it?' heuristic when making judgments about current or past events. For example, in depressed moods, the subjects of their study gave lower life satisfaction ratings. The participant in the current study may have been in a different mood state in each of the two interviews, leading to a different evaluation of his experience.

4.1.4 Higher levels of PTSD were associated with more discrepancies

This finding has perhaps the most serious implications for the assumptions behind asylum decisions based on discrepancies. If it is the case that individuals with higher levels of distress are more likely to have inconsistencies in their memory, then these are the people who are most likely to be refused asylum, all else being equal.

4.1.4.1 The nature of traumatic memory

One of the central tenets of the emerging cognitive models of PTSD is that the memory of the traumatic event is fragmented. The extent of the fragmentation will be affected by the individual's state at the time of the event, the extent to which they dissociate, and possibly their appraisal of the event as it occurs (Ehlers & Clark, 2000). It may be that those individuals whose memory is more fragmented are more prone to PTSD, and are also more likely to be unable to tell a consistent account of their experiences.

Van der Kolk (1996a) describes a study where traumatic and non-traumatic memories were compared, in which he concludes that memories of traumatic experiences are distinct from normal memories:

> "the very nature of a traumatic memory is to be dissociated, and to be stored initially as sensory fragments that have no linguistic components"
>
> van der Kolk, 1996a:289.

Brewin, Dalgleish and Joseph (1996) argue that the notion of a single emotional memory is insufficient to explain the nature of the recall of traumatic experience. They suggest that there are both situationally accessible memories and verbally accessible memories. Situationally accessible memories may correspond somewhat with the 'sensory fragments', in that they consist of the encoded sensory and physiological aspects of the experience. They are not available to, nor limited by conscious processing. Verbally accessible memories, on the other hand, represent the individual's conscious experience. They provide the 'narrative' of the experience.

One of the effects of PTSD is the difficulty in constructing a narrative account of the event (Meichenbaum, 1997), which may be due to the disparities between situationally accessible and verbally accessible memories, as suggested above. Van der Kolk suggests a process of "constructing a narrative which 'explains' what happened" (van der Kolk, 1996a:289). So, for example, a person in a car accident might say that she remembers driving and then sitting on the grass verge and so "must have" got out of the car. In the context of the present study, this might be leading to inconsistencies in individuals' accounts if the construction of the narrative is still under development.

4.1.4.2 Reconstructing the narrative

It seems fair to assume in these research interviews, and all the more so in asylum interviews, that interviewees were motivated to tell a credible story to the interviewer. Writers who have interviewed survivors of the Nazi Holocaust emphasise how important

it is to many of those individuals that people who were not there believe their accounts (e.g. Barclay, 1995). Regardless of whether they have something to gain from being believed in terms of legal status, there is in many survivors of state organised violence a need to give testimony, and for outsiders to believe (Weine et al., 1995). One of the explanations for discrepancies between accounts is that individuals are indeed, possibly wholly unconsciously, fabricating answers when they are unable to access actual memories. Baddeley et al., in their consideration of psychotic delusions (Baddeley, Thornton, Chua, & McKenna, 1995) define one type of confabulation as the "relatively normal tendency to go beyond the mnemonic evidence by producing a plausible guess" (p.385). Weine et al. (1995) cite a Bosnian refugee in the United States who gave an account of her trauma, and three weeks later was unable to recall it at all. Even survivors themselves may 'question whether it ever happened at all' (p.541). For such individuals, the ability to produce a plausible account of their experiences is crucial to their sense of self (Barclay, 1995; Heuer & Reisberg, 1992).

I will return to the reconstruction of memory below, in considering why details are particularly important to this process.

4.1.4.3 Cognitive capacity/concentration

A number of the transcripts seemed to show that participants were confusing different events. Poor concentration is a symptom of both PTSD and depression and this may be causing such confusion. Turner (1998) argues that concentration is one of the possible reasons for discrepancies in asylum applications.

McNally et al. (1994) suggest a more general mechanism (albeit in reference to the effort to retrieve specific memories) : "reminders may prompt intrusive recollections that consume cognitive capacity, making it difficult for patients to conduct an effortful search for memories having sufficient specificity" (p.365). In support of this, their priming manipulation, whereby they exposed one group to reminders of the traumatic events, seemed to increase memory processing deficiencies in PTSD-diagnosed participants.

4.2 Hypotheses three and four - central/peripheral discrepancies

4.2.1 Discrepancies in peripheral details

There was strong evidence for the hypothesis that there would be more inconsistencies in peripheral than central details. This result was found in the whole sample and also in the smaller more homogenous sample of Kosovan refugees. This hypothesis was drawn from predictions following the eye-witness testimony literature: that memory is better for central details than peripheral details in the recall of traumatic material.

In investigating these different recall effects, the present study addresses some of the criticisms of the eye-witness testimony literature. Yuille and Tollstrup (1992) have observed that most of the studies in this area have used what they term 'upsetting material'. The videos or pictures shown have no (known) emotional salience for the participants and cannot realistically be compared to personal traumatic experiences. The memories of the current study clearly answer this point. Wessel and Merckelbach

(1997) also refer to studies where the emotionality of personal events is rated retrospectively, suggesting that such reports may not give an accurate reflection of the emotion at the time of the event. Again, by asking participants to report events during which they felt their life was in danger, a somewhat more standard level of emotionality may be assumed. However, the current study is prone to the circularity of the central/peripheral ratings which Wessel and Merckelbach (1997) have also identified. Participants may well have rated as peripheral those details which they could not remember so well.

4.2.2 Traumatic and neutral memories

The lack of any difference in recall of details between traumatic and non-traumatic memories is not consistent with the literature. It was hypothesised that the difference between recall of central and peripheral details would be differential across traumatic and non-traumatic memories (Christianson & Nilsson, 1984; Christianson & Safer, 1996). It may be that the failure to demonstrate this effect was due to the low sample size, and the trend of the data does suggest this, insofar as it is in the right direction, but fails to meet statistical significance. However, in the current study the non-traumatic events were perhaps not sufficiently like those in previous studies to be able to demonstrate the same effects. Two issues arose in the eliciting of non-traumatic memories.

Firstly, the types of memories that were offered in the current study, whilst mostly happy memories, were often highly emotional ones. Many recounted memories of the birth of their own first child, or a family wedding. Eliciting neutral memories did not seem to be

possible with the participant group and the circumstances of the project. Interestingly, this is more in line with van der Kolk's (1995) study of traumatic and non-traumatic autobiographical memory outlined (see section 4.1.4.1 above). However, in the eye-witness testimony literature, the alternative scenarios to the 'traumatic' ones are usually described as 'neutral'.

Secondly, the ability of participants to relate non-traumatic memories in the current study seemed to be particularly subject to the effects of mood disorder. Three participants could not recall any memories that they would describe as happy, and two more needed a full ten minutes of prompting before describing a happy family event. Another participant's happy memory was of a work colleague who fell almost to his death, but was saved by the rest of the work team. All six of these respondents had high scores on the BDI, suggesting the presence of major depression. Their responses are thus consistent with the literature on recall bias in depression which predicts that depressed individuals are more likely to recall negative memories than positive memories (Williams et al., 1997). Mood-congruent recall may also be pertinent, but no measure of mood was taken.

The problem with these findings, then, is that they only demonstrate that there are more mistakes made in the recall of peripheral details, without showing any effect of the nature (traumatic or not) of the material. The same effect might be achieved, for example, by asking ridiculously irrelevant questions ("exactly how many clouds were there in the sky at that moment?").

However, the general picture, whilst non-significant, did seem to indicate some differences between memories which are consistent with the literature, and a post-hoc test did suggest that the difference between central and peripheral recall was significant for traumatic and not for non-traumatic memories.

4.2.3 Discrepancies not recall failure

Although the hypothesis addressed in the current study was drawn from notions explored in the eye-witness testimony, the nature of the task is subtly different in the two different paradigms. In eye-witness testimony studies, participants are asked to recall details, and whether or not they succeed in this task is recorded (along with the type of detail and type of material being recalled). The focus of the current study was consistency. If participants answered 'don't know' on both occasions, this was not recorded as a discrepancy. In comparison to the eye-witness testimony studies, then, it may be that the data presented here are conservative. However, it does leave open the question of why there should be inconsistencies, as opposed to consistent failure to recall, for peripheral details.

One explanation might be that many of the peripheral details given were in fact 'plausible guesses' (Baddeley et al., 1995) and thus less stable under repeated questioning. I have considered the suggestion that survivors of state organised violence are motivated to give testimony about their experiences and to be believed (see above, section 4.1.4.2 : Reconstructing the narrative). A number of writers argue that it is the details of a

memory that make an account more believable and persuasive (Tromp, Koss, Figueredo, & Tharan, 1995; Heuer & Reisberg, 1992). This is partly based on an understanding of how schematic knowledge (generalised structures based on repeated experiences and knowledge of the world) is used in the formation of autobiographical accounts. The gist of an autobiographical memory, it is argued, can be reconstructed from schematic knowledge, whereas detail of a specific event cannot, thus detail is seen as a good way of distinguishing between "accurate recollection and plausible reconstruction" (Heuer & Reisberg, 1992). This is presumably in part the principle which guides the Immigration and Nationality Directorate's reliance on consistent details as an indication of credibility. However, there are problems with accepting that assumption at face value. We know that peripheral information is more susceptible to post-event disruption. For example, both discussions about the event (Hollin & Clifford, 1983) and the exact wording of questions about the event (Harris, 1973; Lipton, 1977) can change the detail of the responses given. Harris (1973) found that asking 'how tall?' as opposed to 'how short?' could make a ten inch difference in the means of participants' estimates of the height of a person they saw minutes previously.

Thus the suggestion is that there is pressure to produce peripheral detail from both the interviewee who wants to be believed and from the interviewer who is making that judgement. According to the eye-witness testimony literature, peripheral detail is less likely to be recalled. Confabulation (guessing) of those details is thus highly likely. When this is added to post-event effects such as discussion with other refugees, or the

different wording of questions, the likelihood of those details being inconsistent is considerably raised.

4.2.4 Asylum process implications

In terms of the asylum process, this distinction between different types of memories is less critical. If the only finding is that details rated peripheral by interviewees are likely to be prone to discrepancies, then the use of discrepancies in judging credibility is still under question. It must be remembered that many of the questions used for the study were taken from asylum interview transcripts, and are not excessively irrelevant details as suggested above. More positively, it suggests that an awareness of such differences could help credibility decisions to be more finely tuned. By recognising the difference between central and peripheral details, asylum officials might be able to decide that a discrepancy is more or less likely to indicate fabrication in order to achieve refugee status on the part of the applicant.

4.3 Hypothesis five - overgeneral memories

The findings offer further evidence for the robustness of the overgeneral memory concept.

4.3.1 Nature of first response

The findings of this study have provided some replication of the effects of overgeneral memory in a non-English, non-clinical sample. Non-depressed participants gave specific autobiographical memories without prompting to sixty-seven percent of the cue words. Depressed participants gave specific responses to only thirty-two per cent of the cue words.

These findings can be compared to previous studies. These previous studies have found effects of cue valence and so break down their results by positive or negative cues. The current study failed to find significant cue valence effect, so the data given are for all cues together. McNally et al. (1994) compare their findings to Williams and Dritschel's (1988) results by describing the data in terms of percentage overgenerality, that is, the percentage of first responses that were overgeneral. The mean overgenerality scores for their PTSD patients were 58% for positive cues and 55% for negative cues. They compare this to 57% for positive and 50% for negative in the Williams and Dritschel study. The same figures for Williams and Broadbent's (1986) early study show mean scores of 57% (positive) and 42% (negative). The mean overgenerality score to all cues for depressed participants in the current study was 68%; higher than all of these figures.

McNally et al.'s control subjects had a mean overgenerality score of 44% (positive) and 40% (negative), compared to Williams and Dritschel's mean scores of 27% (positive) and 33% (negative). The same scores in Williams and Broadbent's (1986) study were 22% (positive) and 25% (negative). The mean overgenerality score in the non-depressed group of the current study was 33% (all cues).

Interestingly, McNally et al. (1994) are comparing their figures for the group who were not primed. Half of their sample were shown video scenes from the Vietnam war, with the hypothesis that this would increase the likelihood of intrusive memories. The overgenerality figures for these participants was higher (68% for positive cues; 53% for negative cues). These figures are closer to the overall figure of the current study (68%). Although the current study was not intended to investigate priming effects similar to those of McNally et al.'s study, it may be that by asking participants to recall traumatic war time memories was inadvertently serving that purpose. Participants did the Autobiographical Memory Task at the start of the second interview, so strictly speaking it did not directly follow questions about traumatic memories. Nonetheless, participants had been interviewed once, and were aware that the second interview would cover the same material, so it might be the case that they were prepared, which would serve as priming.

Such comparisons are made with caution. McNally et al. (1994) used identical words to Williams and Dritschel (1988). Although care was taken in the current study to match words for frequency and emotionality with previous studies, different words may be

responsible for differences in results, and translating them into different languages can only increase the likelihood of unforeseen connotations. Furthermore, there are clearly cultural differences between the English and American samples of Williams' studies (1986; 1988) and McNally et al. (1994) and the Southern European sample of the current study.

Nonetheless, the indications are that the findings of the current study replicate and extend the findings of the literature which addresses this mechanism.

4.3.2 Latencies

Latencies were similarly in line with previous studies, showing that it took depressed participants significantly longer to retrieve specific responses than non-depressed participants. It should be noted that these two results may be aspects of the same finding. If a participant fails to retrieve a specific memory in response to the cue, then they are prompted and the timing of their response continues. Hence those who fail to respond with a specific memory initially are far more likely to have longer latencies.

4.3.3 Valence effects

An effect of the cue valence was not found, although non-significant trends were identified in the smaller Kosovan-only group. The failure to replicate this effect may be due to the connotations of different words in this particular group (see below, section 4.5.5 Standard tests - culturally appropriate?). For example 'proud', was used as a

positive word but tended to elicit negative responses. However, it is also the case that this effect has not been found consistently in the literature (McNally et al., 1994:363; Kuyken & Brewin, 1995).

4.3.4 Depression, or history of trauma?

McNally et al. (1994) suggest that it may not be depression, but a history of trauma that underlies overgeneral memory. They argue that Williams and Broadbent's (1988) suicide attempters may have had comorbid borderline personality disorder, which may in turn imply a history of trauma, given that the majority of individuals with this condition report childhood sexual abuse (Zanarini et al., 1997). They also cite Kuyken and Brewin's (1995) findings that overgeneral memory was associated with reported childhood abuse. Indeed, Kuyken and Brewin (1995) found no relationship between overgeneral memory and score on the BDI.

For the current study to make a significant contribution to this debate it would have needed a controlled investigation of exposure to trauma. To find a refugee group that have not had potentially traumatic experiences is, unfortunately, a contradiction in terms. However, the current study did analyse levels of overgenerality in relation to BDI scores and also separately (which McNally et al. (1994) did not do) in relation to PTSD symptomatology. The results of these analyses suggest support for the hypothesis that depression is the key.

4.3.5 Overgeneral memory and discrepancies

The mechanism of overgeneral memory does not account directly for changes in memory, which are the focus of the current study. We know that changes in depression are not reflected in changes in ability to retrieve specific memories (Williams, 1995). Williams and Dritschel (1988) studied a group of current suicidal patients and ex-patients whose mood had recovered. Although both differed significantly from non-depressed controls, they did not differ from each other, suggesting that depressed mood is not a cause of overgeneral memory. A subsequent longitudinal study also showed that the overgeneral memory effect did not remit as depression lifted (Brittlebank, Scott, Williams, & Ferrier, 1993). Accordingly, we cannot conclude in the current study that the ability to retrieve specific autobiographical material could have changed over the course of the study.

However, difficulties with retrieving specific events may be implicated in the observed effects for some participants of confusing different events. Not being able to distinguish instances of oft-repeated events is probably a normal memory effect (Brewer, 1996). However, if a tendency towards overgeneral memory is present then that effect is likely to be enhanced.

There is also the possibility that participants attempted to construct meaningful memories, as van der Kolk suggests, in connection with fragmented traumatic memory (van der Kolk, 1996a). As discussed above, if the memory for an event is poor, but the motivation to respond to an interviewer's detailed questions is high, then it is possible

that a respondent would fill in 'likely' answers to those questions. We might expect these 'likely' responses to be less stable (consistent over two interviews) than responses based on memories of an actual event.

Williams (1996) suggests that overgeneral memory is associated with poor problem solving and this has been shown also in social problem solving (Goddard, Dritschel, & Burton, 1996; Goddard, Dritschel, & Burton, 1997). It is not clear how this is distinguished from the established link between depression and problem solving (Williams et al., 1997). However, overgeneral memory may be the mechanism by which the deficit arises. For refugees facing problems of housing, acculturation and decisions regarding return, problem-solving and social problem-solving skills deficits have a particularly acute impact (Silove et al., 1997).

4.4 Psychopathology

Thirty-seven out of the forty-three initial participants (86%) met diagnostic criteria for PTSD. Thirty-two of thirty seven participants (84%) fell into BDI-II score categories for mild (n=10), moderate (n=11) or severe (n=11) depression.

These levels of psychopathology are at the higher end of the rates reported in the literature and, whilst coming from a community sample, are equivalent to some of the highest prevalence rates found previously in clinical samples. Clinic based studies have showed ranges of prevalence of over 50% for PTSD and 42%-89% for depressive

disorders (Silove et al., 1997). Population based studies have shown rates of 15%-80% for depression and 3.5% - 86% for PTSD (Silove et al., 1997).

Thulesius et al. (1999) surveyed a community sample of two hundred Bosnian refugees in 1993 and found that between 17.5% and 32.5% could be diagnosed with PTSD and 20% with depression. This may suggest that the current study's small sample is not representative. The generalisability of the sample is discussed in more detail below (see section 4.5.3).

Of particular concern in this sample is the Bosnian sub-group. They have been in this country typically about 8 years. 13 of the 16 Bosnians met criteria for PTSD suggesting either a delayed, or chronic PTSD reaction. Of the 12 measured on the BDI, 4 rated as moderate and 4 as severe. Only two of this sub-group were known to be receiving clinical attention. Interestingly, one of the two attending psychotherapy did not rate as currently suffering from PTSD or depression.

Weine (1998) found that the number of PTSD cases in his sample of 34 Bosnians in the US dropped from 25 to 15 after one year. If Weine's results generalise to the UK Bosnian population, then the sample of the current study may be drawn from the sub-group whose symptoms remain.

However, in terms of depression, all but two of the Kosovan sample had some measure of depression, thirteen (of 25) of them falling into the moderate or severe categories.

Depression is known to be associated with poor problem solving - including interpersonal problems (Williams et al., 1997). The Kosovans interviewed for the current study were facing decisions related to finding housing in this country and of returning to Kosovo. Clinical levels of depression must have implications for similar problems and practical decisions of housing, return, getting help in this country, as well as constructing a case for refugee status in order to seek asylum (Silove et al., 1997).

4.5 Methodological Limitations

There were a number of methodological problems which may limit the reliability and validity of the conclusions that are drawn from this study. These are outlined and considered in the following sections.

4.5.1 Design/rationale

The assumption underlying the design of the study was that, by virtue of being program refugees, the participants in the study would have no motivation to fabricate their autobiographical accounts. This is an assumption that was not tested, and there were indeed individuals who were in the process of applying for state benefits, who may have felt that talking to the researcher could influence their claims. Others, particularly in the Kosovan group, were facing uncertainty as government policy on repatriation remained unclear. However, there were no indications that any of the participants regarded the researcher as in any way able to influence such decisions. Participants were told that the researcher was interested in their memories, and most seemed to regard the interviews as an opportunity for testimony.

4.5.2 Measures

The BDI-I translated into Bosnian has been used in previous studies and appears to perform similarly to the English version (Perrin, 2000). This was also true of the PTSD measure (Weine et al., 1995; Weine et al., 1998c). However, the Kosovan BDI-II and the Kosovan PTSD measures are in the course of being evaluated for concurrent validity.

Due to the practicalities of data collection from the two groups, two different versions of the BDI were used. A conversion table was used to give equivalent BDI-II scores for the Bosnian group, who were originally measured with the BDI-I. This is described in more detail above (see section 2.4.5.3 - Depression), but is mentioned here as a possible limitation on the validity of the interpretations based on depression scores.

4.5.3 Generalisability of the sample

The original intention had been to sample a culturally homogenous group, which led to approaching Bosnian community groups, as there is a population of Bosnian program refugees in the London area. However, it soon became clear that this is a group who have been approached many times, by television, film and news media, as well as by researchers.

Consequently a second cultural group were approached, in order to provide a larger sample for study. There were some differences between the groups - the mean age of the

Bosnian group was older, there was more clinical depression in the Kosovan group - but there seemed to be no theoretical reason why these differences should preclude the analysis of the sample as a whole.

The eventual sample was not large. Forty-three participants engaged in the sample, but only thirty-nine completed both interviews. However this size of sample does conform with other surveys of refugees (e.g. Weine et al., 1998b : n=34; Silove et al., 1997 : n=40) and some of the studies of overgeneral memory (e.g. Williams & Dritschel, 1988 : n=24)

It seemed that the Bosnian group consisted of both the best adjusted, who were happy to talk about their past, and the least well adjusted, who were hoping for more help or support. The Kosovan group were recruited at their reception centre, and so are probably the more representative sample.

This study did not include a predefined control group. For the analyses involving psychopathology, low scorers (on PTSD or the depression measure, for example) served as a comparison group for high scorers.

In terms of adding to the existing literature on repeated recall, it might have been interesting to use a control sample and ask about memories of a similar age, but it is difficult to see what this would tell us about the differences between the groups, given that there are so many factors which distinguish refugees. Similarly, studies of overgeneral memory have typically been controlled studies, but again, it is difficult to

define a control group for this particular sample. Writers in this area have argued that the complex combination of repeated trauma, displacement, loss of employment, status, social networks and community are unique to this population (Silove et al., 1997; Lavik, Hauff, Skrondal, & Solberg, 1996).

4.5.4 Central / Peripheral ratings

The current study aims to be ecologically valid in terms of focussing on autobiographical, life-threatening events. In order to investigate the hypotheses arising from the eye-witness testimony literature, the details of each account had to be rated as central or peripheral. One approach would have been for the researcher to rate the questions in advance of data collection, with second ratings to confirm reliability. However, it became apparent that many of the questions had significantly different meanings for some participants. For example, 'what were you wearing' was classified as a peripheral detail by most individuals, but for one, the answer was central to his account - "I was wearing three jumpers as I knew I was going to be beaten, and I'd learned that more clothes cushioned the blows a bit". Similarly for others, whether anyone was with them or not might be of no matter, or crucial to their emotional experience.

Participants were therefore asked to give ratings after each of their answers in the first interview. However, there are doubts about the validity of their ratings. Some participants did not seem to understand the task and some items were rated as peripheral when they were clearly a central part of the story. There is also the possibility, as raised

by Wessel and Merckelbach (1997) that details which were not remembered were rated as peripheral.

In order to check whether these inconsistencies were having a systematic effect on the findings, a brief exercise was undertaken whereby any clearly misjudged central/peripheral ratings were re-rated, and the main discrepancy rates were recalculated. It did not make a significant difference to the scores. It would seem that the number of central details mis-assigned as peripheral are cancelled out by the number mis-assigned in the opposite direction.

4.5.5 Standard tests - culturally appropriate?

The literacy level of many of the individuals interviewed was low. Particularly in the Kosovan group, the length of formal education received ranged from four to - in one case - no years. This had implications for the self-report measures (BDI; PTSD scale), most of which were completed by oral administration, following manual instructions where possible (Beck, 1996).

The Autobiographical Memory Test that was used in the study is based on a method of presenting cue words which have previously been reliably rated as having positive or negative connotation (Williams, 1999). The method of translating the words chosen for this study are described above (see section 2.4.4 - Overgeneralized memory : AMT). Whilst care was taken to translate and back-translate each word, this can only be a rough guide to the equivalent meaning of the words across different cultures. The further

problem in the sample of refugees in the current study, is that they have been through unusual circumstances, which might lead to quite different connotations being attached to some of the words used. For example, the word 'proud' is rated as positive and routinely used in this test. However, for survivors of a war situation, the word was frequently associated with memories of war and often death. For example, one response given was "I'm proud of my son as he wasn't afraid to die".

In the light of this consideration, the lack of significant effects due to the valence of the cue words is less surprising (see section 3.2.5 - Hypothesis 5 : overgeneral memory).

4.5.6 Traumatic memory and PTSD

Participants were asked to report an event during which they felt that their life was in danger. Although it was not encouraged, for some this will have been their most traumatic event, and possibly the index event of their PTSD symptoms. Intrusive memories and flashbacks to a traumatic event tend to be highly clear, vivid images, which remain fixed over time (van der Kolk, 1996b). It might have been interesting to determine whether the event described to the researcher was the individual's index event and to explore the relationship of this aspect of the memory to the number or nature of discrepancies. There were no indications that participants were experiencing flashbacks during the course of the research interviews. This does raise questions concerning the generalisability of the findings of the study to the asylum process, since in the asylum interview, applicants are expected to disclose their most traumatic experiences.

However, discrepancies in all traumatic events recounted by asylum applicants are of significance in the asylum process.

4.5.7 Different interpreters

It was not possible in all cases to use the same interpreter for the first and second interviews. This unfortunately introduced a confounding variable into the interpretation of the results. A between groups analysis on the whole sample suggested that the effect of this variable on the discrepancy rates was not significant, but it did approach significance in the Kosovan-only group.

4.5.8 Teasing out psychological effects from practical

In terms of the psychology literature, many of the limitations considered above serve to attenuate the conclusions which may be drawn from the findings. However, in terms of asylum applications, these limitations are also present in the asylum process. For example, using a different interpreter between first and second interviews in this study undermines the conclusions that may be drawn concerning the source of any discrepancies. However, in the course of applying for asylum, applicants may well have different interpreters, so the fact of the discrepancies is still pertinent.

4.6 Refugees and asylum seekers

It is one of the assumptions of the current study that the findings of an investigation of a sample of refugees will also apply to asylum seekers. It might be argued that this is not the case. The participants of this study have housing, most are living together with at least some family members and, in the case of the Bosnians, are relatively settled in this country, compared to the asylum seeker, newly arrived at a port. However, upon closer examination, the sample of this study are facing considerable uncertainty. Kosovan refugees are awaiting a decision from the UK Home Office concerning repatriation - something over which they have no control. In the short term, the issue of return may not be so salient for the Bosnian refugees, but in the longer term, it may be argued that they will face bigger problems since a large part of what was Bosnia is currently controlled by Serbian or Croatian forces. Silove (1997) addresses the distinction between refugees and asylum seekers, noting the evidence of mental illness in refugees, together with the assumption that asylum seekers are likely to have experienced at least some of the same traumata as refugees. He concludes that,

> "in addition to past trauma exposure and displacement, asylum-seekers live in a state of insecurity and are faced with the constant fear of repatriation"
>
> Silove et al., 1997:351

The sample in the current study may be considered in the same light, although their fear of repatriation might be described more as a fear of the unknown state of the country

from which they were collectively ejected, and the job of rebuilding their homes and lives.

4.7 Clinical implications

This study has focused on the asylum process, and how our understanding of memory functioning can inform it. In terms of clinical service planning the findings regarding mental health problems in this group can only add to previous surveys (e.g. Lavik et al., 1996; Silove, McIntosh, & Becker, 1993; Weine et al., 1998c; Ramsay, Gorst-Unsworth, & Turner, 1993; Van-Velsen et al., 1996), all of which show a level of need that has to be recognised in host countries.

In finding that high levels of PTSD symptoms are associated with a greater likelihood of discrepancies, this study also serves to highlight the role of psychiatric assessment in asylum applications and appeals.

4.8 Future directions

In their guidelines to interviewing officials, the Immigration and Nationality Directorate do advise interviewing officials to give applicants the opportunity to explain why their answers have changed:

> "Applicants should be given the opportunity to explain any apparent discrepancies and the reasons for any changes in their accounts."
>
> Asylum Directorate Instructions : Chapter 1 Section 2 - Assessing the Claim (July 1998)

A useful extension to the current study might be to take a qualitative approach and include the explanations of participants for their discrepancies. It may be possible to draw on the body of evidence that investigates the relationship between individuals' confidence in their own recall and accuracy (Brewer, 1996). Such a study would give the opportunity to explore the assumption in the Asylum Directorate Instructions that "genuine" discrepancies are explainable by the individual.

4.9 Conclusion

This study is an ecologically valid study of repeated recall. It has shown evidence that, without any ostensible motivation to fabricate, refugees questioned twice about autobiographical events have discrepancies between their accounts. These discrepancies are more likely to arise in details which the individual rates as peripheral to the account. Individuals with high levels of PTSD symptomatology are more likely to make such discrepancies. This study has also replicated findings on overgeneral memory, using a non-English, community group.

In summary, in terms of asylum claimants, this study suggests that

1. there are likely to be discrepancies between accounts of autobiographical events
2. such discrepancies are more likely to arise in details which the individuals themselves would rate as peripheral to the account.

Furthermore, the psychopathology of the claimant has an impact on individuals' memory functioning in that they are :

1. less likely to be consistent
2. less likely to be able to distinguish specific events (due to overgeneral memory)

For all of the limitations of this study, the findings strongly suggest that it is unsound to use inconsistency of recall as a judge of individuals' credibility, and that this appears to be even more pertinent to highly traumatised individuals.

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Appendix A : Recruitment letters

English Version :

Memory and Seeking Asylum

I am writing to tell you about a research project which could help people who come to this country, like yourselves, as refugees, and have to claim asylum. Often such people appear to have a difficulty with their memory and this affects the way they answer questions.

We think that people who are refugees may remember things differently from people who have not had experience of war or other traumatic events. If we can show that this is the case, we might be able to help people who are genuinely seeking asylum in this country. To do this, we need to ask people like yourself to help.

If you agree to help, we will simply ask you about one good memory and one bad memory from before you came to this country. You will decide what it is you want to tell us - we will not ask you to talk about anything you do not wish to. We will then ask you some questions about how you feel now. This will include 4 questionnaires. We will need to visit you twice, and each interview should take about 11/2 hours.

You do not have to take part in this study if you do not want to. If you decide to take part you may withdraw at any time without having to give a reason. **All the information you give us is confidential**. It will be kept separately from your name and referred to only by a code number.

We realise that you may have been approached many times for other research and media features. Doing this study may help you to talk over how you are feeling with us. We also hope that the study will help other refugees in the future.

Researchers :

Jane Herlihy is training in Clinical Psychology at the University of London (University College). She has worked in psychology for four years, mostly with adults with mental health problems.

Boba Dobretic is a freelance interpreter who has worked extensively in this country with people from Bosnia. She works regularly as an interpreter for the Traumatic Stress Clinic, and is currently studying Psychoanalytic Psychotherapy.

Dr. Stuart Turner is a Psychiatrist and team leader at the Traumatic Stress Clinic in London. He is experienced in the psychological understanding of torture and the trauma of war and state violence. He works regularly with refugees and asylum seekers.

Bosnian Version

Pamcenje i Trazenje Izbjeglistva

Zelimo da vas upoznamo sa ovim psiholoskim istrazivanjem, koje bi moglo pomoci ljudima koji su dosli u ovu zemlju kao izbjeglice i traze azil. Cesto ti ljudi imaju poteskoca sa pamcenjem, sto utice na nacin na koji odgovaraju na pitanja.

Mi mislimo da ljudi koji su dozivjeli izbjeglistvo, vijerojatno pamte stvari razlicito od ljudi koji nisu dozivjeli rat ili slicne traume. Ako cemo to ovim istrazivanjem moci dokazati, to ce biti od velike pomoci ljudima koji traze azil u ovoj zemlji. Da se to omoguci trebamo pomoc ljudi poput vas.

Ako odlucite da nam pomognete, mi cemo vas pitati samo da se prisjetite jednog pozitivnog i jednog negativnog dozivljaja prije dolaska u ovu zemlju. Vi cete sami odluciti sta. Mi vas necemo pitati nista o cemu ne zelite razgovarati. Takoder cemo vas pitati o tome kako se licno osijecate. Sve zajedno imamo 4 upitnika. Trebat cemo vas posijetiti 2 puta. Svaki bi intervju trajao sat vremena.

Vi ne trebate ucestvovati u ovom projektu ako ne zelite. Ako pristanete, bilo se kada mozete povuci bez ikakvoga objasnjenja. Sve dane informacije su cuvane u strogoj povijerlijivosti. Mi cemo ih drzati odvojeno od vasega imena, pod sifriranim brojem.

Svijesni smo da ste vjerojatno u proslosti bili ukljuceni u mnoge naucne ankete i upitnike. Kroz saradnju na ovom projektu imat cete prilike da popricate o tome kako se osijecate. Mi se nadamo da ce ovo istrazivanje biti od velike pomoci izbjeglicama.

Istrazivaci :

Jane Herlihy : je dokotorant klinicke psihologije na Londonskom Univerzitetu (University College London). Ona ima cetvorogodisnje iskustvo rada u psihologiji.

Boba Dobretic : je radila kao socijalni radnik i prevodioc za Bosanski Projekt (The Refugee Council) od 92 do 95 godine. Od 95 godine stalno radi za Traumatski Stres Kliniku (Traumatic Stress Clinic).

Stuart Turner : je psihijatar i jedan od direktora Traumatske Stres Klinike (Traumatic Stress Clinic) u Londonu. On stalno radi sa izbjeglicama i ima veliko iskustvo psiholoskog razumijevanja ratnih trauma, nasilja i mucenja.

Albanian Version

Kujtesa dhe Azil Kerkimi

Po ju shkruaj qe t'ju tregoj rreth ketij studimi qe mund te ndihmoje njerrezit qe hyjne ne kete vend, si ju, si refugjate, dhe duhet te kerkojne azil (strehim). Shpesh njerez te tille duket se kane veshtiresi lidhur me kujtesen dhe kjo ndikon pastaj dhe ne menyren si ata u pergjigjen pyetjeve.

Ne mendojme se njerez qe jane refugjate mund ti sjellin nder mend gjerat ndryshe nga njerezit qe nuk kane perjetuar ngjarjet e luftes apo ndodhi te tjera traumatike. Ne se ne mund te provojme kete realitet, mund te jemi te afte te ndihmojme njerez qe ne te vertete kane nevoje per strehim ne kete vend. Per kete arsye, kemi nevoje te kerkojme ndihmen tuaj.
Ne se ju pranoni te ndihmoni,ne thjesht do ju pyesim rreth kujtimit per nje ngjarje mire dhe nje te keqe nga e kaluara juaj para se te vinit ne kete vend. Do vendosni ju se cfare do donit te na rrefenit – ne nuk kerkojme qe ju te flisni me ne per gjera qe nuk do donit. Ne atehere do ju bejme ca pyetje qe kane lidhje me ate si ndjeheni ju tani. Kjo do perfshihet ne 4 pyetesore. Ne do kemi nevoje t'ju vizitojme dy here, dhe seicila interviste kerkon afersisht 1 ore e gjysem.

Ju jeni te lire te mos merni pjese ne kete studim ne se nuk doni. Edhe ne se vendosni te merrni pjese perseri jeni te lire ta lini studimin ne cdo moment pa dhene spiegime pse. **I gjithe informacioni qe ju do na jepni eshte konfidencial**. Ai do te ruhet vecmas emrit tuaj dhe do u referohet te tjereve i koduar.
Ne e dime qe ju mund te keni marre pjes dhe ne te tjera studime apo takime me mdiat e ndryshme. Pjesemarja ne kete studim mund tu ndihmoje per tu shprehur se si ndjeheni me ne. Ne gjithashtu shpresojme qe ky studim te ndihmoje refugjate te tjere ne te ardhmen.

Kerkuesit :

Jane Herlihy eshte e trejnuar ne Psikologjine Klinike prane Universitetit te Londres (Kolegji Universitar). Ajo ka punuar ne fushen e psikologjise se te rriturve me probleme te shendetit mendor per afro kater vjet.

Laidon Shapo eshte mjek epidemiolog me master ne shendet publik ne Londer (LSHTM) i cili do marre pjese ne kete studim si interpret dhe qe ka nje pervoje ne kete fushe.

Dr. Stuart Turner eshte psikiater dhe drejtues i grupit te punes ne Kliniken e Stresit dhe Traumave ne Londer. Ai ka nje ekspeience si psikiater per problemet e traumave te luftes dhe dhunes shteterore. Ai ka punaur rregullisht me refugjate dhe azil kerkues.

Appendix B : Memory Task

Original

Traumatic Memory

- I'd like you to think about an event in <your country> when you thought that your life was in danger - preferably a time that you haven't talked about too much, but that wouldn't upset you too much to talk about now.

<free recall>

- Now I'm going to ask you some details about this event. After each one, like before, I'm going to ask you whether this detail was really important to how you felt at the time, or whether it was irrelevant.

1. where were you in the room, in relation to the door/what side of the street were you on ?
- and how important or relevant was this to how afraid you felt?

2. which town was this in ?
- and how important or relevant was this to how afraid you felt?

3. why were you there on this occasion ?
- and how important or relevant was this to how afraid you felt?

4. what was the date ?
- and how important or relevant was this to how afraid you felt?

5. what one thing made you most afraid ?
- and how important or relevant was this to how afraid you felt?

6. what were you wearing ?
- and how important or relevant was this to how afraid you felt?

7. what day was it ?
- and how important or relevant was this to how afraid you felt?

8. who was with you ?
- and how important or relevant was this to how afraid you felt?

9. was there anyone else around ?
- and how important or relevant was this to how afraid you felt?

10. what was the colour of their hair ?
- and how important or relevant was this to how afraid you felt?

11. what were they doing when it happened ?
- and how important or relevant was this to how afraid you felt?

12. what time of day was it ?
- and how important or relevant was this to how afraid you felt?

13. what happened immediately before ?
- and how important or relevant was this to how afraid you felt?

14. what was the weather that day ?
- and how important or relevant was this to how afraid you felt?

15. what happened immediately afterwards ?
- and how important or relevant was this to how afraid you felt?

Non-traumatic memory

- I'd like you to tell me briefly about an ordinary, everyday event from before the war, when you were in <your country>

  <free recall>

- Now I'm going to ask you some details about this event. After each one, I'm going to ask you to show me on this scale whether this detail was really important to how you felt at the time, or whether it was irrelevant. <explain that some of the questions might seem strange, but that we will ask each one, even if it doesn't seem relevant. If not clear, use the example of the date - probably irrelevant, but if it was your birthday, it might have some impact on how you felt>

1. where were you in the room, in relation to the door/what side of the street were you on ?
- and how important or relevant was this to how happy you felt?

2. which town was this in ?
- and how important or relevant was this to how happy you felt?

3. why were you there on this occasion ?
- and how important or relevant was this to how happy you felt?

4. what was the date ?
- and how important or relevant was this to how happy you felt?

5. what one thing do you best remember about it ?
- and how important or relevant was this to how happy you felt?

6. what were you wearing ?
- and how important or relevant was this to how happy you felt?

7. what day was it ?
- and how important or relevant was this to how happy you felt?

8. who was with you ?
- and how important or relevant was this to how happy you felt?

9. was there anyone else around ?
- and how important or relevant was this to how happy you felt?

10. what was the colour of their hair ?
- and how important or relevant was this to how happy you felt?

11. what were they doing when it happened ?

- and how important or relevant was this to how happy you felt?

12. what time of day was it ?
- and how important or relevant was this to how happy you felt?

13. what happened immediately before ?
- and how important or relevant was this to how happy you felt?

14. what was the weather that day ?
- and how important or relevant was this to how happy you felt?

15. what happened immediately afterwards ?
- and how important or relevant was this to how happy you felt?

Bosnian version

Traumatic Memory

- Dali mozete ukratko opisati neki po zivot opasni dogadaj iz Bosne o kome niste puno pricali, i nebi vas suvise uznemirio.

<free recall>

- Pitat cemo vas o nekim detaljima iz toga dozivljaja, i dali je svaki taj detalj svojevremeno znacajno uticao na sam dozivljaj ili na vase rospolozenje, ili je bio nevazan. <explain that some of the questions might seem strange, but that we will ask each one, even if it doesn't seem relevant. If not clear, use the example of the date - probably irrelevant, but if it was your birthday, it might have some impact on how you felt>

1. Gdje ste bili u sobi u odnosu na vrata (ili na primjer) na kojoj strani ulice?
- dali je to uticalo na sam dogadaj i na jacinu vase preplasenosti, ili nije?

2. U kojem se je mijestu to dogodilo?
- dali je to uticalo na sam dogadaj i na jacinu vase preplasenosti, ili nije?

3. Zasto ste tom prilikom tamo bili ?
- dali je to uticalo na sam dogadaj i na jacinu vase preplasenosti, ili nije?

4. Kada se je to desilo ?
- dali je to uticalo na sam dogadaj i na jacinu vase preplasenosti, ili nije?

5. Sta vas je najvise preplasilo?
- dali je to uticalo na sam dogadaj i na jacinu vase preplasenosti, ili nije?

6. Sta ste nosili na sebi, kakvu odijecu ?
- dali je to uticalo na sam dogadaj i na jacinu vase preplasenosti, ili nije?

7. Koji je to bio dan u tijednu ?
- dali je to uticalo na sam dogadaj i na jacinu vase preplasenosti, ili nije?

8. Tko je bio sa vama ?
- dali je to uticalo na sam dogadaj i na jacinu vase preplasenosti, ili nije?

9. Dali je jos neko drugi bio prisutan?
- dali je to uticalo na sam dogadaj i na jacinu vase preplasenosti, ili nije?

10. Koja je bila boja njihove kose ?

- dali je to uticalo na sam dogadaj i na jacinu vase preplasenosti, ili nije?

11. Sto su radili kada se je to desilo?
- dali je to uticalo na sam dogadaj i na jacinu vase preplasenosti, ili nije?

12. Koliko je sati bilo ?
- dali je to uticalo na sam dogadaj i na jacinu vase preplasenosti, ili nije?

13. Sta se je desilo odma prije toga dogadaja?
- dali je to uticalo na sam dogadaj i na jacinu vase preplasenosti, ili nije?

14. Kakvo je bilo vrijeme toga dana ?
- dali je to uticalo na sam dogadaj i na jacinu vase preplasenosti, ili nije?

15. Sta se je desilo odmah poslije toga dogadaja?
- dali je to uticalo na sam dogadaj i na jacinu vase preplasenosti, ili nije?

Non-traumatic memory

- Dali nam mozete ukratko opisati iz vase proslosti svakodnevni dozivljaj nepovezan uz rat ili bilo kakve nevolje.

<free recall>

- Pitat cemo vas pojedinacno o nekim detaljima povezanih sa tim dozivljajem, i dali su oni svojevremeno direktno i znacajno uticali na vase raspolozenje ili na sam dogadaj, ili nisu.

1. Gdje ste bili u sobi u odnosu na vrata (ili na primjer) na kojoj strani ulice?
- dali je to uticalo na sam dogadaj i na jacinu vase preplasenosti, ili nije?

2. U kojem se je mijestu to dogodilo?
- dali je to uticalo na sam dogadaj i na jacinu vase preplasenosti, ili nije?

3. Zasto ste tom prilikom tamo bili ?
- dali je to uticalo na sam dogadaj i na jacinu vase preplasenosti, ili nije?

4. Kada se je to desilo ?
- dali je to uticalo na sam dogadaj i na jacinu vase preplasenosti, ili nije?

5. Sta od toga dozivljaja najbolje pamtite ?
- dali je to uticalo na sam dogadaj i na jacinu vase preplasenosti, ili nije?

6. Sta ste nosili na sebi, kakvu odijecu ?
- dali je to uticalo na sam dogadaj i na jacinu vase preplasenosti, ili nije?

7. Koji je to bio dan u tijednu ?
- dali je to uticalo na sam dogadaj i na jacinu vase preplasenosti, ili nije?

8. Tko je bio sa vama ?
- dali je to uticalo na sam dogadaj i na jacinu vase preplasenosti, ili nije?

9. Dali je jos neko drugi bio prisutan?
- dali je to uticalo na sam dogadaj i na jacinu vase preplasenosti, ili nije?

10. Koja je bila boja njihove kose ?
- dali je to uticalo na sam dogadaj i na jacinu vase preplasenosti, ili nije?

11. Sto su radili kada se je to desilo?
- dali je to uticalo na sam dogadaj i na jacinu vase preplasenosti, ili nije?

12. Koliko je sati bilo ?
- dali je to uticalo na sam dogadaj i na jacinu vase preplasenosti, ili nije?

13. Sta se je desilo odma prije toga dogadaja?
- dali je to uticalo na sam dogadaj i na jacinu vase preplasenosti, ili nije?

14. Kakvo je bilo vrijeme toga dana ?
- dali je to uticalo na sam dogadaj i na jacinu vase preplasenosti, ili nije?

15. Sta se je desilo odmah poslije toga dogadaja?
- dali je to uticalo na sam dogadaj i na jacinu vase preplasenosti, ili nije?

Kosovan version

Ushtrim Kujtese I

Ushtrim per Kujtesen traumatike

- Do deshiroja qe ju te mendoni rreth nje ngjarje te shkuar < nga vendi tuaj> kur ju menduat se jeta juaj qe ne rrezik-mundesisht nje ngjarje per te cilen s'keni folur shume atehere, por qe nuk do ju shqetsonte shume nese do flisnit per te tani.

  <kujtime te lira>

- Tani une do ju pyes mbi disa detaje rreth kesaj ngjarje. Pas seicilit detaj, une do ju kerkoj juve te me rrefeni nese ky detaj qe vertet i rrendesishem ne ate cka ngjau dhe si u ndjete ju ne ato momente, apo nuk qe dhe aq me rrendesi.

<spiego qe disa nga pyetjet mund te duken te cuditshme, but qe duhet ti kalojme nje per nje, megjithese mund te duken palidhje. Ne se s'eshte e qarte, perdor shembullin e dites-qe mund te duket si pa lidhje, por qe po te qe data e lindjes suaj, mund te kishte nje fare rrendesie ne ate se si ju u ndjete>

1. Ku ishit ju ne lidhje me dhomen, ne lidhje me deren/ne c'ane te rruges ishit ju ?
   dhe sa e rrendesishme qe kjo ne lidhje me friken qe ju perjetuat ?

2. Cili qyetet /qyteze ishte ai ku ndodhi ngjarja ?
   dhe sa e rrendesishme qe kjo ne lidhje me friken qe ju perjetuat ?

3. Pse ndodheshit ju aty ne ato momente ?
   dhe sa e rrendesishme qe kjo ne lidhje me friken qe ju perjetuat ?

4. Ne c'dite ndodhi ngjarja ?
   dhe sa e rrendesishme qe kjo ne lidhje me friken qe ju perjetuat ?

5. C'gje ju friksoi me teper ?
   dhe sa e rrendesishme qe kjo ne lidhje me friken qe ju perjetuat ?

6. C'gje ju mundoi (lodhi) me shume ?
   dhe sa e rrendesishme qe kjo ne lidhje me friken qe ju perjetuat ?

7. C'dite qe kjo ngjarje ?
   dhe sa e rrendesishme qe kjo ne lidhje me friken qe ju perjetuat ?

8. Kush qe me ju ?
   dhe sa e rrendesishme qe kjo ne lidhje me friken qe ju perjetuat ?

9. Qe ndokush tjeter aty rrotull ?

dhe sa e rrendesishme qe kjo ne lidhje me friken qe ju perjetuat ?

10. C'ngjyre kishin floket e tyre ?
    dhe sa e rrendesishme qe kjo ne lidhje me friken qe ju perjetuat ?

11. C'po benin ata kur ndodhi ngjarja ?
    dhe sa e rrendesishme qe kjo ne lidhje me friken qe ju perjetuat ?

12. Ne c'moment te dites ndodhi ngjarja ?
    dhe sa e rrendesishme qe kjo ne lidhje me friken qe ju perjetuat ?

13. Cfare ndodhi fill pas ngjarjes ?
    dhe sa e rrendesishme qe kjo ne lidhje me friken qe ju perjetuat ?

14. C'kohe bente ate dite ?
    dhe sa e rrendesishme qe kjo ne lidhje me friken qe ju perjetuat ?

15. Cfare ndodhi me pas ?
    dhe sa e rrendesishme qe kjo ne lidhje me friken qe ju perjetuat ?

Kujtesa jo-traumatike

- Tashti do doja qe ju te me rrefenit shkurt rreth ndonje ngjarje tjeter qe ju mund te sillni ne mend - qe s'ka te beje me luften - dicka normale, apo dicka te gezueshme.

  <Prompt : nga berja e pazarit, ndonje shetitj, ndonje dite kur dicka ndodhi ne pune ?>

  <Kujtime te lira>

- Tani do ju bej disa peyetje mbi detaje qe kane te bejne me kete ndodhi. Pas seicilit detaj, si dhe me pare do t'ju pyes nese ky detaj qe i rrendesishem dhe kishte lidhje me ate se si ju u ndjete ato momente, apo nuk kishte lidhje me ngjarjen.

1. Ku ishit ju ne lidhje me dhomen, ne lidhje me deren/ne c'ane te rruges ishit ju ?
   dhe sa e rrendesishme qe kjo ne lidhje me kenaqesine qe ju perjetuat ?

2. Cili qyetet /qyteze ishte ai ku ndodhi ngjarja ?
   dhe sa e rrendesishme qe kjo ne lidhje me kenaqesine qe ju perjetuat ?

3. Pse ndodheshit ju aty ne ato momente ?
   dhe sa e rrendesishme qe kjo ne lidhje me kenaqesine qe ju perjetuat ?

4. Ne c'dite ndodhi ngjarja ?
   dhe sa e rrendesishme qe kjo ne lidhje me kenaqesine qe ju perjetuat ?

5. C'gje ju kenaqi me teper ?
   dhe sa e rrendesishme qe kjo ne lidhje me kenaqesine qe ju perjetuat ?

6. C'gje ju lehtesoi (clodhi) me shume ?
   dhe sa e rrendesishme qe kjo ne lidhje me kenaqesine qe ju perjetuat ?

7. C'dite qe kjo ngjarje ?
   dhe sa e rrendesishme qe kjo ne lidhje me kenaqesine qe ju perjetuat ?

8. Kush qe me ju ?
   dhe sa e rrendesishme qe kjo ne lidhje me kenaqesine qe ju perjetuat ?

9. Qe ndokush tjeter aty rrotull ?
   dhe sa e rrendesishme qe kjo ne lidhje me kenaqesine qe ju perjetuat ?

10. C'ngjyre kishin floket e tyre ?
    dhe sa e rrendesishme qe kjo ne lidhje me kenaqesine qe ju perjetuat ?

11. C'po benin ata kur ndodhi ngjarja ?
    dhe sa e rrendesishme qe kjo ne lidhje me kenaqesine qe ju perjetuat ?

12. Ne c'moment te dites ndodhi ngjarja ?
dhe sa e rrendesishme qe kjo ne lidhje me kenaqesine qe ju perjetuat ?

13. Cfare ndodhi fill pas ngjarjes ?
dhe sa e rrendesishme qe kjo ne lidhje me kenaqesine qe ju perjetuat ?

14. C'kohe bente ate dite ?
dhe sa e rrendesishme qe kjo ne lidhje me kenaqesine qe ju perjetuat ?

15. Cfare ndodhi me pas ?
dhe sa e rrendesishme qe kjo ne lidhje me kenaqesine qe ju perjetuat ?

Appendix C : Example pair of transcripts

Interview One : Traumatic event

Free Recall :
The military police picked us up; put the two of us into the boot of the car and we were taken to Police Station - there beaten until completely blue <lots more details and story>

1. where were you in the room, in relation to the door/what side of the street were you on — Centrality rating : **C**

sitting outside the house;

2. which town was this in — Centrality rating : **C**

Banjalukka

3. why were you there on this occasion — Centrality rating : **C**

were afraid of being picked up so were gathering together for safety in numbers; neighbours above were Serbs and they called the military to get them.

4. what was the date — Centrality rating : **P**

don't know <asked wife - she said September 1993>

5. what one thing made you most afraid — Centrality rating : **C**

when arrived - told they wouldn't survive and they would be swimming in the river by night fall

6. what were you wearing — Centrality rating : **P**

T-shirt, short sleeves, trousers - can't remember if jacket; had to take T-shirt off so they could beat me bare-skinned

7. what day was it — Centrality rating : **P**

don't know

8. who was with you — Centrality rating : **P**

three neighbours - A--, A--, myself and C--.

9. was there anyone else around — Centrality rating : **P**

no-one

10. what was the colour of <the neighbours'> hair — Centrality rating : **P**

black and brown

11. what were they doing — Centrality rating : **P**

drinking coffee; when they saw the soldiers they went like dead

<the bruises - we had to kill a whole calf for steaks to put on them; one of us couldn't pee>

12. what time of day was it Centrality rating : **P**
4 or 5 p.m.
we were vomiting and swallowing it so they didn't know, for fear

13. what happened immediately before Centrality rating : **P**
sunbathing; my friend is six foot - can you believe they pushed us in car - they pushed our legs into the boot

14. what was the weather that day Centrality rating : **P**
sunny

15. what happened immediately after Centrality rating : **P**
very late at night - let us go - couldn't sleep all night for the pain

Interview One : Happy event

Free Recall :

<could not generate a 'normal' event> In 1995 left Bosnia and entered Croatia; I kneeled and kissed the ground - happy that children now in safety.

1. where were you in the room, in relation to the door/what side of the street were you on — Centrality rating : **C**

got out of boat - kneeled and kissed ground; felt reborn

2. which town was this in — Centrality rating : **C**

don't know

3. why were you there on this occasion — Centrality rating : **C**

because chased out; ethnically cleansed; taken in buses; being asked for $40 - without it they were taken off the bus and killed - or taken to war to fight for them; many stops

4. what was the date — Centrality rating : **P**

1995, August - don't know

5. what one thing made you most happy — Centrality rating : **C**

people rallied, welcomed us, bringing food, carrying us, pampering us

6. what were you wearing — Centrality rating : **P**

don't know

7. what day was it — Centrality rating : **P**

don't know

8. who was with you — Centrality rating : **C**

my family; extended family; my brother, his wife, 2 children; a second brother (half brother) - his mother, his wife and 2 children; my wife and one child

9. was there anyone else around — Centrality rating : **P**

lots - buses of people; 150 people in one bus

10. what was the colour of <the driver's> hair — Centrality rating : **P**

don't know

11. what was <the driver> doing — Centrality rating : **C**

was helping us - stopping so that we could buy cigarettes and sweets so that we could give them over and say that that was all we had - getting rid of our money

12. what time of day was it Centrality rating : **P**

4 - 5pm.

13. what happened immediately before Centrality rating : **C**

people arrived from the country in vans to help them take their stuff (there was so much food - like a feast)

14. what was the weather that day Centrality rating : **P**

good weather

15. what happened immediately after Centrality rating : **C**

got into vans and went to feast; at same time, writing names to be allocated to refugee camps. At 3am. Taken to Varazkin - waited until the morning to be placed. Only available was cellars so we sat outside to await morning.

Interview Two : Traumatic event

<Do you remember the event you told me about last time, when you were afraid that your life was in danger ?> **yes**

Free Recall : **life in Bosnia; the Military Police used to come, I was saved by a Serb friend; did slave labour for Serbian military - it was when they came to get us**

1. where were you in the room, in relation to the door/what side of the street were you on

I was sitting in my house. You weren't allowed to move around freely - go out, around

2. which town was this in

Banja Lucca

3. why were you there on this occasion

I lived there - all my family including my great grandparents

4. what was the date

don't know - maybe my wife remembers - I don't

5. what one thing made you most afraid

I knew that either they'd kill me or by chance - only by chance - I'd survive

6. what were you wearing

dressed, but can't remember what in

7. what day was it

don't know - at least once in two weeks they would come - the only way to avoid it was to bribe them

8. who was with you

the whole family

9. was there anyone else around

my older brother and my sister-in-law

<how many policemen came?>

two

10. what was the colour of their hair

don't know - one short cut, I knew their names

11. what were they doing

came into the house - they knocked; I opened the door and they entered the house

12. what time of day was it
9 pm.

13. what happened immediately before
watching TV

14. what was the weather that day
don't think it was sunny, think it was cloudy

15. what happened immediately after
came in and asked which help we needed and I said no thanks - we wnet out in the garden and he said you know I'm saving your head - next week I want DM500. I said I don't have money but you can take my fridge, my cooker, my furniture. After that I spoke with my wife and told her.

Interview Two : Happy event

Do you remember the other, more happy event, that you told us about before? **yes**

Free Recall : **the day I left Banja Lukka and went to Bosnia. The Croatian place - Davor - when I arrived, the day they threw us out of the house = when we arrived we didn't care any more about house, belongings etc.**

1. where were you in the room, in relation to the door/what side of the street were you on

we'd crossed the river - when we got out of the boat the people received us with open arms. As good as getting married!

2. which town was this in

Davor

3. why were you there on this occasion

because the boat went there; there were thousands waiting on the Bosnian side - but only 20 people per boat

4. what was the date

16th or 18th - yes, 18th August, 1995

5. what one thing made you most happy

as we arrived we saw people taking the luggagee and putting it in their Combis - helping us; they took us to a restaurant - a great feast - 3 hours feasting

6. what were you wearing

suit with stripes, otherwise, don't know

7. what day was it

don't know

8. who was with you

my wife, son, two cousins, their wives, their families; each had two children

9. was there anyone else around <how many people were on the bus?>

couldn't say - people piled up

10. what was the colour of <the drivers> hair

was hefty looking chap; bus coming - blond hair?;

11. what were they doing

he collected money, drink, cigarettes to bribe people at the blockades; driver told us if we collect these gifts we won't be maltreated at the roadblocks; he was experienced at that sort of thing

12. what time of day was it
pm. - 4-5pm.
Late afternoon; summer

13. what happened immediately before
we knew what had happened to other people on buses to Croatia - our biggest fear was that we'd all be taken out and killed

14. what was the weather that day
sunny

15. what happened immediately after
when we got on buses from Davor we went to Varojdin in Croatia - in cellars - all the women started crying; next day we got better accommodation, but still military; 50 people in a room.
<what time did you get on the bus to go?>
9pm - 10 or 11 pm.

Appendix D : DES

Original

Directions

This questionnaire consists of eight questions about experiences that you may have in your daily life. We are interested in how often you have these experiences. It is important, however, that your answers show how often these experiences happen to you when you are not under the influence of alcohol or drugs. To answer the questions, please determine to what degree the experience described in the question applies to you and mark the line with a vertical slash at the appropriate place, as shown in the example below.

Example:

0% _____ 100%

1. Some people have the experience of finding themselves in a place and having no idea how they got there. Mark the line to show what percentage of the time this happens to you.

   0% _____ 100%

2. Some people have the experience of finding new things among their belongings that they do not remember buying. Mark the line to show what percentage of the time this happens to you.

   0% _____ 100%

3. Some people sometimes have the experience of feeling as though they are standing next to themselves or watching themselves do something and they actually see themselves as if they were looking at another person. Mark the line to show what percentage of the time this happens to you.

   0% _____ 100%

4. Some people are told that they sometimes do not recognise friends or family members. Mark the line to show what percentage of the time this happens to you.

   0% _____ 100%

5. Some people have the experience of feeling that other people, objects, and the world around them are not real. Mark the line to show what percentage of the time this happens to you.

   0% _____ 100%

6. Some people have the experience of feeling that their body does not seem to belong to them. Mark the line to show what percentage of the time this happens to you.

   0% _____ 100%

7. Some people find that in one situation they may act so indifferently compared with another situation that they feel almost as if they were two different people. Mark the line to show what percentage of the time this happens to you.

0% _____ 100%

8. Some people sometimes find that they hear voices inside their head that tell them to do things or comment on things that they are doing. Mark the line to show what percentage of the time this happens to you.

0% _____ 100%

Bosnian Translation

DISSOCIATIVE EXPERIENCES SCALE
UPUTSTVA

Ovajse upitnik so-stoji od 8 pitanja o dogodojimo koje ste moguee dozivijeli u vosem svokodnevnom Zivotu.
Vos zamima koko se cesto ti dozivljaji desovaju vama. Vazno je da vasi odgovori uzmu u obzir samo dozivljaje kada niste pod utjecajem alkoholia ili droga. Kod odgovora na pitanja odlucite do koje se jijere dozivljoj opisam u upitmiku odnosi na vas, I crticom ozmocite stepen togadozivljajo, kao sto vidite na doljnjem primjeru.

Primjer :

0% _____ 100%

1. Neki ljudi kadkada dozive do se madu negdje, bez da znaju dodo su tu stigli. Oznacite na liniji dolje dodo se cesto, u omjeru od nule do sto posto, to vama desova.

0% _____ 100%

2. Nekim se ljudima dogodi da naidu na nesto novo medu svojim stvarimo, I nemogu se sijetiti kada su tokupili. Oznacite na liniji dolje dodo se cesto, u omjeru od nule do sto posto, to vama desova.

0% _____ 100%

3. Nekim se ljudima kotdada desi da se osjecaju dao da stoje pored sebe, ili dao da promatraju sami sebe dok nesto rade, I u stvarnosti vide sebe dao da gledaju drugu osobu. Oznacite na liniji dolje dodo se cesto, u omjeru od nule do sto posto, to vama desova.

0% _____ 100%

4. Neki ljudi kadkado ne prepoznaju prijatelje, ili clanove svoje porodice. Oznacite na liniji dolje dodo se cesto, u omjeru od nule do sto posto, to vama desova.

0% _____ 100%

5. Neki ljudi kodkodo osjecaju kao da drugi ljudi , stvari I svijet oko njih nije stvoran. Oznacite na liniji dolje dodo se cesto, u omjeru od nule do stoposto, to vama desova.

0% _____ 100%

6. Neki ljudi kodkado imaju osjecoj kao da mi vlastito tijelo ne pripada. Oznacite na liniji dolje dodo se cesto, u omjeru od nule do sto posto, to vamo desava.

0% _____ 100%

7. Neki ljudi u jednoj situacije reagiraju do te mijere razlicito u usporedbi na neku drugu situacija, da se osjecaju skoro kao da su droije razlicite osobe. Oznacite na liniji dolje dodo se cesto, u omjeru od nule do sto posto, to vamo desava.

0% _____ 100%

8. Neki ljudi kodkada luju glasove u glavi koji im kozuju sta da rode, ili komentiraju no ono sto rade. Oznacite na liniji dolje dodo se cesto, u omjeru od nule do sto posto, to vamo desava.

0% _____ 100%

Back Translation

Instructions

This questionnaire consists of 8 questions about everyday possible events. We are interested how often do they occur. It is important that your answers take into account only those events when you are not under influence of alcohol or drugs. When answering your question you decide to what extent or degree is the event described relevant to you. Mark with a dash the appropriate place as shown on the example below.

1. At times people find themselves in places (somewhere) not knowing how they arrived there.
   Indicate on the line below (from 0 % to 100 %) how often this happens to you.

2. It happens to some people that they find among their things or belongings something that they do not remember buying.
   Indicate on the line below (from 0 % to 100 %) how often this happens to you.

3. It happens to some people sometimes that they feel as if they are standing alongside themselves, or as if they were observing themselves when doing something. This is as if they saw themselves as if they were another person.
   Indicate on the line below (from 0 % to 100 %) how often this happens to you.

4. Some people are at times unable to recognize friends or members of their family.
   Indicate on the line below (from 0 % to 100 %) how often this happens to you.

5. Some people feel at times as if other people, things and the world around them is not real.
   Indicate on the line below (from 0 % to 100 %) how often this happens to you.

6. Some people at times experience feeling that their own body does not belong to them.
   Indicate on the line below (from 0 % to 100 %) how often this happens to you.

7. Some people react in one situation to such a degree differently in comparison to another situation, that they feel that they are almost two different people.
   Indicate on the line below (from 0 % to 100 %) how often this happens to you.

8. Some people sometimes hear voices in their heads which tell them what to do or make comments on what they are doing.
   Indicate on the line below (from 0 % to 100 %) how often this happens to you.

Kosovan translation

Udhezime

Ky pyetesor konsiston ne tete pyetje rreth eksperiencave qe ju mund te keni perjetuar gjate jetes suaj. Ne jemi te interesuar se sa shpesh ju perjetoni te tilla eksperienca. Eshte e rrendesishme, megjithate, qe pergjigjet tuaja te reflektojne se sa shpesh te tilla eksperienca ju ndodhin kur nuk jeni nen ndikim te alkolit ose barnave mjeksore. Per t'ju pergjigjur pyetjes, ju lutemi percaktoni se e cfare shkalle kjo eksperience qe pershkruat ne pyetje ju pershtatet dhe shenoni nje vize vertikale ne vendin e duhur, treguar si ne shembullin me poshte.

Shembull:

0% _____|_____ 100%

1. Disa njerez perjetojne sikur gjenden diku r ıd dhe nuk kane asnje ide se si kane perfunduar aty. Shenoni si tek shembulli me lart me vi. . . . ı ku mund te jete % qe kjo ju ndodh juve.

   0% _____ 100%

2. Disa njerez perjetojne sikur gjejne sende te reja mes gjerave qe ju perkasin si sende qe nuk kujtohen ti kene blere me pare. Shenoni si tek shembulli me lart me vije vendin ku mund te jete % qe kjo ju ndodh juve.

   0% _____ 100%

3. Disa njerez ka raste qe perjetojne ndjenja sikur qendrojne prane vetes se tyre ose kqyrin veten duke bere dicka (nje veprim) dhe faktikisht e shohin veten e tyre sikur te shihnin nje tjeter person. Shenoni si tek shembulli me lart me vije vendin ku mund te jete % qe kjo ju ndodh juve.

   0% _____ 100%

4. Disa njerez thuhet ka raste qe nuk njohin miqte ose pjestare te familjes. Shenoni si tek shembulli me lart me vije vendin ku mund te jete % qe kjo ju ndodh juve.

   0% _____ 100%

5. Disa njerez perjetojne ndjenjen sikur te tjere njerez, objekte, dhe bota rreth tyre nuk jane reale. Shenoni si tek shembulli me lart me vije vendin ku mund te jete % qe kjo ju ndodh juve.

   0% _____ 100%

6. Disa njerez perjetojne sikur trupi i tyre duket sikur s'eshte trupi i tyre. Shenoni si tek shembulli me lart me vije vendin ku mund te jete % qe kjo ju ndodh juve

   0% _____ 100%

7. Disa njerez shohin se ne situata te caktuara ata mund te veprojne aq indiferent ne krahasim me situata te tjera, si te ishin dy njerez krejt te ndryshem. Shenoni si tek shembulli me lart me vije vendin ku mund te jete % qe kjo ju ndodh juve.

   0% _____ 100%

8. Disa njerez u duket sikur degjojne zera brenda kokes se tyre qe ju tregojne si te veprojne ose ju komentojne mbi veprimet qe ata bejne. Shenoni si tek shembulli me lart me vije vendin ku mund te jete % qe kjo ju ndodh juve.

   0% _____ 100%

Appendix E : PTSD questionnaire

PTDS Original

Part 1

Many people have lived through or witnessed a very stressful and traumatic event at some point in their lives. Below is a list of traumatic events. Put a checkmark in the box next to ALL of the events that have happened to you or that you have witnessed.

- ☐ Serious accident, fire, or explosion (for example, an industrial, farm, car, plane, or boating accident)
- ☐ Natural disaster (for example, tornado, hurricane, flood, or major earthquake)
- ☐ Non-sexual assault by a family member or someone you know (for example, being mugged, physically attacked, shot, stabbed, or held at gunpoint)
- ☐ Non-sexual assault by a stranger (for example, being mugged, physically attacked, shot, stabbed, or held at gunpoint)
- ☐ Sexual assault by a family member or someone you know (for example, rape or attempted rape)
- ☐ Sexual assault by a stranger (for example, rape or attempted rape)
- ☐ Military combat or a war zone
- ☐ Sexual contact when you were younger than 18 with someone who was 5 or more years older than you (for example, contact with genitals, breasts)
- ☐ Imprisonment (for example, prison inmate, prisoner of war, hostage)
- ☐ Torture
- ☐ Life-threatening illness
- ☐ Other traumatic event

If you marked Item 12, specify the traumatic event below.

IF YOU MARKED ANY OF THE ITEMS ABOVE, CONTINUE. IF NOT, STOP HERE.

Part 2

(14) If you marked more than one traumatic event in Part 1, put a checkmark in the box below next to the event *that bothers you the most.* If you marked only one traumatic event in Part 1, mark the same one below.

- ☐ Accident
- ☐ Disaster
- ☐ Non-sexual assault/someone you know
- ☐ Non-sexual assault/stranger
- ☐ Sexual assault/someone you know
- ☐ Sexual assault/stranger
- ☐ Combat
- ☐ Sexual contact under 18 with someone 5 or more years older
- ☐ Imprisonment
- ☐ Torture
- ☐ Life-threatening illness
- ☐ Other

In the box below, briefly describe the traumatic event you marked above.

Below are several questions about the traumatic event you just described above.

(15) How long ago did the traumatic event happen? (circle ONE)

1 Less than 1 month
2 1 to 3 months
3 3 to 6 months
4 6 months to 3 years
5 3 to 5 years
6 More than 5 years

For the following questions, circle Y for Yes or N for No.

During this traumatic event:

(16) **Y N** Were you physically injured?

(17) **Y N** Was someone else physically injured?

(18) **Y N** Did you think that your life was in danger?

(19) **Y N** Did you think that someone else's life was in danger?

(20) **Y N** Did you feel helpless?

(21) **Y N** Did you feel terrified?

Part 3

is a list of problems that people sometimes have perienciing a traumatic event. Read each one y and circle the number (0–3) that best describes en that problem has bothered you IN THE PAST H. Rate each problem with respect to the ic event you described in Item 14.

ot at all or only one time
hce a week or less/once in a while
to 4 times a week/half the time
or more times a week/almost always

01 2 3 Having upsetting thoughts or images about the traumatic event that came into your head when you didn't want them to

01 2 3 Having bad dreams or nightmares about the traumatic event

01 2 3 Reliving the traumatic event, acting or feeling as if it was happening again

0 1 2 3 Feeling emotionally upset when you were reminded of the traumatic event (for example, feeling scared, angry, sad, guilty, etc.)

0 1 2 3 Experiencing physical reactions when you were reminded of the traumatic event (for example, breaking out in a sweat, heart beating fast)

---

0 1 2 3 Trying not to think about, talk about, or have feelings about the traumatic event

0 1 2 3 Trying to avoid activities, people, or places that remind you of the traumatic event

0 1 2 3 Not being able to remember an important part of the traumatic event

0 1 2 3 Having much less interest or participating much less often in important activities

0 1 2 3 Feeling distant or cut off from people around you

0 1 2 3 Feeling emotionally numb (for example, being unable to cry or unable to have loving feelings)

0 1 2 3 Feeling as if your future plans or hopes will not come true (for example, you will not have a career, marriage, children, or a long life)

(34) 0 1 2 3 Having trouble falling or staying asleep

(35) 0 1 2 3 Feeling irritable or having fits of anger

(36) 0 1 2 3 Having trouble concentrating (for example, drifting in and out of conversations, losing track of a story on television, forgetting what you read)

(37) 0 1 2 3 Being overly alert (for example, checking to see who is around you, being uncomfortable with your back to a door, etc.)

(38) 0 1 2 3 Being jumpy or easily startled (for example, when someone walks up behind you)

---

(39) How long have you experienced the problems that you reported above? (circle ONE)
- 1 Less than 1 month
- 2 1 to 3 months
- 3 More than 3 months

(40) How long after the traumatic event did these problems begin? (circle ONE)
- 1 Less than 6 months
- 2 6 or more months

Part 4

Indicate below if the problems you rated in Part 3 have interfered with any of the following areas of your life DURING THE PAST MONTH. Circle Y for Yes or N for No.

(41) Y N Work

(42) Y N Household chores and duties

(43) Y N Relationships with friends

(44) Y N Fun and leisure activities

(45) Y N Schoolwork

(46) Y N Relationships with your family

(47) Y N Sex life

(48) Y N General satisfaction with life

(49) Y N Overall level of functioning in all areas of your life

PTDS Bosnian translation

STRESOM UZROKOVANI SIMPTOMI

1. Prije koliko vremena su se traumatski dozivljaji dogodili?

(zaokruzite jedan odgovor)

Prije manje od 1 mjeseca .. 1
1 do 3 mjeseca..... 2
3 do 6 mjseci..... 3
6 mjeseci do 3 godine..... 4
3 do 5 godina..... 5
vise od 5 godina..... 6

2. U slijedecim pitanjima zaokruzite odgovor DA ili NE Za vrijeme traumatskih dogadjaja,

	DA	NE
a) Da li ste bili tjelesno ozlidjeni	1	0
b) Da li je neko drugi bio tjelesno ozlidjen.	1	0
c) Da li ste mislili da Vam je zivot u opasnosti	1	0
d) Da li ste mislili da je neciji tudji zivot bio u opasnosti?.....	1	0
e) Da li ste se osjecali bespomocno?.....	1	0
f) Da li ste bili prestraseni.....	1	0

Ispod se nalazi popis poteskoca koje Ijudi ponekad imaju nakon sto prezive traumatske dogadjaje. Pazljivo procitajte svaki od njih I zaokruzite broj od 0 do 3 koji najbolji opisuje kako cesto ste Vi imali taj problem TOKOM POSLJEDNJEG MJESECA. Sve ove poteskoce odredite u odnosu na traumatske dogadjaje koji ste opisali gore.

1. Uznemirujuce misli ili slike traumatskih dozivljaja koje se vracaju bez Vase zelje

Nikada ili samo jedan put 0
Jedan put sedmicno ili manje / ponekad... 1
2-4 puta sedmicno..... 2
5 ili vise puta sedmicno / gotovo stalno ... 3

2. Ruzni snovi ili nocne more

Nikada ili samo jedan put..... 0
Jedan put sedmicno ili manje / ponekad... 1
2-4 puta sedmicno..... 2
5 ili vise puta sedmicno / gotovo stalno.... 3

3. Ponovno prozivljavanje traumatskih dozivljaja, ponasate se ili se Osjecate kao da se traumatski dogadjaji ponovo desavaju

Nikada ili samojedan put..... 0
Jedan put sedmicno ili manje / ponekad.. 1
2-4 puta sedmicno..... 2
5 ili vise puta sedmicno / gotovo stalno.. 3

4. Osjecali ste se emocionalno uzbudjeno kada ste se podsjecali na traumatske dogadjaje (npr. osjecali ste se prestraseno, ljuto, tuzno, krivo, itd.)

Nikada ili samo jedan put..... 0
Jedan put sedmicno ili manje / ponekad... 1
2-4 puta sedmicno..... 2
5 ili vise puta sedmicno / gotovo stalno.... 3

5. Kada se prisjecate traumatskih dogadjaja, dozivljavate tjelesne reakcije (npr. preznojavanje, lupanje srca)

Nikada ili samo jedan put..... 0
Jedan put sedmicno ili manje / ponekad... 1
2-4 puta sedmicno..... 2
5 ili vise puta sedmicno / gotovo stalno.... 3

6. Pokusavate ne razmisljati, ne razgovarati ili izbjegavati osjecaje vezane za traumatske dozivljaje

Nikada ili samo jedan put..... 0
Jedan put sedmicno ili manje / ponekad... 1
2-4 puta sedmicno..... 2
5 ili vise puta sedmicno / gotovo stalno.... 3

7. Pokusavate izbjegavati aktivnosti, mjesta ili ljude koji vas podsjecaju na traumatske dogadjaje

Nikada ili samo jedan put..... 0
Jedan put sedmicno ili manje / ponekad... 1
2-4 puta sedmicno..... 2
5 ili vise puta sedmicno / gotovo stalno.... 3

8. Niste se vise u stanju sjetiti nekih vaznih traumatskih dogadjaja

Nikada ili samo jedan put..... 0
Jedan put sedmicno ili manje / ponekad... 1
2-4 puta sedmicno..... 2
5 ili vise puta sedmicno / gotovo stalno.... 3

9. Mnogo Vas manje interesuju nekada vazne aktivnosti ili mnogo manje ucestvujete u njima

Nikada ili samo jedan put..... 0
Jedan put sedmicno ili manje / ponekad... 1
2-4 puta sedmicno..... 2
5 ili vise puta sedmicno / gotovo stalno.... 3

10. Osjecate se udaljeno ili odvojeno od drugih ljudi

Nikada ili samo jedan put..... 0
Jedan put sedmicno ili manje / ponekad... 1
2-4 puta sedmicno..... 2
5 ili vise puta sedmicno / gotovo stalno.... 3

11. Osjecate se emocionalno otupjelo (npr. niste u stanju zaplakati ili niste u stanju osjecati ljubav)

Nikada ili samo jedan put..... 0
Jedan put sedmicno ili manje / ponekad... 1
2-4 puta sedmicno..... 2
5 ili vise puta sedmicno / gotovo stalno.... 3

12. Osjecate se kao da se vasi planovi I nade za buducnost nece ostvariti (npr. necete postici uspjeh u karijeri, braku, sa djecom, drugom zivotu)

Nikada ili samo jedan put.....	0
Jedan put sedmicno ili manje / ponekad...	1
2-4 puta sedmicno.....	2
5 ili vise puta sedmicno / gotovo stalno....	3

13. Imate teskoce da zaspite ili prespavate cijelu noc

Nikada ili samo jedan put.....	0
Jedan put sedmicno ili manje / ponekad...	1
2-4 puta sedmicno.....	2
5 ili vise puta sedmicno / gotovo stalno....	3

14. Osjecate se razdrazijivo ili imate provale bijesa

Nikada ili samo jedan put.....	0
Jedan put sedmicno ili manje / ponekad...	1
2-4 puta sedmicno.....	2
5 ili vise puta sedmicno / gotovo stalno....	3

15. Imate poteskoce sa koncentracijom (npr. odlutate u mislima iz razgovora, ne mozete pratiti pricu na TV, zaboravljate sta citate)

Nikada ili samo jedan put.....	0
Jedan put sedmicno ili manje / ponekad...	1
2-4 puta sedmicno.....	2
5 ili vise puta sedmicno / gotovo stalno....	3

16. Pretjerano ste na oprezu (npr. provjeravate koje oko Vas, neugodno Vamje kada su Vam ledja okrenuta vratima, sl.)

Nikada ili samo jedan put.....	0
Jedan put sedmicno ili manje / ponekad...	1
2-4 puta sedmicno.....	2
5 ili vise puta sedmicno / gotovo stalno....	3

17. Osjecate se napeto i lako se prenete na male podrazaje (npr. Nagli zvuk, dodir,)

Nikada ili samo jedan put.....	0
Jedan put sedmicno ili manje / ponekad...	1
2-4 puta sedmicno.....	2
5 ili vise puta sedmicno / gotovo stalno....	3

18. Koliko dugo vremena ste imali gore opisane poteskoce? (zaokruzitejedan odgovor)

manje od 12 mjeseci.....	1
vise od 12 mjeseci.....	2
vise od 3 godine.....	3

19. Koliko dugo nakon pocetka Vase izlozenesti traumatskim dogadjajima su se sve ove poteskoce prvi put javile? (zaokruzite jedan odgovor)

manje od 6 mjeseci.....1
6 ili vise od 6 mjeseci.....2

20. Oznacite ispod ovog teksta da li su poteskoce opisane u prethodnom dijelu uticale na. navedena podrucja Vaseg zivota TOKOM PROSLOG MJSECA

	DA	NE
a) Posao	1	0
b) Kucanski poslovi i obaveze	1	0
c) Odnosi sa prijateljima	1	0
d) Zabava i slobodno vrijeme	1	0
e) Skolske obaveze	1	0
f) Odnosi sa porodicom	1	0
g) Seksualni zivot	1	0
h) Opste zadovoljstvo sa zivotom	1	0
i) Ukupni nivo funkcionisanja u svim podrucjima zivota	1	0

PTDS Kosovan translation

Pjesa e pare - Part 1

Ka shume njerez qe kane perjetuar ose kane qene deshmitare te ndonje ngjarje traumatike apo stersante gjate jetes se tyre. Me poshte eshte nje liste ngjarjesh traumatike. Ver nje kryq ne kutine anash asaj ngjarje qe te ka ndodhur ty ose ku ti ke qene deshmitar.

(1) ☐ Aksident serioz, zjarr ose shperthim (psh, ne industri,ferme,makine, aeroplan, ose aksident ne anije)

(2) ☐ Fatkeqesi natyrore (psh, ciklon, uragan, permbytje, apo termet i forte)

(3) ☐ Sulm jo-seksual (psh, kur jeni grabitur, sulmuar fizikisht, qelluar, goditur me thike, apo mbajtur nen shenjester)

(4) ☐ Perdhunim (seksualisht) nga nje i panjohur (psh, perdhunim me force ose tentative per perdhunim)

(5) ☐ Beteje ushtarake ose zone lufte

(6) ☐ Abuzim seksual ose fizik gjate femijerise (psh, kontakt me organet gjenitale, gjoksin)

(7) ☐ I burgosur (psh, bashkevuajtes ne burg, I burgosur lufte, apo rob)

(8) ☐ Jeni torturuar

(9) ☐ Semundje qe ju kane rrezikuar jeten

(10) ☐ Ngjarje te tjera traumatike

(11) ☐ Ne se vute kryq tek pyetja 10, specifiko ngjarjen traumatike me poshte.

If you marked item 10, specify the traumatc event

Shenoni dicka fare shkurt, pasi me gjate do e pershkruani ne kutite e anes tjeter.

Pjesa e 2-te - Part 2

(12) Nese keni vene me shume se nje kryq tek pjesa e pare, vendos nje kryq ne kutite e meposhtme perbri ngjarjes qe ju ka shqetesuar ju me shume. Nese keni vendosur vetem nje kryq tek pjesa e pare, vendos perseri te njejtin kryq dhe ne kutite perkatese me poshte

☐ Aksident

☐ Fatkeqesi

☐ Sulm jo-seksual

☐ Sulm seksual

☐ Burgosje

☐ Torture

☐ Semundje qe ju ka rrezikuar jeten

Ne kutine e meposhme pershkruaj shkurtimisht ngjarjen traumatike per te cilen ke vene kryqin me lart.

Me poshte jane disa pyetje rreth ngjarjes traumatike qe sapo keni pershruar me lart.

(13) Sa kohe ka qe kjo ngjarje ka ndodhur ? (rretho nje)

1 Me pak se 1 muaj 2 1 deri ne 3 muaj

3 3 deri ne 6 muaj 4 6 muaj deri ne 3 vjet

5 3 deri ne 5 vjet 6 me shume se 5 vjet

Per pyetjet ne vijim, rrethoni P per Po dhe J per Jo

Gjate kesaj ngjarje traumatike :
During this traumatic event

(14) P J A u demtuat ju fizikisht?
(15) P J A u demtua ndokush tjeter?
(16) P J A menduat se jeta juaj qe ne rrezik?

(17) P J A u ndjete i pafuqishem (per te ndihmuar) ?
(18) P J A u ndjete i tmerruar (shume i frikesuar) ?

Pjesa e 3-te / Part 3

Me poshte eshte nje liste problemesh qe njerezit disa here perjetojne gjate nje ngjarjeje traumatike. Lexo cdonjeren me kujdes dhe rretho ate numer (nga 0 tek 3) qe pershkruan me mire shpeshtesine e problemit qe ju ka shqetesuar **gjate muajit te fundit**. Radhit cdo problem ne lidhje me ngjarjen traumatike qe pershkruat ne piken 12 te faqes parardhese.

0 Asnjehere ose vetem nje here
1 Nje here jave ose me pak
2 2 deri 4 here ne jave/gjysmen e kohes
3 5 ose me shume here ne jave/thuajse gjithmone

(19) 0 1 2 3 Imagjinoni ngjarje te merzitshme ose pamje nga ngjarja traumatike qe ju vijne neper mend kur nuk doni ti kujtoni.

(20) 0 1 2 3 Shihni endra te keqija ose makthe mbi ngjarjen traumatike

(21) 0 1 2 3 E rijetoni ate ngjarje, duke vepruar ose u ndjere sikur te ndodhte rishtas

(22) 0 1 2 3 Ndjeheni keq emocionalisht kur ajo ngjarje ju vjen neper mend (psh, keni frike, shqetesoheni, jeni i merzitur, apo fajtor)

(23) 0 1 2 3 A perjetoni shqetesime fizike kur sillni ne mend ate ngjarje (psh, beheni me djerse, ju shpeshtohet ritmi i zemres)

(24) 0 1 2 3 Perpiqeni mos te mendoni, flisni apo emocionoheni prej asaj ngjarjeje

(25) 0 1 2 3 Perpiqeni t'iu shmangeni aktiviteteve, njerezve ose vendeve qe ju bien ne mendje ate ngjarje

(26) 0 1 2 3 E keni te pamundur te kujtoni nje moment (pjese) te rrendesishem nga ajo ngjarje.

(27) 0 1 2 3 Ju ka rene interesi ose merrni pjese shume rralle ne aktivitete te rrendesishme

(28) 0 1 2 3 Ndjeheni te larguar (i vetmuar) nga njerezit qe ju rethojne

(29) 0 1 2 3 Ndjeheni i mpire emocionalisht (psh, nuk mund te qani ose te shfaqni ndjenja dashurie)

(30) 0 1 2 3 Ndjeheni sikur planet tuaja ose shpresat tuaja per te ardhmen nuk do realizohen (psh, nuk do beni me dot kariere, nuk do martoheni, s'do keni femije, ose jete te gjate)
Feeling as if your future plans or hopes will not come true (for example, you will not have a career, marriage, children, or a long life)

(31) 0 1 2 3 Keni veshtiresi per t'ju zene gjumi apo per te fjetur

(32) 0 1 2 3 Ndjeheni i shqetesuar ose i inatosur

(33) 0 1 2 3 Keni veshtiresi te perqendroheni (psh, hidheni dege me dege kur bisedoni, humbisni rrjedhen e ngjarjeve kur shihni nje film ne TV, ose harroni cka lexoni)

(34) 0 1 2 3 Jeni ne gjendje alarmi - gadishmerie (psh, kontrolloni ke keni prapa, nuk ndjeheni rehat kur jeni me kuriz nga dera, etj)

(35) 0 1 2 3 Kerceni ose levizni menjehere (psh, kur dikush ju afrohet ose vjen drejt jush)

(36) 0 1 2 3 Per sa kohe e perjetoni problem in/et qe keni raportuar me lart ? (rretho nje)

1 Me pak se 1 muaj 2 1 deri ne 3 muaj
3 Me shume se 3 muaj

(37) 0 1 2 3 Sa kohe pas ngjarjes traumatike filluan keto probleme ? (rretho nje)

1 me pak se 6 muaj 2 6 ose me shume muaj

Pjesa e 4-te / Part 4

Tregoni me poshte ne se problemet qe lexuat ne pjesen e 3-te kane lidhje (ndertthurje) me ndonje prej fushave te jetes suaj **gjate muajit te fundit**. Rretboni P-ne per Po ose J-ne per Jo.

(38) P J Me punen

(39) P J Detyrat ose punet e shtepise

(40) P J Maredheniet me miqte (shoket)

(41) P J Qejfet dhe aktivitetet e kohes se lire

(42) P J Detyrat e shkolles

(43) P J Maredhoniet ne familje

(44) P J Jeten seksuale

(45) P J Me kenaqesite e jetes ne pergjithesi

(46) P J Me nivelin e pergjithshem te gjithe treguesve te jetes tuaj

Overall level of functioning in all areas of your life

Appendix F : BDI-I

BDI-I Original

Date .....

questionnare are groups of sentences. Please reach each group of statements carefully. Then pick out the one statement
roup which best describes the way you have been feeling during the PAST WEEK, INCLUDING TODAY. Circle
er beside the statement you picked. If several statements in the group seem to apply equally well, circle each one. Be s
d all the statements in each group before making your choice.

I do not feel sad
I feel sad
I am sad all the time and I can't snap out of it
I am so sad or unhappy that I can't stand it

I am not particularly discouraged about the future
I feel discouraged about the future
I feel I have nothing to look forward to
I feel that the future is hopeless and things cannot improve

I do not feel like a failure
I feel I have failed more than the average person
As I look back on my life, all I can see is a lot of failures
I feel I am a complete failure as a person

I get as much satisfaction out of things as I used to
I don't enjoy things the way I used to
I don't get real satisfaction out of anything any more
I am dissatisfied or bored with everything

I don't feel particularly guilty
I feel guilty a good part of the time
I feel quite guilty most of the time
I feel guilty all the time

I don't feel I am being punished
I feel I may be punished
I expect to be punished
I feel I am being punished

I don't feel disappointed in myself
I am disappointed in myself
I am disgusted with myself
I hate myself

I don't feel I am any worse than anybody else
I am critical of myself for my weaknesses or mistakes
I blame myself all the time for my faults
I blame myself for everything bad that happens

I don't have any thoughts of killing myself
I have thoughts of killing myself, but would not carry them out
I would like to kill myself
I would kill myself if I had the chance

I don't cry any more than usual
I cry more now than I used to
I cry all the time now
I used to be able to cry, but now I can't even though I want to

I am no more irritated now than I ever am
I get annoyed or irritated more easily than I used to
I feel irritated all the time now
I don't get irritated at all by the things that used to irritate me

12. 0 I have not lost interest in other people
1 I am less interested in other people than I used ot be
2 I have lost most of my interest in other people
3 I have lost all of my interest in other people

13. 0 I make decisions about as well as I ever could
1 I put off making decisions more than I used to
2 I have greater difficulty in making decisions than before
3 I can't make decisions at all anymore

14. 0 I don't feel I look any worse than I used to
1 I am worried that I am looking old or unattractive
2 I feel that there are permanent changes in my appearance that make me look unattractive
3 I believe that I look ugly

15. 0 I can work about as well as before
1 I takes an extra effort to get started at doing something
2 I have to push myself very hard to do anything
3 I can't do any work at all

16. 0 I can sleep as well as usual
1 I don't sleep as well as I used to
2 I wake up 1-2 hours earlier than usual and find it hard to back to sleep
3 I wake up several hours earlier than I used to and cannot back to sleep

17. 0 I don't get more tired than usual
1 I get tired more easily than I used to
2 I get tired from doing almost anything
3 I am too tired to do anything

18. 0 My appetite is no worse than usual
1 My appetite is not as good as it used to be
2 My appetite is much worse now
3 I have no appetite at all anymore

19. 0 I haven't lost much weight, if any, lately
1 I have lost more that 5 pounds I am purposely tryir
2 I have lost more than 10 pounds to lose weight by ea
3 I have lost more than 15 pounds less. Yes .....No ..

20. 0 I am no more worred about my health than usual
1 I am worred about physical problems such as aches & p or upset stomach, or constipation
2 I am very worried about physical problems and it's hard think of much else
3 I am so worried about my physical problems that I cann think about anything else

21 0 I have not noticed any recent change in my interest in s
1 I am less interested in sex than I used to be
2 I am much less interested in sex now
3 I have lost interest in sex completely

BDI-I Bosnian translation

Beck Depression Inventory

Datum:

Id. : _____

Bracno stanje _____ Starost _____ Pol _____

Zanimanje _____

Skolska sprema _____

Ovaj upitnik se sastoji od 21 skupine izjava. Nakon sto pazljivo procitate svaku skupinu, zaokruzite broj (0,1,2 ili 3) do one izjave koja najbolje opisuje kako ste se osjecali tokom protekle sedmice, ukljucujuci i danasnji dan. Ako Vam se ucini da nekoliko izjava unutar jedne skupine jednako vaze za vas, zaokruzite svaku od njih. Ne propustite procitati sve izjave unutar skupine prije nego sto napravite svoj izbor.

1
0 Ne osjecam se tuznim.
1 Tuzan sam.
2 Tuzan sam cijelo vrijeme i ne mogu se osloboditi toga.
3 Toliko sam tuzan ili nesrecan da to ne mogu podnijeti.

2
0 Nisam posebno obeshrabren sto se tice buducnosti.
1 Osjecam se obeshrabrenim u vezi buducnosti.
2 Osjecam da nema nista cemu bih se radovao.
3 Mislim daje buducnost beznadezna i da stvari ne mogu krenuti nabolje.

3
0 Ne osjecam se kao gubitnik.
1 Mislim da sam neuspjesniji od prosjecne osobe.
2 Kada pogledam unazad na svoj zivot, sve sto vidim je gomila neuspjeha.
3 Osjecam da sam potpuni promasaj kao osoba.

4
0 Crpim jednako zadovoljstvo iz stvari isto kao i prije.
1 Ne uzivam u stvarima onako kako sam obicavao.
2 Ne crpim istinsko zadovoljstvo vise ni iz cega.
3 Sve mi je dosadno ili sam sa svime nezadovoljan.

5
0 Ne osjecam se posebno krivim.
1 Osjecam da sam kriv dobar dio vremena.
2 Osjecam se potpuno krivim vecinu vremena.
3 Stalno se osjecam krivim.

6
0 Ne osjecam se kaznjenim.
1 Mislim da cu mozda biti kaznjen.
2 Ocekujem da budem kaznjen.

XXX'

3 Osjecam da sam kaznjen.

7
0 Nisam razocaran u sebe.
1 Razocaran sam u sebe.
2 Gadim se sam sebi.
3 Mrzim sebe.

8
0 Ne mislim da sam bilo sta gori od bilo kog drugog.
1 Kritikujem sam sebe zbog svoje slabosti ili gresaka.
2 Cijelo vrijeme sam samo kritican zbog svojih pogresaka.
3 Okrivljujem sebe za sve ruzno sto se desi.

9
0 Nemam nikakvih pomisli o samoubistvu.
1 Pomisljam na to da se ubijem, ali ne bih to ucinio.
2 Volio bih pociniti samoubistvo.
3 Ubio bih se kada bih imao priliku.

10
0 Ne placem vise nego obicno.
1 Sada placem vise nego sto sam obicavao.
2 Sada stalno placem.
3 Nekada sam mogao plakati, ali sad ne mogu iako zelim.

11
0 Ne nerviram se vise nego inace.
1 Lakse se iznerviram ili mi prije postane dosadno nego ranije.
2 Sad sam stalno iznerviran.
3 Vise me uopste ne iritiraju stvari koje su me prije iritirale.

12
0 Nisam izgubio interes za druge ljude.
1 Drugi ljudi me zanimaju manje nego prije.
2 Izgubio sam vecinu svog zanimanja za ostale ljude.
3 Izgubio sam sve svoje zanimanje za ostale ljude.

13
0 Donosim odluke jednako uspjesno kao i uvijek.
1 Odlazem donosenje odluka vise nego sto sam obicavao.
2 Imam vece poteskoce u donosenju odluka nego prije.
3 Vise uopste nisam u stanju donositi odluke.

14
0 Ne mislim da izgledam ista losije nego prije.
1 Brinem se da izgledam staro ili neprivlacno.
2 Osjecam da su u mom izgledu nastale trajne promjene koje me cine neprivlacnim.
3 Vjerujem da izgledam ruzno.

15
0 Sposoban sam za rad jednako kao i prije.
1 Potreban mi je dodatni napor da zapocnem nesto raditi.
2 Moram sebe vrlo jako prisiljavati da nesto uradim.

3 Ne mogu vise uopste da radim.

16
0 Spavam jednako dobro kao i obicno.
1 Ne spavam onako dobro kao sto sam obicavao.
2 Probudim se 1-2 sata ranije nego inace i onda mi je tesko ponovo zaspati.
3 Budim se vise od 2 sata ranije nego prije i onda ne mogu spavati.

17
0 Ne umaram se vise nego obicno.
1 Brze se umorim nego prije.
2 Umori me skoro sve sto radim.
3 Preumoran sam da bih ista uradio.

18
0 Apetit mi je isti kao i uvijek
1 Apetit mi nije jednako dobar kao prije.
2 Apetit mi je sada puno losiji.
3 Vise uopste nemam apetita.

19
0 Nisam puno smrsao, a ako jesam, onda tek u posljednje vrijeme.
1 Smrsao sam vise od 3 kilograma.
2 Smrsao sam vise od 5 kilograma.
3 Smrsao sam vise od 8 kilograma.

Namjerno pokusavam da izgubim na tezini tako da manje jedem.
Da _____ Ne _____

20
0 Nisam zabrinut za svoje zdravlje vise nego obicno.
1 Brinu me fizicki problemi kao sto su bolovi, muka u stomaku ili zatvor (stolica).
2 Jako sam zabrinut za svoje fizicke probleme tako da mi je tesko misliti o drugim stvarima.
3 Moji fizicki problemi me toliko brinu da ne mogu misliti ni o cemu drugom.

21
0 Nisam primijetio nikakve novonastale promjene u mom zanimanju za seks.
1 Manje sam zainteresovan za seks nego sto sam bio.
2 Seks me sada puno manje zanima.
3 U potpunosti sam izgubio sve zanimanje za seks.

Appendix G : BDI-II

BDI-II Original

BDI-II

Date:

e: _____ Marital Status: _____ Age: _____ Sex: _____

ıpation: _____ Education: _____

ructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and pick out the **one statement** in each group that best describes the way you have been feeling during the **past two ks, including today**. Circle the number beside the statement you have picked. If several statements in the group ı to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one :ment for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

. Sadness

0 I do not feel sad.
1 I feel sad much of the time.
2 I am sad all the time.
3 I am so sad or unhappy that I can't stand it.

: Pessimism

0 I am not discouraged about my future.
1 I feel more discouraged about my future than I used to be.
2 I do not expect things to work out for me.
3 I feel my future is hopeless and will only get worse.

3. Past Failure

0 I do not feel like a failure.
1 I have failed more than I should have.
2 As I look back, I see a lot of failures.
3 I feel I am a total failure as a person.

4. Loss of Pleasure

0 I get as much pleasure as I ever did from the things I enjoy.
1 I don't enjoy things as much as I used to.
2 I get very little pleasure from the things I used to enjoy.
3 I can't get any pleasure from the things I used to enjoy.

5Guilty Feelings

0 I don't feel particularly guilty.
1 I feel guilty over many things I have done or should have done.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

6. Punishment Feelings

0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

7. Self-Dislike

0 I feel the same about myself as ever.
1 I have lost confidence in myself.
2 I am disappointed in myself.
3 I dislike myself.

8. Self-Criticalness

0 I don't criticize or blame myself more than usual.
1 I am more critical of myself than I used to be.
2 I criticize myself for all of my faults.
3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes

0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10. Crying

0 I don't cry anymore than I used to.
1 I cry more than I used to.
2 I cry over every little thing.
3 I feel like crying, but I can't.

_____ Subtotal Page 1

Continued on Back

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11. Agitation

0 I am no more restless or wound up than usual.

1 I feel more restless or wound up than usual.

2 I am so restless or agitated that it's hard to stay still.

3 I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest

0 I have not lost interest in other people or activities.

1 I am less interested in other people or things than before.

2 I have lost most of my interest in other people or things.

3 It's hard to get interested in anything.

13. Indecisiveness

0 I make decisions about as well as ever.

1 I find it more difficult to make decisions than usual.

2 I have much greater difficulty in making decisions than I used to.

3 I have trouble making any decisions.

14. Worthlessness

0 I do not feel I am worthless.

1 I don't consider myself as worthwhile and useful as I used to.

2 I feel more worthless as compared to other people.

3 I feel utterly worthless.

15. Loss of Energy

0 I have as much energy as ever.

1 I have less energy than I used to have.

2 I don't have enough energy to do very much.

3 I don't have enough energy to do anything.

16. Changes in Sleeping Pattern

0 I have not experienced any change in my sleeping pattern.

1a I sleep somewhat more than usual.

1b I sleep somewhat less than usual.

2a I sleep a lot more than usual.

2b I sleep a lot less than usual.

3a I sleep most of the day.

3b I wake up 1–2 hours early and can't get back to sleep.

17. Irritability

0 I am no more irritable than usual.

1 I am more irritable than usual.

2 I am much more irritable than usual.

3 I am irritable all the time.

18. Changes in Appetite

0 I have not experienced any change in my appetite.

1a My appetite is somewhat less than usual.

1b My appetite is somewhat greater than usual.

2a My appetite is much less than before.

2b My appetite is much greater than usual.

3a I have no appetite at all.

3b I crave food all the time.

19. Concentration Difficulty

0 I can concentrate as well as ever.

1 I can't concentrate as well as usual.

2 It's hard to keep my mind on anything for very long.

3 I find I can't concentrate on anything.

20. Tiredness or Fatigue

0 I am no more tired or fatigued than usual.

1 I get more tired or fatigued more easily than usual.

2 I am too tired or fatigued to do a lot of the things I used to do.

3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex

0 I have not noticed any recent change in my interest in sex.

1 I am less interested in sex than I used to be.

2 I am much less interested in sex now.

3 I have lost interest in sex completely.

_____ Subtotal Page 2

_____ Subtotal Page 1

_____ Total Score

BDI-II Kosovan translation

BDI-II

Gjendja Civile: *Martuar* ☐ *Beqar* ☐ *I ve* ☐ **Mosha** ☐☐ ne vjec

Profesioni _____ **Shkollimi :** *Pa shkolle* ☐ *I ulet* ☐ *I mesem* ☐ *I larte* ☐

Udhezime : Ky pyetesor perbehet nga 21 grupe pyetjesh. Ju lutemi lexoni me kujdes cdonjeren prej tyre, pastaj zgjidhni *vec nje percaktim* ne cdo seksion qe pershkruan me sakte se si jeni ndjere gjate *dy javeve te fundit, perfshi diten e sotme*. Rrethoni numrin anash zgjedhjes qe keni bere. Ne se ka me shume se nje percaktim ne cdo grup pyetjesh qe ju shkojne njeherazi pershtat, rrethoni numrin me vlere me te madhe tek ai grup. Sigurohuni qe per cdo grup-pyetjesh te keni zgjedhur nje e vec nje percaktim, perfshi ketu dhe grup-pyetjen 16 (Ndryshimet ne menyren e gjumit) dhe ne te 18-ten (Ndryshime te oreksit).

1. Trishtimi *Sadness*

0 Nuk ndjehem i trishtuar
1 Ndjehem i trishtuar shumicen e kohes
2 Jam i trishtuar gjithe kohes
3 Jam aq i trishtuar ose i pakenaqur sa s'thuhet

2. Pesimizmi

0 Nuk jam i dekurajuar per te ardhmen
1 Ndjehem me i dekurajuar per te ardhmen se Ç'duhet
2 Nuk pres gjera te mira per vehten
3 E shoh te ardhmen te pashprese dhe e ndjej se me keq do behet

3. Deshtimet e se kaluares

0 Nuk ndjehem i deshtuar
1 Kam desbtuar me shume sec duhej
2 Kur shoh prapa, shoh shume deshtime
3 E ndjej qe jam i teri nje deshtim

4. Humbja e kenaqesise

0 Marr aq shume kenaqesi sa kurre me pare nga gjerat qe me pelqejne
1 Nuk i gezoj gjerat aq sa duhet (si me pare)
2 Marr shume pak kenaqesi nga gjerat (se me pare)
3 Nuk me gezojne hic gjerat qe duhet te me kenaqnin

5. Ndjenjat e fajit *Guilty feelings*

0 Nuk ndjehem vecanerisht fajtor
1 Ndjehem fajtor per shume gjera qe kam bere apo qe duhej te beja
2 Ndjehem fajtor shumicen e kohes
3 Ndjehem fajtor gjithe kohes

5. Ndjenjat ndeshkimore ndaj vehtes

0 Nuk e ndjej qe kam qene i ndeshkuar
1 E ndjej se mund te ndeshkohem
2 Pres qe te ndeshkohem
3 E ndjej qe kam qene i ndeshkuar

7. Ndjenja per mimin ndaj vetes

0 Ndjehem njelloj per vehten si perhere
1 Kam humbur besimin tek vetja
2 Jam i pakenaqur nga vetja
3 Nuk me pelqen vetja

8. Auto-kritika

Nuk e kritikoj apo fajesoj veten me shume sec duhet 0
Jam me shume kritik ndaj vehtes sec duhet 1
E kritikoj vehten per gjithe gabimet e mia 2
E fajesoj vehten per gjithe sa kane ndodhur 3

9. Mendime ose deshira per vetevrasje

0 Nuk me shkon ne mend te vras vehten
1 Me shkon neper mend te vras vehten, por nuk do ta kryeja dot nje gje te atille
2 Do doja ta vrisja vehten
3 Do doja te vrisja vehten sapo te jepej rasti

10. Te qaret

0 Nuk qaj me shume sec duhet
1 Qaj me shume sec duhet
2 Qaj edhe per gjera te vogla
3 Me vjen per te qare, por s'mundem

11. Agjitimi *Agitation*

0 Une nuk jam me nervoz sec duhet (se me pare)
1 Ndihem me nervoz sec duhet (se me pare)
2 Jam aq nervoz dhe i agjituar sa s'me ze vendi
3 Jam aq nervoz dhe i agjituar sa qe dua te leviz a te bej dicka

12. Humbja e interesit

0 Nuk e kam humbur interesin per njerezit apo per aktivitet
1 Jam me pak i interesuar per njerezit ose gjerat se me pare
2 E kam humbur thuajse interesin per njerezit a gjerat
3 E kam shume te veshtire te interesohem per ndonjegje

13. Pavendosmeria

0 I marr vendimet njelloj si me pare
1 E kam me te veshtire te vendos ne krahasim me perpara
2 E kam goxha te veshtire te marr vendime (se me pare)
3 Bezdisem kur me duhet te vendos per dicka

14. Pavlefshmeria (kotesia)

0 Nuk mendoj qe jam i pavlere
1 Nuk e konsideroj veten te vlefshem si me pare
2 Ndjehem me i pavlefshem krahasuar me te tjeret
3 Ndjehem thuajse kot (i pavlere)

15. Humbja e energjise (fuqise)

0 Kam po aq energji si me pare
1 Kam me pak energji se me pare
2 Nuk kam aq energji sa te bej ndonje gje te madhe
3 Nuk kam energji per te bere asgje (shume i pafuqi)

16. Ndryshime ne menyren e gjumit

0 Nuk kam perjetuar ndonje ndryshim ne menyren e gjumit
1a Fle dicka me shume se me pare
1b Fle dicka me pak se me pare
2a Fle goxha me shume se me pare
2b Fle goxha me pak se me pare

17. Irritimi

0 Nuk jam me i irrituar sec duhet (se me pare)
1 Jam me i irrituar sec duhet (se me pare)
2 Jam goxha me i irrtuar sec duhet (se me pare)
3 Jam i irrituar gjithe kohes

18. Ndryshime te oreksit

0 Nuk kam perjetuar ndonje ndryshim te oreksit
1a Oreksi im eshte dicka me i ulur se me pare
1b Oreksin e kam dicka me te shtuar se me pare
2a Oreksi im eshte goxha me i ulur se me pare
2b Oreksin e kam goxha me te shtuar se me pare
3a Me ka ikur oreksi thuajse fare
3b Pertypem gjithe kohen (ha si ujk)

19. Veshtiresi ne perqendrim

0 Mund te perqendrohem njelloj si me pare
1 Nuk mund te perqendrohem aq mire si me pare
2 E kam te veshtire te perqendrohem ne ndonje gje per kohe te gjate
3 Nuk mund te perqendrohem ne asgje

20. Lodhja ose keputja

0 Nuk jam me i lodhur a i keputur se me pare
1 Lodhem dhe keputem me shpejt se me pare
2 Jam aq i lodhur a i keputur sa s'mund te bej dot ato gjera qe duhet ti bej
3 Jam aq i lodhur a i keputur sa s'mund te bej dot shumicen e gjerave qe me duhet ti bej

21. Humbje e interesit tek seksi

0 Nuk shikoj ndonje ndryshim momentalisht tek interesi per seks
1 Jam me pak i interesuar per seksin se me pare
2 Jam goxha me pak i interesuar per seksin se me pare
3 E kam humbur fare interesin per seksin
3a Fle shumicen e dites
3b Zgjohem 1-2 ore me shpejt se me pare dhe s'me ze gjumi

Appendix H : Autobiographical Memory Task

ABMT Instructions

I am interested in your memory for events that have happened in your life. I am going to read to you some words. For each word, I want you to think of an event that happened to you which the word reminds you of. The event could have happened recently (yesterday, last week) or a long time ago. It might be an important event or a trivial event.

Just one more thing : the memory you recall should be of a specific event. So if I said the word "good" it would not be okay to say "I always enjoy a good party" because that does not mention a specific event, but it would be okay to say "I had a good time at Monika's party" because that is a specific event.

Appendix I : Ethical approval - correspondence

Copy of provisional approval letter

CAMDEN & ISLINGTON
Community Health Services NHS Trust
Your Partner for Health

LOCAL RESEARCH ETHICS COMMITTEE

Research Office, 3rd Floor, West Wing, St. Pancras Hospital,
London. NW1 OPE
tel: 0171 530 3376 fax: 0171 530 3235
e-mail: research.office@dial.pipex.com
Chair: *Stephanie Ellis* Administrator: *Michael Peat*

5th May 1999

Dr. Stuart Turner
Traumatic Stress Clinic
73 Charlotte Street
London
W1P 1LB

Dear Dr. Turner

Ref: 99/53 (please quote in all further correspondence)
Title: Discrepancies in Autobiographical Memory: Informing the Asylum Process

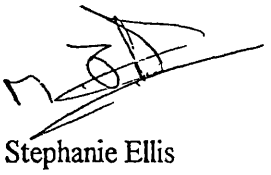
Thank you for your recent application to the Ethics Committee. Before the Committee can give ethical approval for this study, it was agreed that the following amendments to the information sheet should be addressed:

a) The opening sentence should give a clear indication that this is a research project.
b) A clear account of the way in which individuals were identified as appropriate for this study is needed.
c) There should be a more accurate account of the procedure involved, including a clear indication that there will be *two* interviews.
d) The wording concerning the offer of money is ambiguous. There should be a clear statement as to whether money is to be offered or not.
e) The final sentence implies a definite outcome that cannot be predicted by the researcher in advance. Therefore it should either be removed, or modified so as to read: "We hope that it will help other refugees in the future".

pls can you fax/post to Irene Heilig

Please forward any other requested additional information/amendments regarding your study to the Ethics Committee Administrator, at the above address. If you have any queries, please do not hesitate to contact Michael Peat or myself at the above address.

Yours Sincerely



Stephanie Ellis
Committee Chair

Copy of resubmission letter, asking for extension of approval to include Kosovan participants

Traumatic Stress Clinic,
73, Charlotte Street,
London
W1P 1LB

June 9th, 1999

Ref: 99/53
Title - Discrepancies in Autobiographical Memory: Informing the Asylum Process

Dear Michael,

Many thanks for your letter of May 5th 1999. I am replying on behalf of Dr. Turner as he is currently out of the country.

Firstly, you asked for a number of modifications to be made to the information letter. I enclose a copy of the new proposed letter. The modifications have been as follows :

1. the opening sentence now describes the project as a research project;
2. the last sentence of the second paragraph now explains how we identified the individuals for the project;
3. the last sentence of the third paragraph specifies the number of questionnaires that will be administered and tells the individual that they will be seen twice;
4. the ambiguous statement regarding money has been removed;
5. the suggested amendment to the final sentence has been made and now reads "We hope that the study will help other refugees in the future".

We trust that this will meet with the approval of the chairman and that we can proceed with the project in the near future.

Secondly, in view of the recent influx into the UK of large numbers of Kosovan Albanian refugees we would like to ask the committee to consider a separate request for a minor variation on the study. As chairperson of the UK trauma group, Dr. Turner is involved in co-ordinating the national response to the arrival of Kosovan refugees. It may be possible to extend the current study to a second group : Kosovan refugees. The Kosovan group would fit the inclusion criteria for the study, and we may be able to offer some clinical benefit in terms of diagnostic screening.

The end of paragraph two of the information letter would be modified accordingly.

Many thanks for your consideration. We look forward to receiving your comments.

Jane Herlihy
Clinical Psychologist in Training

cc: Dr. Stuart Turner

Copy of final approval letter

CAMDEN & ISLINGTON
Community Health Services NHS Trust
Your Partner for Health

LOCAL RESEARCH ETHICS COMMITTEE

Research Office, 3rd Floor, West Wing, St. Pancras Hospital,
London. NW1 0PE
tel: 0171 530 3376 fax: 0171 530 3235
e-mail: research.office@dial.pipex.com
Chair: *Stephanie Ellis* Administrator: *Michael Peat*

28th June 1999

Ms. Jane Herlihy
Traumatic Stress Clinic
73 Charlotte Street
London
W1P 1LB

Dear Ms. Herlihy

Ref: 99/53 (please quote in all further correspondence)
Title: Discrepancies in Autobiographical Memory: Informing the Asylum Process

Thank you for your letter dated 9th June 1999. I am pleased to inform you that your proposed amendments to this project have been approved. Please could you write and inform **Angela Williams** of the start date of your project, at the above address.

Please note that the following general conditions of approval apply:

- Investigators must ensure that all associated staff, including nursing staff, are informed of research projects and are told that they have the approval of the Local Research Ethics Committee.

- If data are to be stored on a computer in such a way as to make it possible to identify individuals then the project must be registered under the Data Protection Act 1984. Please consult your department data protection officer for advice.

- The Committee *must* receive immediate notification of any adverse event or unforeseen circumstances arising out of the trial.

- The Committee *must* receive notification: (a) when the study is complete; (b) if it fails to start or is abandoned; (c) if the investigator/s change; and (d) if any amendments to the study are proposed or made.

- The Committee will request details of the progress of the research project periodically (i.e. annually) and require a copy of the report on completion of the project.

Please forward any other requested additional information/amendments regarding your study to the Ethics Committee Administrator, at the above address. If you have any queries, please do not hesitate to contact Michael Peat or myself at the above address.

Yours sincerely

Stephanie Ellis
Committee Chair

Appendix J : Consent forms

English

Discrepancies in Autobiographical Memory Informing the Asylum Process

Consent Form

Delete as necessary

1. I have read the letter about this study YES/NO

2. I have had an opportunity to ask questions and discuss this study YES/NO

3. I have received satisfactory answers to all my questions YES/NO

4. I have received sufficient information about this study YES/NO

5. I understand that I am free to withdraw from this study:-

   *at any time
   *without having to give a reason for withdrawing
   *without affecting my future medical care YES/NO

6. Do you agree to take part in this study? YES/NO

Signed.....Date.....

Name in Block Letters .....

Bosnian

Pamcenje i Trazenje Izbjeglistva

Pristanak

1. Procitao sam informacije o ovom projektu. DA/NE

2. Imao sam prilike da postavim pritanja i da razgovaram o tome. DA/NE

3. Zadovoljan sam odgovorima DA/NE

4. Dobio sam dovoljno informacija o ovom projektu DA/NE

5. Znadem da sam slobodan do se povucem iz ovoga projekta :-

- bilo kado
- bez ikakvogo objasnjenja
- da to nikako ne utijece na moje buduce ljecnicke tretmane

DA/NE

6. Dali se zelite pridruziti ovom projektu ? DA/NE

Potpis .....Datum .....

Ime i Prezime .....
(stampanim slovima)

Kosovan Albanian

Mosperputhje ne Kujtesen Autobiografike
Informacion mbi procesin e kerkimit te Azilit

Forme Miratimi

Prish njeren prej tyre

1. E kam lexuar letren mbi qellimin e ketij studimi PO/JO

2. Pata mundesi te bej pyetje dhe te diskutoj rreth studimit PO/JO

3. Kam marre pergjigje te kenaqshme per te gjitha pyetjet e mija PO/JO

4. Kam marre informacion te mjaftueshem rreth ketij studimi PO/JO

5. E kuptoj qe jam i lire te vendos mbi pjesmarrjen ne kete studim:-

   *ne cdo kohe
   *pa qene nevoja te jap arsye per mospjesmarje ne te
   *pa ndikuar ky vendim ne kujdesin mjekesor ne te ardhmen PO/JO

6. Jeni dakort te merni pjese ne kete studim? PO/JO

Firma.....**Date**.....

Emri me shkronja te zeza (kapitale) .....

L