WHAT PREVENTS REFUGEES AND ASYLUM SEEKERS EXPOSED TO VIOLENCE FROM DISCLOSING TRAUMA?

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CONTENTS

OVERVIEW

Part 1 of this thesis is a literature review, which explores the factors surrounding refugees' and asylum seekers' disclosure during Home Office interviews. It places particular emphasis on the role of shame in trauma and disclosure. The first section is an outline of the UK immigration system. Section 2 explores the potential factors involved in inconsistent recall and disclosure by drawing on the literature of patient disclosure in psychological therapy and memory research. Section 3 looks at the psychological impact of trauma in refugees. The last section provides an overview of the shame literature and focuses particularly on the role of shame in disclosure and psychopathology.

Part 2 is an empirical study that aims to test some of the issues discussed in the literature review. Semi-structured interviews with refugees and asylum seekers showed that people with a history of sexual violence found it more difficult to disclose during their Home Office interview than those with a history of non-sexual violence. Feelings of shame were frequently cited in this group as a factor preventing disclosure. These findings were confirmed by quantitative analyses, which found that this group scored significantly higher on measures of posttraumatic stress symptoms, shame, dissociation and disclosure. The study also replicated previous findings showing that sexual violence is linked to avoidance symptoms, and it also supported the hypothesis that there is an association between shame and avoidance reactions.

Part 3 is a critical appraisal, which focuses on the challenges of researching refugees and asylum seekers. It includes sections on methodological and systemic issues and on research participation.

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PART 1: LITERATURE REVIEW

Shame and Disclosure in Traumatised Refugees and Asylum Seekers

ABSTRACT

This review aims to explore the factors surrounding asylum seekers' disclosure during Home Office interviews and places particular emphasis on the role of shame in trauma and disclosure. It starts with an overview of the UK immigration system. Asylum seekers undergo one or more interviews by the Home Office as part of the process of claiming asylum. Many find it hard to disclose personal information during these interviews, but the reasons for this are largely undocumented. Section two will further explore the phenomenon of disclosure and the potential factors involved by reviewing the literature on patient disclosure in psychological therapy. Part three will look at the psychological impact of trauma in refugees. Refugees have by definition been subjected to persecution and many have been subjected to torture and organised violence in their home countries. This puts them at a higher risk of psychological difficulties. Evidence from the empirical literature will be reviewed. The last section provides an overview of the shame literature and focuses particularly on the role of shame in disclosure and psychopathology. The review concludes with recommendations for future research and for interviewing people in a variety of settings, proposing that the process of revealing personal information can be experienced as deeply shaming and thus impact negatively on disclosure. The implications of this for the asylum process will be discussed.

1. REFUGEES AND ASYLUM SEEKERS AND THE LEGAL SYSTEM

1.1 Definitions

The 1951 United Nations Convention Relating to the Status of Refugees, also known as the 'Refugee Convention' passed the first internationally binding refugee law. It defined a refugee as someone who,

> *...owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it* (United Nations High Commissioner for Refugees, 1992: 8).

The 1951 Refugee Convention initially applied to European nationals only and was extended worldwide in the 1967 UN Protocol Relating to the Status of Refugees (United Nations High Commissioner for Refugees, 1992). To date, 144 countries, including the UK, have signed the 1951 Convention and/or the 1967 Protocol. Although countries differ in the interpretation and implementation of these laws, signatories are committed to three basic obligations: 'non-refoulement' (not sending people back who are in danger of persecution); protection of refugees and equal rights to recognised refugees.

It seems that there is still some confusion today about the definition of refugees and asylum seekers as the media and the public often use these terms interchangeably or synonymously with migrants or illegal immigrants. In the UK, a person is considered a refugee when the Home Office has accepted their asylum claim. An asylum seeker is someone who has applied to the government for asylum and is awaiting decision by the Home Office to be recognised as a refugee.

1.2 Immigration Grounds and Statistics

There are many reasons why people flee their home country including war, oppressive regimes, ethnic conflict or religious and socio-economic reasons. The origin of asylum seekers is determined by the international situation at any given time. The United Nations High Commissioner for Refugees (UNHCR) publishes detailed statistics on this issue. According to their 2004 Annual Report (UNHCR, 2005), the top three countries of origin of asylum seekers are the Russian Federation, Serbia and Montenegro, and China. Furthermore, it was reported that asylum application levels in Europe decreased by 21 per cent between 2003 and 2004. According to the Refugee Council Information Service the majority of asylum seekers entering the UK are from Somalia, Iran, China, Zimbabwe, Turkey and the Democratic Republic of Congo where people are exposed to human rights abuses and unstable political situations (Refugee Council, 2004). However, against common belief, the majority of refugees are housed by the developing world, mainly by countries in Africa and Asia. The UK was ranked at number seven of the 15 countries in Europe and at number 32 internationally in terms of applications per capita (UNHCR, 2002).

In 2002 the Home Office commissioned research to investigate why people sought asylum in the UK (Robinson & Segrott, 2002). It was revealed that the main reasons for claiming asylum was to find a place of safety. Many people reported that they had no choice of destination and had to rely on agents for documentation and travel arrangements. Those who had a choice over their final destination based their decision on existing family and community ties, colonial history, a belief in a democratic society and the English language. Economic reasons were only relevant to a small group of people, and most had little knowledge of the asylum system in the UK including welfare support. Finally, most respondents wanted to work and support themselves during the determination of their asylum claim.

1.3 The Asylum Process

Application for asylum can be made either on arrival to the UK (port applications) or after entry (in-country applications). Port applications are made to an immigration officer and in-country asylum applications must be made in person to the Home Office. In-country applicants must prove that they have applied for asylum at the earliest opportunity to be eligible for welfare support.

Most applicants have a brief screening interview shortly after arrival by government officials from the Asylum Screening Unit. This is to establish the applicant's identity, their route and means of entry to UK. All asylum seekers are fingerprinted and photographed to prevent multiple applications by individuals. All in-country applicants will have to go through a 'Restricted Access to NASS Support' (RANS) screening to ascertain whether they applied for asylum at the earliest opportunity. This screening can happen at the initial screening interview or at a separate

screening. After confirmation of identity, applicants are issued with an Application Registration Card (ARC), which is to show that they formally have applied for asylum and enables them to access services.

In addition, the authorities may provide the asylum seeker with a Statement of Evidence Form (SEF). This form gives the person an opportunity to put his or her case in writing and must be filled out and returned to the Home Office within ten working days. It is long and complex and has to be submitted in English with all supporting documents also translated into English. Alternatively, the authorities may not issue a SEF, but instead decide on the asylum seeker's application on the basis of information he or she provides at the interview.

Most asylum seekers will have to attend a Home Office interview, which is key to deciding on their application, although in some cases information provided in the SEF is used instead. During the interview the asylum seeker is expected to disclose all relevant information to their application, such as what happened to them in the country of origin as well as medical reports (that is if the person has a legal representative who has thought it necessary to request such reports). The authorities will also compare what is said in this interview with their SEF or screening interview(s). The Integrated Casework Unit at the Home Office Immigration and Nationality Directorate is responsible for processing and deciding on asylum claims.

In case of refusal it is possible to appeal to the Immigration Appellate Authority and if that fails then the applicant may apply for permission to be heard at the Immigration Appeals Tribunal. Appeal can be made on the grounds that reasons for

an asylum claim have not been fully considered or on the grounds that protection under the Human Rights Act (1998) has been broken.

1.4 Home Office Decision Making

Asylum applications are assessed in terms of an asylum seeker's credibility, the information the individual can supply, the current political situation in their country of origin, evidence on the country's human rights records and, if applicable, medical evidence of torture and abuse. Late disclosure, omission of information and discrepancies in the asylum seeker's story are often taken as evidence against the applicant's credibility. The Home Office has been criticised for the poor quality of decision making over asylum claims. According to the National Audit Office (NAO, 2004) pressure to meet targets has resulted in neglect of the complexity and sensitivity of certain cases. The high number of successful appeals reflects the poor quality of decision-making at the initial stage. One in five appeals heard by the Immigration Appellate Authority in 2003 overturned initial decisions. A report by Amnesty International (2004) revealed that Home Office asylum decisions are based on inaccurate and out-of-date country information, unreasoned decisions about people's credibility and a failure to properly consider complex torture cases. A survey by Asylum Aid (1999) found that the Home Office frequently ignores relevant evidence such as medical reports, bases refusal on inaccurate or incomplete information about the country of origin, requires detailed evidence and proof of persecution. Smith (2004) investigated the Home Office asylum interviews and found that when discrepancies or mistakes were identified in people's accounts, they were not given the chance to address these or explain these. In 2004, the UNHCR was invited to assist the Home Office in improving the quality of first instance

decision making through auditing existing practice. In this so-called Quality Initiative Project (UNHCR, 2005) 267 first instance Home Office decisions (approximately two per cent of decisions made) were reviewed and it was concluded that the quality of decisions was variable; problems remain with asylum claims being subjected to flawed procedures, such as unsustainable reasoning, misapplications of the law, failure to refer to and misapplication of country of origin information, failure to consider human rights issues, as well as inaccuracies and errors in drafting.

1.5 Summary

The UK is one of the many countries worldwide that has legally committed itself to the protection of refugees and asylum seekers. The majority of asylum seekers are fleeing their home country due to human rights abuses and unstable political situations trying to find a place of safety elsewhere. Once they enter the UK they are faced with a complex system for claiming asylum that typically involves completion of paperwork as well as possibly several interviews. The purpose of these interviews is to establish the asylum seeker's credibility based on the information the person supplies. Discrepancies in people's stories during successive interviews and late disclosure are some reasons why asylum applications are refused as this is seen as evidence against the asylum seeker's credibility.

The next section will focus on the issue of disclosure in greater detail, especially the potential factors affecting asylum seekers' disclosure during Home Office interviews. A greater understanding of this phenomenon might be provided by looking at what prevents people from disclosing personal information in other

settings. Part 2 will therefore start with a review of the literature on patient disclosure in psychological therapy.

2. DISCLOSURE

2.1 Patient Disclosure in Psychological Therapy

There is a growing body of literature into disclosure in psychological therapy with the main focus in the area concentrating on therapist self-disclosure to patients (e.g., Hill, Mahalik & Thompson, 1989; Knox, Hess, Peterson & Hill, 1997; Lundeen & Schuldt, 1992). Although in recent years this interest has been extended to patient disclosure in therapy, research into what is discussed in psychotherapy and what not and the reasons for non-disclosure is scarce; the factors surrounding patient disclosure are still largely unknown. The literature into this topic divides disclosure in terms of positive and negative consequences of disclosing personal information. Since we are interested in what prevents people from disclosing, the following paragraphs will review the literature on negative consequences of disclosure, focusing specifically on factors that make it difficult for people to disclose in therapy. Positive aspects of disclosure are not reviewed here, but extensive reviews can be found elsewhere (see Kelly & McKillop, 1996; Pennebaker, 1993).

2.1.1 History and Conceptual Issues

Empirical work in the field of self-disclosure dates back to the work of Jourard (1971). Later work done on encounter groups and group-therapy members revealed that people are most likely to withhold sexual information or feelings of failure and alienation (Norton, Feldman & Tafoya, 1974; Yalom, 1985). The main body of

systematic research into patient disclosure in therapy however started in the 1990's with the work of Clara Hill and colleagues. Hill, Thompson, Cogar and Denman (1993) proposed three types of patient covert processes in therapy: hidden reactions (clients' cognitions and emotions as a response to specific therapist interventions), things left unsaid (cognitions and emotions patients do not share with their therapist in a session), and secrets (major life events and other facts or emotions patients do not tell their therapist). They found that hidden reactions and things left unsaid are a direct response to events occurring within therapy, whereas secrets occur over a longer period of time and do not necessarily reflect specific events within therapy. Revealing secrets involves risks, such as a fear of being negatively evaluated and being rejected by the listener (Lehman, Ellard & Wortman, 1986), and most secrets involve negative information about the person holding the secret (Norton et al., 1974), which explains why people often choose to hide personal information from others. Kelly and McKillop (1996) distinguish between secret keeping and self-disclosure (i.e., revealing personal information to others). They conclude that secret keeping is empirically different from self-disclosure in that keeping a secret is an active process that uses cognitive resources and can be experienced as an emotional burden by the person holding the secret (Lane & Wegner, 1995).

2.1.2 Empirical Studies of Non-Disclosure

Several studies found that patients tend to hide negative reactions or are reluctant to express negative feelings in the sessions (Hill et al., 1993; Thompson & Hill, 1991). Hill et al. (1993) found that 65 per cent of long-term therapy patients leave something unsaid during sessions (most commonly negative feelings towards their therapist) and 46 per cent admitted to keeping secrets from their therapist (most

commonly of a sexual nature). In Kelly's (1998) study 40.5 per cent of patients admitted keeping a secret from their therapist, reflecting relationship difficulties and issues of a sexual nature. Brown, Russell and Thornton (1999) reported problems with disclosure in eating disordered inpatients with a history of abuse, despite efforts to create an encouraging, non-judgmental environment. In line with other studies for this population (e.g., Miller, 1993) they found that many of their sample had not disclosed their abuse prior to admission and only one quarter had ever disclosed to another health professional.

2.1.3 Contents of Disclosure

Specific themes have also been examined. It was found that disclosure occurred mainly around themes of self-worth, positive emotions and relationships with others (Farber & Hall, 2002; Roe & Farber, 2001). This is in line with a previous investigation by Orlinsky and Howard (1975) who showed that patients mainly talk about feelings and attitudes towards themselves as well as relationships with others. Non-disclosure mainly centers on themes of a sexual nature and body-related experiences. Especially themes reflecting violence and abuse have been rated as high non-disclosure items (Norton et al., 1974; Weiner & Shuman, 1984). Larson and Chastain (1990) found that the most painful and traumatic personal experiences are often concealed.

2.1.4 Factors Impeding Disclosure

Failure to disclose certain issues in therapy has been attributed to conscious inhibition, typically to avoid feelings of shame and embarrassment, or exposure due to a fear of confronting certain cognitions and emotions (Hill et al., 1993; Kelly,

1998). These feelings impact on the timing, focus and depth of what is discussed. For example, rape and sexual abuse victims were found to experience shame as a result of having suffered a stigmatizing event, which explains their desire to conceal this from others (Derlega, Metts, Petronio & Margulis, 1993; Pennebaker, 1985, 1989). Farber and Hall (2002) concluded that non-disclosure of sexual issues within therapy might be a reflection of culture-specific norms of what should be spoken about. Cultural issues however have been largely neglected in studies on patient self-disclosure. Previous research has shown decreased disclosure of Black outpatients compared with Whites (Wolkon, Moriwaki & Williams, 1973). Other research however has not found differences in disclosure between Asian and British outpatients (Bennett & Rutledge, 1989), nor have there been any differences in disclosure patterns between North American and Israeli therapy patients (Roe & Farber, 2001). More research in this area is clearly needed, especially since there has been an increased awareness of the role of culture in the therapeutic process.

Finally, it was found that a decision to withhold information could serve to reduce anxiety. Several researchers have found that denial and avoidance of negative thoughts may reduce distress in patients (Bonanno, Keltner, Holen & Horowitz, 1995; Kelly, 1998, 2000). People who have experienced traumatic or negative events may choose to conceal this from others for fear of upsetting the listener (Pennebaker, 1993; Pennebaker, Barger & Tiebout, 1989). Kelly and McKillop (1996) showed that recipients of disclosure indeed find it difficult to deal with others' emotional distress, which shows that an anticipation of negative interpersonal responses might be realistic rather than merely reflecting dysfunctional beliefs. In line with this, Hagan and Donnison (1999) showed that people's dysfunctional beliefs about

themselves were a reflection of their social reality (i.e., racist, sexist, homophobic). Moreover, Brown et al. (1999) reported negative affect post-disclosure, which is consistent with findings by McNulty and Wardle (1994) showing that disclosure of sexual abuse can lead to psychological distress.

2.1.5 Factors Facilitating Disclosure

There has been very little information in the literature on what factors contribute in facilitating disclosure. Brown et al. (1999) in their study on eating disordered patients found that secrets were more often revealed to a primary nurse over time than to the treating psychiatrist and they attributed this to the authoritarian role of the psychiatrist and the more frequent contact with the nurse. Trust and confidence in the staff member as well as non-judgmental attitude were frequently cited amongst this sample as facilitating disclosure. Duration in therapy and the therapeutic alliance have also been predictors for therapy disclosure (Hall & Farber, 2001). It is assumed that over time patients have more opportunity to disclose and generally the depth of discussion increases. Moreover, therapeutic alliance fosters an atmosphere where increased disclosure and self-discovery can occur.

The above paragraphs have provided a review of the literature into patient disclosure in psychological therapy and have specifically focused on the negative consequences of revealing personal information. Before looking in more detail at disclosure during Home Office interviews, a related issue will be outlined, namely discrepancies in asylum seekers' stories during successive interviews, as there may be similarities between the two.

2.2 Inconsistencies of Recall

Discrepancies in asylum seekers' stories of an event are a common reason for adversely judging their credibility and represent a common reason for refusing asylum claims:

Discrepancies, exaggerated accounts, and the addition of new claims of mistreatment may affect credibility (Immigration and Nationality Directorate, 2003).

The asylum process can span several months or years and it is not uncommon for new statements and appeals to be added to the original statement made on arrival. These subsequent statements often add new or more elaborate details to the original story, which can be interpreted by the Home Office as inconsistent and can lead to the asylum seeker being accused of fabricating their story. This is despite the fact that the UNHCR's training module on interviewing applicants for refugee status states,

A claim may be credible even though the applicant provides information during a later interview which was not submitted during an earlier examination. The reason for the discrepancy may be that the applicant was reluctant to speak freely during the first interview, but provides a full and accurate account on the later occasion (UNHCR, 1995: 34).

Cohen (2001) outlined several explanations to account for memory discrepancies in asylum seekers and she cited findings from general memory research as well as factors, such as emotional arousal, weight loss and malnutrition, minor traumatic brain injury, stress and arousal, post-traumatic stress disorder, mood disorders, and

chronic pain. Several of these factors will be examined in more detail in the following paragraphs.

2.2.1 Autobiographical Memory Research

There has been a range of clinical and non-clinical empirical studies demonstrating discrepancies in successive recall for the same event. Anderson, Cohen and Taylor (2000) confirmed the variability of personal memories. They compared successive recalls of autobiographical memories of older and younger people and found that older people's memory showed greater stability, whereas younger people's memory varied more in both content and output order. They also found that recent memories varied more than older ones. Furthermore, in both age groups the second recall of a memory produced an elaboration of the original version with less than 50 per cent of the facts being identical and new details being added. The authors pointed to the effect of demand characteristics to explain these findings. Previous research has shown that when people are asked to repeat information they have already provided, they assume that their first account is somewhat unsatisfactory and they subsequently try to rectify this by providing more and different details (Edwards & Potter, 1992).

Emotional states seem to have an impact on memory processes. Bradley & Baddeley (1990) showed that when events are encoded during high levels of arousal they are more difficult to retrieve. Southwick, Morgan, Nicolaou and Charney (1997) explored the consistency of traumatic autobiographical memories. They provided Gulf War veterans with a checklist of 19 significant experiences, one month and two years after their return. They found that 52 of their 59 participants changed their response to at least one item. Especially items assessing personal safety were

changed by 36 per cent of participants. These findings clearly have implications for the current asylum process that assesses asylum seekers' levels of fear based on their past experiences. They also suggest that there is a marked variability in the recall of both non-traumatic and traumatic personal memories and experiences, which means that it would be unfeasible to expect asylum seekers' successive memories to be perfectly consistent. Schwarz, Kowalski and McNally (1993) explored changes in retrospective accounts 5 and 17 months after a school shooting. Twelve female school staff recalled in identical self-report questionnaires their proximity to the site as well as emotional and sensory experiences on the day of the incident. Results showed that all changed some aspect of their recall on retest: Participants close to the shooting increased their reported proximity to the site, whereas those further away decreased reported proximity. Moreover, most showed both enlarged and reduced accounts of specific emotional and sensory experiences. Retest enlargement seemed associated with PTSD symptoms, and reduction with decreased anxiety and depression and increased self-confidence. Roemer, Litz, Orsillo, Ehlich and Friedman (1998) investigated the temporal stability of war-zone reports in a sample of 460 American soldiers who had served in the peace-keeping mission in Somalia. They found that soldiers showed an increased reporting of traumatic events over two testing sessions, which was positively associated with PTSD symptom severity. These findings highlight the potential impact of emotional states on the recall and reporting of traumatic experiences.

Furthermore, autobiographical memory research often distinguishes between central details, the gist of an autobiographical memory, and peripheral details, details of a specific event. It seems that decisions on an asylum seeker's credibility often are

based on the consistency of such peripheral details. The literature however does not support this view. Research on eye-witness testimony showed that more central details are recalled when an event has high levels of emotional impact than when the event is neutral, and this recall of central details is at the expense of the recall of peripheral details (Christianson & Safer, 1996). It was also found that discussing the event (Hollin & Clifford, 1983) and the wording of questions (Lipton, 1977) can change peripheral details. Christianson, Loftus, Hoffman and Loftus (1991) found that increased arousal of an event led to a focus on central details and decreased recall of peripheral details. They also showed that open-ended questions and free recall produced greater distress and limited reporting, whereas reading from a list of possible events produced greater recall. A study by Herlihy, Scragg and Turner (2002) investigated consistencies in autobiographical memories in refugees who have been granted leave to remain in the UK and thus had no reason to fabricate their stories to influence the asylum process. They found that up to 65 per cent of the details of people's stories changed between interviews, which were between 4 and 30 weeks apart, and they concluded that inconsistent recall does not necessarily imply a lack of credibility. They also found increased discrepancies for details rated as peripheral by the participant. Furthermore, for people with high levels of post-traumatic stress symptoms the number of discrepancies increased with length of time between interviews. The limitation of this study was that no causal explanation for the existence of discrepancies could be provided. It was suspected however that the emotional state of the refugee at the time of the interview might have affected responses.

2.2.2 Hypermnesia

Further light on the issue of memory discrepancies may be provided by a phenomenon called hypermnesia (Erdelyi & Becker, 1974), the improvement in memory recall over time. Most studies into hypermnesia present participants with material to be remembered followed by a series of recall or recognition tests. Payne (1987) demonstrated the existence of hypermnesia even when time between recall of word lists was varied. He also showed that hypermnesia can be obtained with verbal and pictorial images, but that recall increases with the use of high imagery material. Klein, Loftus and Fricker (1994) highlighted that hypermnesia is affected by motivation levels. They manipulated people's self-efficacy beliefs for their performance on memory tasks by providing them with varying levels of feedback. Those who received more positive feedback of their memory capabilities worked harder, persisted longer in their recall attempts, and showed more hypermnesia. Bluck, Levine and Laulhere (1999) carried out a memory study on the verdict of the OJ Simpson trial, demonstrating the existence of hypermnesia in autobiographical memory. They conducted three interviews within one hour. Recall increased between the first and second interview despite the fact that people reported they could not recall further details. No new information was recalled between the second and the third interview, but previously recalled information was lost or omitted. They furthermore showed that the reason for hypermnesia was not due to an increased error rate or confabulation. The authors concluded that autobiographical memories are reconstructed from event-specific knowledge and influenced by the social and situational context in which they are recalled, meaning that reformulations are never identical.

2.2.3 Memory and Disclosure

Delayed disclosure can also be linked to repressed, recovered, or delayed memories (Flathman, 1999; Pope & Brown, 1996). Freud (1915) used the term *repression* to refer to an unconscious mechanism whereby threatening or anxiety-provoking material is kept hidden from conscious awareness. There is a large body of evidence indicating repression and forgetting of memories, particularly of childhood trauma, such as sexual abuse (Alaggia, 2004; Fish & Scott, 1999; Herman & Schatzow, 1987). Wiliams (1994a) investigated memory for documented childhood sexual abuse after a 17-year delay and found that non-disclosure of the former abuse was linked to forgetting. However, there is also evidence that people's memories of traumatic events can be inaccurate. Memory for sexual abuse and other traumatic experiences can be distorted and even fabricated completely through biasing therapeutic suggestions and memory retrieval techniques. New information following the event can become incorporated into the person's memory, thus supplementing and altering recollection (for a review, see Loftus, 1993). For example, Pynoos and Nader (1989) studied children's recollections of a sniper attack in a school playground. Some of the children who were interviewed were not at the school during the shooting, but recalled vivid details about the attack. In light of the repressed-memory controversy, Loftus (1993) concluded that we do not have the means for reliably distinguishing true repressed memories from false ones. However, Brewin, Andrews and Gotlib (1993) argued that people's accounts are more likely to be accurate when structured interviews are used with the focus to elicit specific personal memories as opposed to general or global judgments about childhood experiences.

The above findings indicate that there are a variety of factors that can impact on an asylum seeker's ability to recall information. They also point to other potential factors affecting recall such as aspects of the interviewing process. Clearly, this has implications on legal decision making that aims to assess asylum seekers' credibility based on information they provide during Home Office interviews.

2.3 Disclosure during Asylum Interviews

Concealment of parts of the story do not necessarily detract from the credibility of the applicant. A genuine refugee may not be willing to tell his or her full story for fear of endangering relatives or friends, or for fear of sharing this information with persons in position of authority (UNHCR, 1995: 34).

Late disclosure, or incidents described in later interviews of which no mention was made in the first, is commonly cited as a reason against an asylum seeker's credibility. For example, a Home Office refusal letter stated:

...in the event a well-prepared statement seven months after the asylum interview has little weight on his claim. Had Mr Z a genuine fear of persecution he would have said so in his (first) interview (Cohen, 2001: 2).

Similar examples can be found in a report on home-office decision making (Asylum Aid, 1999). There have also been accounts where asylum seekers were unable to disclose past traumatic experiences during their Home Office interviews, despite

them risking refusal. Caseworkers working for Asylum Aid have observed that female asylum seekers who experienced sexual violence were unable to disclose this during Home Office interviews. The reasons why refugees find it extremely difficult to disclose sensitive information are largely undocumented.

There are a variety of potential factors affecting an asylum seeker's ability to disclose. Current UK and European controls, including visa restrictions, make it almost impossible for asylum seekers to enter the UK legally. However, the fact that they have entered the country illegally should not undermine the credibility of their claim:

> *It should be remembered that genuine asylum seekers sometimes have no alternative but to travel on forged travel documents which may subsequently have to be returned to an agent* (Immigration and Nationality Directorate, 2003).

According to Turner (1989) people subjected to extreme conditions in their country of origin often do not know how much to reveal to British authorities on their arrival and thus conceal important details that would have helped them with their asylum application. Initial interviews are held just hours after arrival, before people get a chance to seek advice or legal representation. Often people have had long journeys and suffer anxiety and distress on arrival. They may be traumatised and are terrified of being refused and sent back. Unsurprisingly, asylum seekers are often unable to give a full account of what happened to them, leave out information or get facts wrong.

Victims of torture and rape find it harder to discuss their experiences. It was found that disclosure is specifically an issue with torture survivors due to their difficulties of trust in authorities. They also avoid retelling their story due to feelings of pain and it often takes time for them to give a more detailed account of what happened to them (Medical Foundation for the Care of Victims of Torture, 2002). According to Laws and Patsalides (1997) the interview situation can bring about earlier feelings of powerlessness and similarities to torture situations, which serve to increase survivors' anxiety and affect their ability to disclose. They also caution that, despite adequate precautions, psychological and medical interviews and examinations may re-traumatise asylum seekers. Furthermore, the context in which asylum seekers disclose personal experiences also needs to be considered. Interview rooms can be small and bare reminding them of places where they were previously tortured (Herlihy, 2003).

Asylum seekers often come from cultures with different attitudes towards sexuality and the role of men and women in society. Sexual violence and rape are often taboo subjects, and survivors may feel very uncomfortable discussing their experiences (Burnett & Peel, 2001). Women who have been subjected to sexual assault or rape are stigmatised and may not disclose this in their asylum interviews, especially if the interviewer is male (Burnett & Peel, 2001). Men also tend to underreport experiences of sexual violence (Peel, Mahtani, Hinshelwood & Forrest, 2000). Sexual violence results in feelings of shame and women often feel personally to blame for what happened. They may be shunned by their community and family if they admit that they were raped (Asylum Aid, 2001; Burnett, 1999; United Nations, 1997). The Immigration Appellate Authority (IAA) states:

Delay in claiming asylum or revealing full details of an asylum claim will not necessarily be due to lack of credibility of a particular asylum claim or claimant. Torture, sexual violence and other persecutory treatment produce feelings of profound shame. This 'shame response' is a major obstacle to disclosure. Many victims will never speak about sexual violence or will remain silent about it for many years (IAA, 2000: 51).

Finally, concepts such as confidentiality and privacy are alien in many cultures and feelings of fear and suspicion can arise when an interpreter from the same ethnic background is in the room. Interpreters can sometimes be torture victims themselves and close working with trauma victims can re-traumatise them. This may lead them to close off certain questions and/or answers and the provision of non-verbal cues to the interviewee discouraging elaboration of detail (Medical Foundation for the Care of Victims of Torture, 2002).

2.4 Summary

The review of the literature on patient disclosure in psychological therapy has shown that patients hide personal information from their therapist, which is reflective of the therapeutic process as well as of more long-term patient concerns, such as fear of being negatively evaluated. Non-disclosure is specifically linked to themes of a sexual nature, violence and abuse, and traumatic experiences. Feelings of shame and embarrassment were a common reason for inhibiting disclosure.

It was further shown that inconsistencies in recall and late or non-disclosure during asylum interviews are some of the reasons for failed asylum applications. Shame, particularly in the case of rape victims, profound humiliation that torture survivors are forced to endure, fear of officials and an unwillingness to confront the past can all account for an asylum seeker omitting relevant details from their initial Home Office interview. There are several empirical studies on consistencies in autobiographical memories as well as facts from general memory studies to account for discrepancies in successive asylum interviews. It was also shown that disclosure processes can be connected to the recovery or remembering of memories. In contrast, there are no known empirical studies on what affects disclosure in refugees and asylum seekers. However, the empirical literature on memory recall has highlighted that there are normal cognitive processes at play that interfere with a person's ability to recall information over time. One can only assume that similar or other cognitive processes might be involved in asylum seekers' ability to disclose information.

The impact of emotional processes will be looked at in the next section. Many refugees and asylum seekers have been subjected to traumatic experiences in their country of origin, and traumatic experiences also seem to play a role in memory and disclosure. Part 3 therefore will explore in greater depth the psychological impact of traumatic experiences in refugees and asylum seekers. Since shame seems to play a role in asylum seekers' ability to disclose personal distressing information the role of shame in psychopathology and disclosure will be further explored in part 4.

3. TRAUMA

3.1 Torture and Organised Violence

Torture is still used by many governments despite its ban under the Human Rights Act (United Nations, 1948). The UN defines torture as,

> *any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.* (United Nations, 1984).

Torture can be used for purposes of repression of political or religious opposition, punishment, intimidation and a means of interrogation. Many refugees who come to the UK have experienced or witnessed torture and organised violence, which is defined as violence with a political motive (Burnett & Peel, 2001; Gorst-Unsworth, 1992; Turner, 1989). It is estimated that around 5 to 30 per cent of asylum seekers have been tortured (Eisenman, Keller & Kim, 2000). In 1999, approximately 8.4 per cent of all asylum applications to the UK were on grounds of torture (Amnesty International, 2000), however, due to difficulties with disclosure this figure is likely to be even higher. Torture includes both physical and psychological components.

Physical torture includes beating, suspension, immersion, electric shock, burning, sexual assault, and medical torture. Psychological torture includes deprivation (sensory, sleep, food, water, sanitary), witnessing torture, verbal threats, solitary confinement, noise, and mock executions.

In many countries where human rights are violated, sexual torture and rape are widespread and the intense shame surrounding these experiences ensures that perpetrators can continue their crimes in silence. Mass rape and sexual torture has been used as a weapon of war specifically, but not exclusively, towards women. This was extensively reported during civil wars and conflicts in Guatemala, the former Yugoslavia and Rwanda, and even more recently in Kosovo and the Democratic Republic of Congo (Asylum Aid, 2001). During times of war when families face displacement and separation, women often face additional stresses as they often take sole responsibility for their children. It is not unheard of that husbands leave their families behind to secure their own safety. Many women are subsequently raped and killed by soldiers. Desjarlais, Kleinman, Eisenberg and Good (1995) reported on conditions in refugee camps where women are often subjected to further sexual abuse and exposed to trafficking in return for documentation and a flight to freedom.

3.2 Physical and Psychological Sequelae of Trauma

Burnett and Peel (2001) published a review about the health of survivors of torture and organised violence and they reported many physical and psychological consequences that torture survivors have to endure. Physical effects linked to specific torture techniques include fractures and soft tissue injuries, pain, head injuries, epilepsy, eye and ear problems, diseases linked to sexual violation, such as

STDs, and sexual dysfunction. It was also reported that survivors frequently complain of physical symptoms that are in fact physical expressions of emotional distress, such as sleep problems, nightmares, headaches, general weakness, tiredness, and neck and back pain that do not have a physical basis. Burnett (1999) found that refugees may show symptoms of anxiety, depression, guilt, and shame as a result of their past history but also because of their current situation in Britain.

3.3 Post Traumatic Stress Disorder

Most empirical studies on psychological sequelae of trauma in refugees have looked at diagnoses of Post Traumatic Stress Disorder (PTSD) and Major Depressive Disorder (MDD) and most rely on self-report measures. The essential feature of PTSD is the development of characteristic symptoms following exposure to an extreme traumatic stressor, leading to feelings of intense fear and helplessness. The characteristic symptoms resulting from the exposure to the extreme trauma include persistent re-experiencing of the traumatic event, persistent avoidance of stimuli associated with the trauma, and persistent symptoms of increased arousal. To make a diagnosis of PTSD the full symptom picture must be present for more than one month, and the disturbance must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. Diagnostic criteria for MDD include depressed mood, reduced levels of interest, loss or gain of weight, difficulty falling or staying asleep, agitated or slowed down behaviour, feeling fatigued, thoughts of worthlessness or guilt, reduced ability to think or concentrate, and suicidal ideation.

One can assume that the presence of these symptoms impact on asylum seekers' reporting and disclosure during Home Office interviews. Re-experiencing symptoms (e.g., flashbacks) may occur during the interview as a result of being reminded of the traumatic event and thus reduce people's ability to give a coherent account. Support for this comes from Brewin, Dalgleish and Joseph's (1996) dual processing theory of PTSD, which proposed that trauma memories are stored in two separate parallel systems. Verbally Accessible Memories (VAMs) represent autobiographical memories of the trauma, which can be deliberately retrieved and edited. Situationally Accessible Memories (SAMs) are encoded at the time of trauma and may be stored in a fragmented, context-less manner. SAMs cannot be deliberately accessed and are not available for progressive editing, however, they can be triggered by cues, leading to re-experiencing symptoms. Moreover, avoidance symptoms can lead to non-disclosure. Symptoms of hyperarousal, such as irritation or anger, reduced concentration and increased hypervigilance (e.g., fear) can also lead to suppression of disclosure. It is also known from the literature that cognitive processes, such as memory and attention, are affected by depression (for a more detailed review see Williams, Watts, Macleod & Mathews, 1997), which needs to be taken into consideration when assessing asylum seekers' accounts of past events.

3.3.1 Empirical Studies

There is an array of empirical studies documenting prevalence rates of PTSD and depression in refugees. Depending on the sample, the rates of PTSD vary widely within any given refugee population, with prevalence rates ranging from 4 to 86 per cent for PTSD and 5 to 31 per cent for depression (Hollifield et al., 2002). Mollica, Wyshak and Lavelle (1987) have demonstrated that Major Affective Disorder and

PTSD were the most common diagnoses in a group of 52 South East Asian refugees. A sample of Bosnian refugees living in Croatia showed self-report measures of Depression (39%) and PTSD (26%) (Mollica, Sarajlic, et al., 1999). In a sample of Cambodian refugees living in Thailand Mollica, McInnes, Poole, et al. (1998) found a 68 per cent rate of Depression and a 37 per cent rate of PTSD. Van Velsen, Gorst-Unsworth and Turner (1996) found a 35 per cent rate of Major Depressive Disorder and a 52 per cent rate of PTSD in an interview study of a mixed sample of London refugees. Their sample however was specifically referred for medical assessments, which means that prevalence rates might be higher than normally expected. Turner, Bowie, Dunn, Shapo and Yule (2003) carried out a study to assess the prevalence of mental health problems in Kosovan Albanian refugees in the UK. They found a diagnosis of PTSD in half their sample and many also had comorbid depressive disorder. Despite their conclusion that resilience factors were at play in many of these survivors, they also highlighted the need for psychosocial interventions in this group. Ramsey, Gorst-Unsworth and Turner (1993) confirmed the presence of PTSD, major depression and somatoform symptoms in tortured individuals. Moreover, their study indicated that different trauma types were associated with different PTSD patterns. Specifically, most forms of torture were associated with intrusive phenomena but sexual torture, in contrast, led to a marked avoidance reaction. Van Velsen et al. (1996) further investigated this and they found a significant relationship between sexual torture and avoidance symptoms of PTSD. They speculated that the intimate nature of the sexual attack and the associated feelings of humiliation are likely to be critical elements leading to subsequent avoidance behaviour. The authors further suggested to include a measure of dissociative phenomena in future research as dissociation might be closely related to avoidance symptoms and play a role in

long-term psychopathological response to trauma (Bremner, Southwick, Brett, Fontana, Rosenheck & Charney, 1992).

3.3.2 Limitations

The above paragraph shows high prevalence rates of PTSD in refugee populations, and specifically survivors of torture. However, not everybody subjected to an extreme traumatic event will develop PTSD. Torture is a broad concept and can occur in a variety of situations and time and can take on different events and experiences. Turner and Gorst-Unsworth (1990) described a multidimensional model of torture and its sequelae. They divided responses of torture survivors into four common themes: incomplete cognitive and emotional processing (including the main diagnostic elements of PTSD), depressive reactions to consequential losses, somatic symptoms (not always related to physical injury), and the existential dilemma (a collection of profound changes in attitude which may last for years and impact on close interpersonal relationships, i.e. survivor guilt).

Several authors have questioned the universal validity and applicability of the PTSD model, particularly in non-Western populations (Bracken, Giller & Summerfield, 1995; Burnett & Peel, 2001; Summerfield, 1995). Symptoms of PTSD have been used widely in the research literature to measure traumatisation. PTSD is assumed to be a universal reaction to trauma; however, the fact that symptoms and signs of PTSD are identified across cultures does not imply that they mean the same thing across cultures. Kleinman (1987) calls this a 'category fallacy'. Indeed, there are several studies that show that many people who would fit the diagnostic criteria of PTSD still manage to function independently and are well adjusted (see

Summerfield, 1995). Moreover, current conceptualisations of trauma typically focus on intra-psychic processes, which means that the importance of social and cultural factors is often underrated. Burnett and Peel (2001) caution against diagnosing PTSD in refugee populations, which they feel essentially medicalises very common reactions to trauma as well as adding to feelings of stigma and powerlessness. They argue that the context in which these symptoms occur and the meaning they present to the individual needs to be understood, as distress itself is not a pathological condition. Summerfield (1995) concludes:

Psychiatric models like PTSD, even if the DSM-IV version brings improvements, have inherent limitations in capturing the complex ways in which individuals, communities, and indeed, whole societies register massive trauma, socialise their grief, and reconstitute meaningful existence. Traumatic experience, and the search for meaning which it triggers, must be understood in terms of the relationship between the individual and his or her society, with outcomes influenced by cultural, social, and political forces (which themselves evolve over time).

3.4 Post-Migratory Factors

The above studies have shown that there is a link between PTSD and the degree of pre-migratory traumatic experiences. However, there is evidence in the literature of a cumulative effect of pre-migration trauma exposure and post-migratory problems, such as racism, violence, hostility and isolation in refugees' overall psychiatric morbidity. Summerfield (1995) points to the role of social factors in transforming personal traumatic experiences and argues that the experience of 'refugeedom' itself has been neglected in studies on traumatised refugees and asylum seekers. Gorst-

Unsworth (1992) argues that the stressors refugees and asylum seekers experience post-migration are grossly underestimated as stress factors and are potentially more powerful factors in people's difficulties in recovery than the original traumatic event. Several authors have pointed out that the concept of PTSD gives no indication of social adjustment or level of psychological functioning, such as the ability to maintain close relationships, neither does it imply a need for psychological treatment (Gorst-Unsworth, 1992; Summerfield, 1995).

There have been several empirical studies pointing to the importance of social factors in psychopathology. Turner et al. (2003) compared their data on mental health problems of Kosovan Albanian refugees living in the UK with the results of a survey of Kosovan Albanians living in Kosovo (Lopes Cardozo, Vergara, Agani, et al., 2000). It was shown that Kosovan Albanians living in the UK experienced greater levels of alienation, isolation and despair. Van Velsen et al. (1996) found an association between levels of depression and social context. Gorst-Unsworth and Goldenberg (1998) carried out a study on Iraqi refugee men in London and found an association between social factors in the UK and levels of PTSD and depression, with poor social support being a stronger predictor for depression than trauma.

Studies looking at pre- and post-migration factors also point to the cumulative effects of these on psychopathology. Steel, Silove, Bird, et al. (1999), in an Australian sample of Tamil refugees, found that pre-migration factors accounted for 20 per cent and post-migration factors for 14 per cent of the variance in PTSD symptoms. They pointed to a complex interplay of pre-migration (e.g., violence) and post-migration factors (e.g., social difficulties) on symptoms of depression and

PTSD. Silove, Sinnerbrink, Field, Manicavasagar and Steel (1997) carried out a study into psychiatric symptoms in a sample of asylum seekers in Sydney as well as into the relationship between pre- and post-migration stressors on psychiatric symptoms. They found that 37 per cent of the sample met diagnostic criteria for PTSD, and over 50 per cent met clinical significance for anxiety and/or depression. There was an association between anxiety scores and female gender, immigration issues and poverty, and depression was associated with loneliness, boredom and anxiety. PTSD diagnosis was directly linked to exposure to past trauma, but also to post-migratory factors, particularly the asylum process. The authors concluded that post-migratory living stressors may interact and potentially exacerbate psychiatric symptoms in asylum seekers.

3.5 Trauma and Dissociation

The DSM-IV (American Psychiatric Association, 1994) defines dissociation as a *disruption of the usually integrated functions of consciousness, memory, identity or perception of the environment.* The experience of dissociation consists of: amnesia (memory loss), depersonalisation (feeling detached from oneself), derealisation (feeling detached from one's surroundings, a sense of loss of external reality), identity confusion (uncertainty about who one is) and identity alteration (display of a surprising skill) (Standardised Clinical Interview for DSM-IV Dissociative Disorders, SCID-D; Steinberg, 1994).

3.5.1 Post-Traumatic Dissociation

There is a vast empirical literature demonstrating a relationship between traumatic life experiences and general dissociative responses. According to Janet (1889, 1920)

dissociation due to a traumatic event increases the likelihood for dissociative responses to subsequent stressors. A review by Spiegel and Cardena (1991) found that there is a strong relationship between repeated childhood sexual or physical abuse and adult dissociative phenomena. Chu and Dill (1990) reported higher levels of dissociative symptoms amongst psychiatric patients with a history of early abuse. Dissociative experiences are commonly reported by individuals with a diagnosis of PTSD (Ehlers & Clark, 2000; Foa & Hearst-Ikeda, 1996a). Bremner et al. (1992) carried out a study comparing current dissociative symptoms and dissociation at the time of specific traumatic events in a sample of 85 Vietnam combat veterans with and without a diagnosis of PTSD. They found a higher level of dissociative symptoms and more dissociative symptoms at the time of the combat trauma in veterans with a diagnosis of PTSD, highlighting the role of dissociative symptoms in the long-term psychopathological response to trauma.

There have been very few studies on dissociation in traumatised refugees. Carlson and Rosser-Hogan (1991) conducted a study to determine the levels of trauma and psychiatric symptoms and the relationship between trauma severity and subsequent psychiatric symptoms in a group of 50 Cambodian refugees who had resettled in the United States. Results showed that 86 per cent met criteria for PTSD, 96 per cent had high dissociation scores and 80 per cent suffered from clinical depression. They also showed that correlations between trauma scores and symptom scores and among symptom scores were moderate to large. Specifically, they found high levels of association between traumatic experiences and the severity of both traumatic stress and dissociative reactions.

3.5.2 Peri-Traumatic Dissociation

Dissociative responses not only occur as an aftermath of a traumatic event, but can also be experienced at the time the traumatic event is unfolding. The literature refers to these acute dissociative responses to trauma as *peritraumatic dissociations* (Marmar, Weiss, Metzler, Ronfeldt, & Foreman 1996b; Weiss, Marmar, Metzler & Ronfeldt, 1995). Trauma victims typically report changes in their experiences of time, place, and person during a traumatic event. Time can be experienced as slowing down or accelerating rapidly. Other symptoms include feelings of unreality, experiences of depersonalisation, out-of-body experiences, confusion, disorientation, altered pain perception, and altered body images, such as feeling disconnected from one's body. Several empirical studies have looked at peritraumatic dissociations. Noyes and Kletti (1977) found several features of peritraumatic dissociation in a group of survivors of car accidents and physical assault. The majority reported feelings of unreality and an altered sense of time during the event. Other features included automatic movement, sense of detachment, depersonalisation, detachment from their body and derealisation. In a study on prison officers held hostage during a prison riot, Hillman (1981) found that hostages employed dissociative alterations to cope with the traumatic experience. Another study on kidnapping and terrorist hostages, found alterations of body imagery and sensations, depersonalisation, disorientation and out-of-body experiences in victims during the hostage experience. Wilkinson (1983) investigated the psychological response in survivors of the Hyatt Regency Hotel skywalk collapse and found symptoms of depersonalisation and derealisation during the time of the collapse.

There also have been several studies showing a link between peritraumatic dissociations and the subsequent development of PTSD. In a long-term prospective study of survivors of an oilrig disaster, Holen (1993) found the level of reported peritraumatic dissociation to be a predictor for the development of PTSD. Koopman, Classen and Spiegel (1994) showed that the level of peritraumatic dissociative symptoms predicted posttraumatic stress symptoms in a group of survivors of the Oakland Hill firestorm. Ozer, Best, Lipsey and Weiss (2003) carried out a meta-analysis of predictors of PTSD and symptoms and found peritraumatic dissociative experiences to be the strongest predictor. They suggested two classes of predictors based on their effect sizes and temporal proximity to the traumatic event: Weaker predictive factors comprising prior characteristics (prior trauma, prior adjustment, and family history of psychopathology), and stronger predictors involving peritraumatic psychological processes (perceived life threat, perceived support, peritraumatic emotionality, and peritraumatic dissociation).

The above findings show that symptoms of dissociation can develop as a result of traumatic experiences. They can also be experienced peritraumatically, acting as a defence mechanism to overwhelming traumatic events. Although the empirical literature on dissociation in refugees is scarce, one might suspect that findings from the empirical literature on dissociation in trauma survivors may generalise to a refugee population as many have experienced or witnessed torture and organized violence. It is further assumed that dissociative responses, such as depersonalisation, derealisation and amnesia, could be activated during the Home Office interviews, which has an impact on asylum seekers' recall memory and their ability to focus on and engage in the Home Office interviews, thus affecting disclosure. This has not

been tested empirically, but there is some indication for this in the literature showing increased dissociative states in PTSD patients during traumatic recall, reading scripts of their traumatic events (Bremner et al.; in Bremner, Vermetten, Southwick, Krystal, & Charney, 1995).

3.6 Summary

Section 3 has explored in greater detail the psychological sequelae of trauma in refugee populations. Many refugees have been subjected to torture and organised violence and as a result of this they often experience a variety of physical and psychological symptoms.

In terms of psychological symptoms, most empirical studies on traumatized refugees have focused on diagnoses of PTSD and depression and there is a small array of empirical studies documenting prevalence rates of PTSD and depression in refugees. There is also an indication in the literature that different trauma types are associated with different PTSD patterns, specifically that there is a link between sexual torture and avoidance symptoms of PTSD.

The review of the literature has also highlighted the role of post-migratory factors in trauma. PTSD is not only an indicator of pre-migration trauma, but post-migratory problems were found to interact with and exacerbate trauma symptoms.

Research on dissociative phenomena has shown that dissociative responses are common in PTSD. Peritraumatic dissociative responses during the time of the

traumatic event may serve as protective factors against states of helplessness and terror, but can also serve as risk factors for the subsequent development of PTSD.

Finally, the impact of psychological symptoms of PTSD, depression and dissociation on disclosure and recall during asylum interviews has been discussed briefly, and this was based on what is known from the literature on how these symptoms affect cognitive and emotional processes.

The next section will explore the role of shame in greater detail. Shame not only plays a role in disclosure, but there is an increasing literature on the role of shame in psychopathology and trauma.

4. SHAME

4.1 Definitions and Conceptual Issues

The word *shame* is believed to originate from an Indo-European word, meaning *hide.* Shame has been termed the 'silent' (Hinshelwood, 1999) or 'hidden' emotion (Gilbert, 1998) as a characteristic of shame is the desire to hide or conceal the self or aspects of it or escape from judgement (Barrett, 1995; Lindsay-Hartz, 1984). There are many definitions of shame. Shame is generally seen as an intense, sometimes debilitating, negative emotion that involves feelings of inferiority, powerlessness and self-consciousness, and a desire to hide deficiencies (Tangney, Miller, Flicker & Barlow, 1996). Paul Gilbert, a leading expert in the field, defines shame as "an inner experience of self as an unattractive social agent, under pressure to limit possible danger to self via escape or appeasement" (Gilbert, 1998). Shame is linked to both

negative self-evaluation and a fear of being judged negatively by others. These two facets have been termed by Gilbert (1998) *internal and external shame*. Internal shame relates to negative self-evaluations, experiences of the self as unattractive and devalued and threatening to one's self-identity. External shame, on the other hand, relates to others' evaluation of the self, particularly a fear of being judged negatively or seen as unattractive and devalued in the eyes of others. These two concepts do not necessarily overlap, although they may at times. It is possible that an individual experiences no shame about personal traits, which are seen as stigmatising in the eyes of others (e.g., obesity). At the same time, it is possible to experience internal shame and feelings of personal inadequacy and undesirability that an audience would not necessarily see. What a person considers shameful will vary according to what the person has learnt from their culture, subculture, and family, and this will be represented in schemas of the self, others, and the world.

There has been some confusion about the difference between shame and other emotions or concepts, such as guilt, humiliation, embarrassment, and social anxiety. Humiliation arises when a person in a powerless position has been ridiculed or abused in some way, but is not to blame for the actions of others (e.g., torture is usually seen as a humiliating event). The humiliated person usually believes that they have been harmed unfairly and they blame others for the damage to themselves, and can entertain feelings of injustice and revenge. Guilt is activated when a person feels personally responsible for having caused harm to others and a desire to make amends. Embarrassment is similar to shame in that it leads to self-consciousness and awareness that social rules have been broken and a fear of others' negative evaluation. In contrast to shame though, embarrassment is a less intense emotion,

and is linked to specific behaviours, which may lead to positive responses such as humour and smiling (Miller, 1996). In terms of contrasting shame and social anxiety, it has been argued that shame is located in actual memories of past events (e.g., rape), whereas a person with social anxiety focuses on what he or she might become, but this can be prevented through the use of safety behaviours. Also, social anxiety often declines when the person leaves the situation, whereas in shame ruminations about one's inadequacies and others' evaluations are a common feature (Beck, Emery & Greenberg, 1985).

4.2 Shame and Psychopathology

Over the last decade, there has been an increasing interest in shame and its social, cultural and clinical aspects (Gilbert & Andrews, 1998), and there is now an increased understanding of the importance that shame plays in psychopathology. Shame has been linked to a variety of psychological problems such as alcoholism (Bradshaw, 1988), depression (Andrews, 1995), hostility (Retzinger, 1995), social anxiety (Gilbert & Trower, 1990), suicide (Mokros, 1995), eating disorders (Frank, 1991), personality disorders (Linehan, 1993), interpersonal relationships (Gilbert, Allan & Goss, 1996), and family problems (Fossum & Mason, 1986). It has also been found that shaming interactions between parents and children impact on brain maturation, especially the development of the orbital frontal cortex, which may hinder the development of prosocial behaviours (Schore, 1994).

4.2.1 Shame and Trauma

The concepts of internal and external shame have become important in thinking about how people perceive personal traumatic experiences. Internal or external

shame can be activated through attributional processes following a traumatic event. For example, a woman who was raped may see herself as devalued in the eyes of others, which represents external shame. Alternatively, if the same woman perceived her experience as confirmation that she is weak or inadequate, this in turn may be associated with internal shame. These attributional processes typically occur in the aftermath of an event when the individual seeks to understand the meaning and cause of the event through cognitive appraising processes (Brewin et al., 1996). The emotions they subsequently give rise to have been termed secondary emotions in the literature. Secondary shame may be associated with the symptoms of PTSD, which may be perceived as a sign of weakness or an inability to cope (Ehlers & Steil, 1995). Secondary shame may also be associated with underlying core beliefs/ schemas, which may become activated after a traumatic event. These, in turn, can interfere in treatment with the person's ability to process the trauma memory. It is also possible to regard shame as a primary emotion arising at the time of the traumatic event (peri-traumatic shame) and several authors have provided theoretical accounts for this (see Gilbert, 1997; Gilbert & McGuire, 1998; Nathanson, 1992). However, most references to shame in the context of traumatic events have focussed on shame as a secondary emotion, which will be the focus of the next part.

4.2.2 Shame and PTSD

There has been a growing interest in the PTSD literature on the role of shame. Most theoretical accounts of PTSD have emphasised the importance of the experience of intense fear in the manifestation of PTSD (Foa and Kozak, 1986). However, other affects such as anger, shame, guilt and sadness are frequently associated with the traumatic event. The DSM-IV (American Psychiatric Association, 1994) mentions

shame as an associate feature in their diagnostic criteria for PTSD. There is a growing literature showing that shame might be linked to the course or onset of PTSD. Shame was found to act as a mediator between abusive experiences and clinical disorders such as depression and eating disorders (Andrews, 1995, 1997). Andrews, Brewin, Rose and Kirk (2000) found that both shame and anger play an important role in the phenomenology of crime-related PTSD and that shame makes a contribution to the subsequent course of symptoms. Wong and Cook (1992) conducted an empirical study on shame in veterans with and without a diagnosis of PTSD. The found that veterans with PTSD scored higher on measures of shame than veterans with substance abuse or a diagnosis of depression. However, limited conclusions can be drawn from this study as neither trauma exposure nor PTSD symptom severity was established. Leskela, Dieperink and Thuras (2002) investigated the relationship between shame and guilt and PTSD symptom severity. The used measures of both shame- and guilt-proneness in a community sample of 107 former prisoner of war veterans with and without a diagnosis of PTSD. Only shame-proneness was positively correlated with PTSD symptom severity. However, no cause-effect conclusions could be drawn and it is therefore unknown whether shame-proneness may act as a risk factor or develop as a result of PTSD.

4.3 Shame and Disclosure

It has been shown that shame motivates people to avoid others and to hide away, which suggests that during this experience the person is unlikely to disclose their feelings. There have been a variety of theoretical accounts to explain the relationship between shame and disclosure. It is often difficult for people to label their own experiences as shame. Lewis (1971) termed this *unacknowledged shame* after

analysing psychotherapy transcripts and discovered that shame often was not identified by either therapist or patients. She therefore concluded that there is a close link between shame and the action of denial and suggested that people may lack the schemas to verbally articulate shame. Lewis also suggested that talking about shame may be taboo and that people might be ashamed of his or her own shame reactions. Goffman (1959) provided a more sociological perspective on the disclosure of shame by his dramaturgical account of human interaction. He argues that the anticipation rather than the consequences of shaming interactions motivates hiding and concealment. Tomkins (1963) proposed that shame is activated by negative social feedback and anticipatory shame and that individuals can learn to avoid such negative affect.

It has been shown that shame leads to behavioural patterns of submission, a desire to escape, hiding from the interpersonal realm and concealment (Gilbert, 2000a). It therefore seems likely that if an individual has a predisposition to feel shame about aspects of his or her character, behaviour or experiences, disclosure might be difficult (Andrews & Hunter, 1997). However, there has been a lack of empirical research into this issue. Recent research has shown that shame may play a role in the nondisclosure of negative emotional experiences generally. Finkenauer, Rime and Lerot (1996) found that non-disclosure is associated with a desire to avoid shame and negative evaluations by others. A limitation however of this study was that it was limited to a non-clinical sample and it also did not solely examine the role shame plays in the disclosure of emotional experiences. Feelings of shame were often a factor preventing patients from disclosing secrets to their therapist (Hill et al., 1993; Kelly, 1998).

There have been several studies on clinical populations on the relationship between shame and disclosure. Swan and Andrews (2003) found a relationship between characterological shame and disclosure in eating disordered women indicating that a tendency to feel ashamed of the self may affect the ability to disclose important personal information. Forty-two per cent of their sample admitted not disclosing certain aspects about themselves or their eating behaviours in therapy. Farber and Hall (2002) failed to find a significant association between patient shame-proneness and overall disclosure. What they did find in their study though was that shame inhibited disclosure of negative affect. They concluded that a state measure of shame, rather than a trait measure as employed in their study, might be needed to adequately test the relationship between disclosure and shame.

Macdonald & Morley (2001) conducted a study to examine the impact of shame on non-disclosure of negative emotional experiences in a sample of 34 psychotherapy outpatients. In accordance with other studies on disclosure they found that 68 per cent of emotional incidents, recorded in diaries, were not disclosed. Qualitative analysis showed that shame was associated with a negative self-assessment and non-disclosure was linked to the anticipation of negative evaluation by others. In addition, it was also hypothesised that disclosure was affected simply because personal experiences were painful and not due to any implications of disclosure. Finally, the study also found that participants expressed a general willingness to disclose under the right circumstances. However, a limitation of their study was the relatively small sample size.

A study on the relationship of non-disclosure in therapy to shame and depression (Hook & Andrews, in press) found that 54 per cent of respondents concealed depression-related symptoms and behaviours or other distressing experiences from their therapist. Shame was the most frequently reported reason for non-disclosure overall. Shame-proneness was significantly related to non-disclosure of symptoms but not to non-disclosure of experiences. These findings suggest that discussing shame symptoms openly in therapy has potentially a positive impact on the treatment of a variety of psychological disorders where shame is linked to symptom course.

4.4 Shame and Psychological Therapy

The role of shame becomes an important consideration in psychological treatment. The process of seeking help and revealing personal problems can be experienced as deeply shaming (Kelly & McKillop, 1996). It is also highly likely that during the course of therapy feelings of shame and humiliation will be reactivated when revealing traumatic events. This explains why people often drop-out early of treatment or do not seek help despite suffering from distressing symptoms. During a clinical interview a person may experience intense feelings of shame, which leads to an inward focus and a feeling of being exposed. The client then may try to hide and avoid those painful memories and also communicates the shame to the therapist via non-verbal means, such as avoidance of eye-contact, lowered gaze, and being unable to think and speak (Kaufman, 1989).

Lee, Scragg and Turner (2001) highlighted the need to address emotional responses such as shame and guilt when assessing and treating PTSD as the activation of

shame and guilt can lead to intrusions and avoidance and interfere with certain treatment techniques for PTSD such as imaginal exposure. Emotions such as shame, guilt or anger can be activated during exposure treatment and thus worsen traumatic reactions and impede the emotional processing of fear (Ehlers & Steil, 1995; Foa, Steketee & Rothbaum, 1989; Joseph, Williams & Yule, 1997; Riggs, Dancu, Gershuny, Greenberg & Foa, 1992). These findings are of relevance when thinking about disclosure during Home Office interviews and suggest that talking about the traumatic event could potentially activate shame reactions and PTSD symptoms during asylum interviews, which would impact negatively on asylum seekers' ability to recall and disclose.

Farber concluded that the decision to self-disclose is a balance between *confessional relief and confessional shame* (Faber, 2003: 599), and that this decision is further influenced by client therapist interaction. This shows that people can be faced with a dilemma when it comes to self-disclosure and suggests that they make decisions regarding disclosure, which it seems are influenced, at least partially, by interpersonal relationships. This is important for asylum interviews and implies that a decision to self-disclose may depend on an interplay of personal and contextual factors, such as the relationship to the interviewer. A quote by Faber further reinforces the crucial role of the interviewer and the interviewing process on disclosure during Home Office interviews:

Some clients need silence, others affirmation, and still others encouragement or questioning to disclose shameful material. But, of course, this is too simplistic an equation: At different times, for different issues, different clients need different

things from their therapist, including sometimes "permission" to stop discussion, at least for the moment. Thus, while many patients wish that their therapists would gently encourage more extensive disclosure (Farber et al., 2001), the reluctance of other patients to continue to explore sensitive issues may represent a degree of wisdom that therapists need respect. (Faber, 2003: 599).

4.5 Summary

Shame is seen as a potentially debilitating negative emotion and a characteristic of it is the desire to hide or conceal the self or escape from judgement. Shame has been divided into internal and external shame, internal shame relating to negative self-evaluations, whereas external shame relates to others evaluation of the self. Shame can be regarded as a primary emotion arising at the time of an event (primary shame), or it can be associated with the meaning of an event, that is, in the aftermath of the event (secondary shame). The difference between shame and other concepts, such as guilt, humiliation, embarrassment, and social anxiety, was also outlined.

It has been shown that secondary shame plays an important role in psychopathology and impacts on how people perceive personal traumatic experiences. There is increasing evidence in the literature that shame might be linked to the course or onset of PTSD.

There have also been a variety of theoretical accounts to explain the relationship between shame and disclosure, however, there has been a lack of empirical research in this area with a small number of studies showing that feelings of shame may affect the ability to disclose important personal information. This has relevance for

psychological therapy, clinical interviews and Home Office interviews as the process of seeking help and revealing personal problems can be experienced as deeply shaming.

5. CONCLUSION

This review has investigated the potential factors involved in refugees' and asylum seekers' self-disclosure during Home Office interviews as discrepancies in successive recall as well as late or non-disclosure are commonly taken as evidence against the asylum seeker's credibility. Evidence from the empirical literature on memory research has shown that inconsistencies in autobiographical memories are a common phenomenon and this has been confirmed with a variety of clinical and non-clinical populations. The reasons why asylum seekers find it hard to disclose personal information during these interviews have been largely undocumented.

The literature on patient disclosure in psychological therapy provided further insight into the factors involved in self-disclosure. It was found that patients typically hide personal information from their therapist; themes of a sexual nature, traumatic personal experiences and feelings of shame have been frequently cited reasons for non-disclosure. This suggests that traumatic life events and feelings of shame are potential contributing factors that impact on asylum seekers' disclosure during Home Office interviews, but this has not been validated by empirical research. This also puts into question whether people make conscious decisions regarding disclosure and, if so, when this decision is made (e.g., before or during therapy/interviews). There is some suggestion in the literature that people make

conscious decisions regarding self-disclosure, typically to avoid feelings of shame and embarrassment, however this has not been replicated in a refugee population. Future research could examine what cognitive processes are involved in decision-making around self-disclosure.

The impact of the role of trauma and shame on disclosure has been explored further. Many refugees have been subjected to torture and organised violence and as a result of this they often experience a variety of physical and psychological symptoms. Empirical studies have documented prevalence rates of Post-Traumatic Stress Disorder and Depression in refugees. There is also an indication in the literature that there are different types of PTSD patterns, specifically that there is a link between sexual torture and avoidance symptoms of PTSD. The literature on shame research has shown that shame is linked to avoidance reactions, to the course and the onset of PTSD, and to disclosure with a small number of studies showing that feelings of shame may affect the ability to disclose personal information. Since the trauma of sexual torture is associated with avoidance symptoms of PTSD and since there is evidence that shame is associated with avoidance reactions, there might be a link between sexual torture and shame reactions. However, this has not been specifically tested to date.

Furthermore, it has also been shown that dissociative responses, particularly at the time of the traumatic event, are common in trauma survivors as a way of coping with overwhelming traumatic experiences. However, the empirical literature on dissociative responses in refugee populations is scarce. There is also some evidence in the literature that dissociative reactions can be activated during traumatic recall in

people with a diagnosis of PTSD, which suggests that this could happen to asylum seekers during their Home Office interview. Future research therefore could investigate the impact of dissociative experiences on refugees' and asylum seekers' self-disclosure during Home Office interviews.

In summary, the literature on patient disclosure in psychological therapy has shown that disclosure can have positive (although this was not reviewed here) as well as negative consequences, such as increasing shame reactions. The positive consequences of disclosure during Home Office interviews seem apparent in that it can support people's asylum application. The question is whether asylum seekers are always aware of this. Sometimes the negative consequences of disclosure, such as the stigma linked to the reporting of rape, might be stronger. Activation of shame has been shown to worsen traumatic reactions in people with PTSD. This needs to be considered when interviewing people in a variety of settings as shame could impact negatively on disclosure, particularly when disclosure concerns personal traumatic events or sensitive information. It certainly has implications for the asylum process where asylum seekers are often traumatized and their claims are assessed based on information they disclose during Home Office interviews. It is unclear however whether the Home Office has an awareness of the positive and negative consequences of disclosure.

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PART 2: EMPIRICAL PAPER

What Prevents Refugees and Asylum Seekers Exposed to Violence from Disclosing Trauma?

ABSTRACT

A study was conducted to explore what prevents asylum seekers from disclosing personal information during Home Office interviews. Semi-structured interviews with refugees and asylum seekers showed that people with a history of sexual violence found it more difficult to disclose during interviews than people with a history of non-sexual violence, and feelings of shame were frequently cited in this group as a factor preventing disclosure. These findings were confirmed by quantitative analyses, which found that this group scored significantly higher on measures of posttraumatic stress symptoms, shame, dissociation and disclosure. The study also replicated previous findings showing that sexual violence is linked to avoidance symptoms. It furthermore found that there is an association between shame and avoidance reactions, indicating that those with higher levels of shame showed increased avoidance symptoms. The implications of these findings for the asylum process will be discussed.

INTRODUCTION

The UK is one of the many countries worldwide that has legally committed itself to the protection of refugees and asylum seekers. Once asylum seekers enter the UK

they are faced with a complex system for claiming asylum that typically involves completion of paperwork as well as possibly several Home Office interviews. To be granted asylum under the 1951 United Nations Convention Relating to the Status of Refugees (United Nations High Commissioner for Refugees, 1992), the asylum applicant has to show a well-founded fear of being persecuted in his or her country of origin for reasons of race, religion, nationality, membership of a particular social group, or political opinion. Since there is often little documentary evidence about the asylum seeker, credibility of the individual is key. According the Immigration and Nationality Directorate (IND), the purpose of the substantive asylum interview is to,

...obtain details about why the claimant has made an application for asylum and/or leave to remain on human rights grounds. It is an opportunity for the interviewing officer to find more out about the claimant's fear of return to their country of nationality, and an opportunity for the claimant to elaborate on the background of his claim and introduce additional information. The interview will provide the interviewing officer with a chance to test or probe the information provided, and where necessary, ask the claimant to explain any apparent discrepancies in evidence previously given in support of the claim (IND, 2003).

The Home Office has been criticised for the poor quality of decision making over asylum claims and the high number of successful appeals reflects this; 1 in 5 appeals heard by the Immigration Appellate Authority in 2003 overturned initial decisions (Amnesty International, 2004).

Late disclosure, or incidents described in later interviews of which no mention was made in the first, is commonly cited as a reason against an asylum seeker's credibility (see Asylum Aid, 1999). It is understandable that the addition of new evidence could be seen as evidence against the claimant's honesty. However, this assumption may fail to take into account other reasons for not disclosing at the outset. Disclosure is specifically an issue with torture survivors due to their difficulties of trust in authorities and their avoidance of painful memories (Medical Foundation for the Care of Victims of Torture, 2002). Laws and Patsalides (1997) caution that the interview situation can bring about earlier feelings of powerlessness and similarities to torture situations, which serve to increase survivors' anxiety and affect their ability to disclose. The context in which asylum seekers disclose personal experiences also needs to be considered; interview rooms can be small and bare reminding them of places were they were previously tortured (Herlihy, 2003). Furthermore, asylum seekers often come from cultures with different attitudes towards sexuality. Sexual violence and rape are often taboo subjects and can bring about feelings of shame. Women who have been subjected to sexual assault may be shunned by their community and family if they admit to this and therefore may not disclose it in their asylum interview (Asylum Aid, 2001; Burnett, 1999; United Nations, 1997), especially if the interviewer is male (Burnett & Peel, 2001). Men also tend to underreport experiences of sexual violence (Peel, Mahtani, Hinshelwood & Forrest, 2000).

These findings have been supported by the empirical literature on patient disclosure in psychological therapy, which showed that non-disclosure is specifically linked to themes of a sexual nature, violence and abuse (Norton, Feldman & Tafoya, 1974;

Weiner & Shuman, 1984), traumatic experiences (Larson and Chastain, 1990), and feelings of shame and embarrassment (Hill, Thompson, Cogar & Denman, 1993; Kelly, 1998). Rape and sexual abuse victims were found to experience shame as a result of having suffered a stigmatising event, which was linked to a desire to conceal this from others (Derlega, Metts, Petronio & Margulis, 1993; Pennebaker, 1985, 1989). According to Farber and Hall (2002) non-disclosure of sexual issues within therapy might be a reflection of culture-specific norms of what should be spoken about. There are however no empirical studies on what affects disclosure in refugees and asylum seekers during legal interviews.

As mentioned above, many refugees who come to the UK have experienced or witnessed torture and organised violence (Burnett & Peel, 2001; Gorst-Unsworth, 1992; Turner, 1989). There is a growing literature on the psychological sequelae of trauma in refugees, which have looked mainly at diagnoses of Post Traumatic Stress Disorder (PTSD) and Major Depressive Disorder (MDD), and most rely on self-report measures. Depending on the sample, the rates of PTSD vary widely within any given refugee population, with prevalence rates ranging from 4 to 86 per cent for PTSD and 5 to 31 per cent for depression (Hollifield et al., 2002). A case-note survey carried out by Ramsey, Gorst-Unsworth and Turner (1993) confirmed the presence of PTSD, major depression and somatoform symptoms in tortured individuals. Moreover, their study indicated that different trauma types were associated with different PTSD patterns; most forms of torture were associated with intrusive phenomena whereas sexual torture was related to the avoidance criteria of PTSD. Van Velsen, Gorst-Unsworth and Turner (1996) further investigated this and they found a significant relationship between sexual torture and avoidance symptoms of

PTSD. It was speculated that the intimate nature of the sexual attack and the associated feelings of humiliation are likely to be critical elements leading to subsequent avoidance behaviour, however this has not been specifically tested. The presence of these symptoms may impact on asylum seekers' reporting and disclosure during Home Office interviews. For example, re-experiencing and/or avoidance symptoms may occur during the interview as a result of being reminded of the traumatic event, which in turn may reduce people's ability to give a coherent account and may lead to non-disclosure.

Furthermore, Van Velsen et al. (1996) suggested to include a measure of dissociative phenomena in future research as dissociation might be closely related to PTSD avoidance symptoms and plays a role in long-term psychopathological response to trauma (Bremner, Southwick, Brett, Fontana, Rosenheck & Charney, 1992). Indeed, dissociative experiences are commonly reported by individuals with a diagnosis of PTSD (Ehlers & Clark, 2000; Foa & Hearst-Ikeda, 1996a). The empirical literature on dissociative responses in refugee populations is scarce. Carlson and Rosser-Hogan (1991) found high levels of association between traumatic experiences and the severity of both traumatic stress and dissociative reactions in a group of 50 Cambodian refugees who had resettled in the United States. However, dissociative responses not only occur as an aftermath of a traumatic event, but can also be experienced at the time of the trauma, that is peritraumatically (Marmar, Weiss, Metzler, Ronfeldt, & Foreman 1996b; Weiss, Marmar, Metzler & Ronfeldt, 1995). A meta-analysis found peritraumatic dissociative experiences to be the strongest predictor for PTSD diagnosis and symptoms (Ozer, Best, Lipsey & Weiss, 2003). These findings suggest that dissociative reactions could be activated during an

anxiety-provoking event, such as the Home Office interview, which may affect disclosure.

Feelings of shame have been mentioned in the literature as a factor affecting disclosure. Shame is generally seen as an intense, sometimes debilitating, negative emotion that involves feelings of inferiority, powerlessness and self-consciousness (Tangney, Miller, Flicker & Barlow, 1996). Shame is linked to both negative self-evaluation and a fear of being judged negatively by others (Gilbert, 1998). Shame plays an important role in psychopathology and impacts on how people perceive personal traumatic experiences. There is increasing evidence that shame might be linked to the course or onset of PTSD (Andrews, Brewin, Rose & Kirk, 2000; Leskela, Dieperink & Thuras, 2002; Wong & Cook, 1992). Lee, Scragg and Turner (2001) highlighted the need to address emotional responses such as shame and guilt when assessing and treating PTSD as the activation of shame and guilt can lead to intrusions and avoidance reactions.

It has also been shown that shame leads to behavioural patterns of submission, a desire to escape, hiding from the interpersonal realm and concealment (Gilbert, 2000a). It therefore seems likely that if an individual has a predisposition to feel shame about aspects of his or her character, behaviour or experiences, disclosure might be difficult (Andrews & Hunter, 1997). However, there has been a lack of empirical research on the link between shame and disclosure. Swan and Andrews (2003) found a relationship between shame and disclosure in 68 eating disordered women indicating that a tendency to feel ashamed of the self may affect the ability to disclose important personal information. Macdonald & Morley (2001) examined

the impact of shame on non-disclosure of negative emotional experiences in a sample of 34 psychotherapy outpatients. Qualitative analysis showed that shame was associated with a negative self-assessment and non-disclosure was linked to the anticipation of negative evaluation by others. The study also found that participants expressed a general willingness to disclose under the right circumstances. However, a limitation of the study was the relatively small sample size. A study on the relationship of non-disclosure in therapy to shame and depression (Hook & Andrews, in press) found that shame was the most frequently reported reason for non-disclosure overall. These findings are of relevance for Home Office interviews as the process of revealing personal information can be experienced as deeply shaming and thus impact negatively on disclosure.

In summary, the above review indicates the importance of shame in disclosure and psychopathology and the paucity of existing research on shame and disclosure in traumatised refugees and asylum seekers. Therefore, the first aim of the current study was to explore more systematically the factors involved in refugees' and asylum seekers' disclosure during Home Office interviews by means of a qualitative interview, but also through more objective quantitative measures. The second aim of the study was to examine the link between trauma types, PTSD symptoms and shame reactions. There is an indication that sexual torture is associated with PTSD avoidance symptoms and that shame is associated with avoidance reactions, which suggests that there might be a link between sexual torture, avoidance and shame reactions. Based on previous research it was specifically hypothesised that sexual violence produces a different pattern of PTSD response, being significantly associated with an avoidance reaction. It was further hypothesised that there is an

association between shame and avoidance symptoms; those with higher levels of shame will show increased avoidance symptoms. The third aim of the study was to examine the relationship between dissociative symptoms and PTSD avoidance symptoms since it was suggested that dissociative responses are linked to avoidance symptoms. It was therefore hypothesised that there is an association between PTSD avoidance symptoms and dissociative experiences.

METHOD

Participants

Refugees and asylum seekers with a history of pre-migration trauma were included in the study. They were recruited from a central London traumatic stress clinic and two London based community services. Participants were invited to take part in a research study about refugees' and asylum seekers' experiences of legal interviews. The study was granted ethical approval by the Camden & Islington Community Local Research Ethics Committee (see Appendix 1). Written informed consent was obtained from all participants. A copy of the consent form can be found in Appendix 2.

Participants were approached in several ways: Some people were sent a patient information sheet (see Appendix 3) and a covering letter (see Appendix 4) informing them that they would be contacted by phone to discuss the study. Some were approached by their clinician or caseworker, who then passed on contact details to the researcher. Others were approached face-to-face at drop-in sessions or community group meetings. Patient information sheets were translated into Albanian (see Appendix 5) and Turkish (see Appendix 6) as a large sub-group of people were

speaking those two languages. The remainder all read English adequately to comprehend the English version.

Measures

Quantitative Measures

PTSD Symptom Scale - Interview (PSS-I; Foa, Riggs, Dancu & Rothbaum, 1993). The PSS-I was used to assess current PTSD symptoms according to DSM-IV (American Psychiatric Association, 1994) criteria. It has been shown to have good validity and reliability using female victims of rape and non-sexual assault (Foa et al., 1993). The PSS-I was chosen above other measures of PTSD, such as the Clinician-Administered PTSD Scale (CAPS: Blake, Weathers, Nagy, et al., 1990) or the Structured Clinical Interview for DSM-IV (SCID: Spitzer, Williams & Gibbon, 1987), as it requires less assessment time. Foa and Tolin (2000) compared the psychometric properties of the CAPS and the PSS-I in a sample of 64 civilian trauma survivors with and without PTSD and concluded that the PSS-I can be used instead of the CAPS in the assessment of PTSD, thus decreasing assessment time without sacrificing reliability or validity. The PSS-I is a semi-structured interview, which consists of 17 items corresponding to the 3 symptom domains of PTSD, yielding a total PTSD severity score as well as re-experiencing, avoidance and arousal subscores. Each item consists of one question and the participant's answer is rated by the interviewer from 0 (Not at all) to 3 (5 or more times per week/Very much). Total severity scores are based on the sums of the raw items. Symptoms measured by the PSS-I are considered present if they are rated as one or greater. However, based on the recommendations of previous research using the PSS (Brewin, Andrews & Rose,

2000; Turner, Bowie, Dunn, Shapo & Yule, 2003), a more stringent method of scoring was employed. PSS items were only counted toward a PTSD diagnosis if they were scored 2 or more on the scale. A copy of the measure can be found in Appendix 7.

Hopkins Symptom Checklist-25 (HSCL-25; Derogatis, Lipman, Rickels, Uhlenhuth & Covi, 1974). A measure of depression was included since it has been found that there is a high degree of comorbidity with PTSD (Blanchard, Buckley, Hickling & Taylor, 1998). Participants completed part II of the HSCL-25, which is a 25-item symptom inventory measuring symptoms of anxiety and depression. This screening tool was particularly chosen due to its high cross-cultural validity. It has been validated on a general population (Winokur, Winokur & Rickels, 1984) and Indo-Chinese versions have been translated and validated by Mollica, Wyshak, de Marneffe, et al. (1987b). Other reviews have also confirmed the cross-cultural robustness of the measure (Kinzie & Manson, 1987; Butcher, 1991). Part I includes ten items for anxiety symptoms; Part II has fifteen items for depression symptoms. Participants rate each symptom on a 4-point scale, ranging from 1 (not at all) to 4 (extremely). The depression score is the average of the 15 depression items and has been shown to correlate with major depression as defined by the DSM-IV (American Psychiatric Association, 1994). Scores above 1.75 indicate clinically significant depression. A copy of the measure can be found in Appendix 8.

Experience of Shame Scale (ESS; Andrews, Qian & Valentine, 2002). Shame was measured using the ESS, which is a 25-item scale assessing three different domains of shame: characterological, behavioural and bodily shame. Items addressing

characterological shame include shame of personal habits, manner with others, the sort of person one is, and personal ability. Behavioural shame assesses shame about doing something wrong, saying something stupid, and failure in competitive situations. Bodily shame includes feeling ashamed of one's body or any part of it. Within each of these domains there are items reflecting the experiential (feeling shame), cognitive (concern over others' opinions) and behavioural (concealment or avoidance) components of shame. Participants rate each item, based on how they have felt in the past year, on a 4-point scale, ranging from 1 (not at all) to 4 (very much). The ESS was chosen as it is a recently developed shame questionnaire and because it reflects Gilbert's (1998) concepts of internal and external shame. The validity and reliability of the measure was assessed using university students. It was found that it has good construct and discriminant validity, internal reliability and test-retest reliability for the total scale and the three subscales, and factor analyses have confirmed the existence of the three subscales (Andrews et al., 2002; Qian, Andrews, Zhu & Wang, 2000). A copy of the measure can be found in Appendix 9.

Peritraumatic Dissociative Experiences Questionnaire: Self-Report Version (PDEQ-SRV; Marmar, Weiss & Metzler, 1997). The PDEQ-SRV consists of 10 items measuring retrospective dissociation at the time of a trauma. Items addressing confusion, depersonalisation, derealisation, time distortion, and out of body sensations are rated on a 5-point scale, ranging from 1 (not at all true) to 5 (extremely true). The PDEQ is strongly associated with measures of traumatic stress responding, general dissociative tendencies and level of stress exposure, and not associated with general psychopathology (Marmar et al., 1997). Since the PDEQ is the principal tool available for the measurement of acute dissociative responses at

the time of traumatic stress exposure (Marmar et al., 1997) it was decided to include this instrument to assess refugees' and asylum seekers' dissociative experiences at the time of their Home Office interview. Participants were thus instructed to complete the items based on their experiences and reactions during the Home Office interview and immediately afterward. The PDEQ has been shown to have good validity and reliability using a variety of primarily Caucasian populations, including military veterans, emergency services providers, and physically injured persons (Marmar et al., 1997). A copy of the measure can be found in Appendix 10.

Difficulty in Disclosure. To get a more systematic measure of disclosure, participants were also asked to rate on a 4-point scale, ranging from 1 (not at all) to 4 (extremely), how difficult they found it to disclose personal information during the Home Office interview.

Qualitative Measures

A semi-structured interview was used to collect the qualitative data regarding people's disclosure during Home Office interviews. Most participants had a screening interview shortly after arrival followed by one or more main Home Office interviews. Participants were interviewed about their main Home Office interview. In case the person had more than one interview, the first Home Office interview was used.

Participants were asked a number of questions relating to the disclosure of their index trauma. However, to avoid further retraumatisation, they were not asked to give a direct verbal account of their traumatic experiences. The interview schedule

can be found in Appendix 11. Interview questions included both open-ended and closed items and were based on issues that have been identified in the literature as potentially affecting asylum seekers' disclosure during interviews. These issues were grouped into four main categories:

(1) Disclosure of sensitive personal information. (Interview questions 1, 2, 4, 5, 17, and 21). Participants were asked about their experience of the Home Office interview as well as more specific questions regarding disclosure, such as to what extent they felt they could open up and how it felt to be asked personal questions. Furthermore, several items were included to find out when the participant first talked about their traumatic experience, who they talked to and if there was anything that they initially did not disclose. They were also asked whether there are things that they have not yet told the Home Office about and the reasons for that.

(2) Reactions towards people in authority. (Interview questions 7, 8, 9, 10, 11, and 12). These questions were aimed to address participants' feelings towards people in authority as the literature has shown that disclosure can be difficult due to issues of trust in authorities. More general questions included how the officials made them feel and how they imagined the officials would react to hearing their story. More specific questions concerned feelings of being judged by the interviewer, and the sex of the interviewer, as this was found to affect disclosure, specifically in women (Burnett & Peel, 2001). Finally, participants were also asked whether they would have felt more comfortable

if they had the chance to meet the interviewer briefly before the actual interview.

(3) Situation- and context-specific factors. (Interview questions 13, 15, 16, and 18). These questions were included to assess situational and context-specific factors affecting disclosure, such as the setting where the interview was held, whether they received prior information about the interview, issues of personal safety, and the impact of being interviewed alone or with others.

(4) Culture-specific issues. (Interview question 20). The literature has shown that refugees and asylum seekers often come from cultures with different attitudes towards sexuality, with issues such as sexual violence not readily disclosed to others due to feelings of shame, social stigma and the risk of being shunned by family members and the community. Therefore, a question was included to assess whether participants could identify any aspects relating to their cultural background that had an impact on their disclosure during the Home Office interview.

(5) Other issues and recommendations. (Interview questions 6, 14, 19, and 22). Finally, participants were invited to make recommendations of how the Home Office interviews could be improved and they were asked whether there was anything that they wanted to add that they had not been asked about by the research interviewer.

Procedure

Two pilot interviews were conducted to finalise the wording of the qualitative interview and the ordering and feasibility of measures. Participants were interviewed on one occasion with an interpreter, if necessary. Participants who were already seen with an interpreter at their clinic or community centre and participants who requested an interpreter were interviewed with an interpreter. Participants whose command of the English language was good and who were able to understand the initial discussion in English were interviewed without one. Using a mixed sample placed considerable constraints on the design. Generally, it ruled out the use of translated questionnaires. Therefore, all measures were presented orally during the interview. Seven participants (26%) were interviewed with the assistance of an interpreter who, in most instances, was officially accredited.

The semi-structured interviews were taped (permission was sought in all cases) and transcribed by the author in order to analyse the qualitative data. Ten participants did not want their interview to be recorded and in these cases process notes were taken instead.

RESULTS

Quantitative Results

Preliminary Analyses

Prior to analysis, the variables gender, age, PSS-I overall severity, PSS-I re-experiencing, PSS-I avoidance, PSS-I hyperarousal, HSCL-25 depression total, ESS total, PDEQ-SRV total, and difficulty in disclosure were examined for accuracy of

data entry, missing values, and fit between their distributions and the assumptions underlying the use of parametric tests. Due to the small sample size, the variables were examined for the whole sample. Most variables were skewed, with PSS-I overall severity, PSS-I re-experiencing, PSS-I hyperarousal and HSCL-25 depression total being negatively skewed, and age and ESS total being positively skewed. The variables gender, PSS-I avoidance, PDEQ-SRV total and difficulty in disclosure had negative kurtosis. Due to the failure of achieving normality through data transformations, non-parametric tests were used for the majority of the analyses. For more complex analyses parametric tests were employed despite the researcher's awareness of the limitations of using these tests with non-normal data. However, there were no alternative non-parametric tests available. Furthermore, as the subscales of the ESS significantly intercorrelated, (Spearman's rho ranged from .63 to .65), the data were analysed using the total shame scores.

Participants

There were 27 participants, 11 men (41%) and 16 women (59%) between the ages of 22 and 73 (median = 39, interquartile range = 18), who had arrived in the UK between 1995 and 2003. Fourteen participants (52%) were granted indefinite leave to remain (ILR[1]); 3 (11%) had exceptional leave to remain in the UK (ELR[2]) and 10 (37%) were asylum seekers[3]. Of the 17 participants granted some form of leave, 10 (59%) were granted leave to remain following appeal and 7 (41%) were granted asylum on first application. The asylum seekers all were under appeal at the time of

[1] When asylum seekers are recognised as refugees under the 1951 United Nations Convention Relating to Refugees, the Home Office grants them ILR, which means they can remain in the UK for as long as they wish.

[2] Before April 2003, ELR was granted when the Home Office decided that the asylum seeker did not qualify for refugee status, but felt it was too dangerous to return the person to their country. ELR is no longer granted. It is now called discretionary leave or humanitarian protection.

[3] An asylum seeker is defined as someone who has applied to the government for asylum and is awaiting decision by the Home Office to be recognised as a refugee.

testing. These data are in line with findings from the literature showing the high proportion of refusals and successful appeals. Participants were from a wide variety of national and ethnic backgrounds, reflecting the diverse population of refugees and asylum seekers in the UK, including Afghanistan (N=1), Algeria (N=1), Burundi (N=1), the Democratic Republic of the Congo (N=2), the Republic of the Congo (N=1), Eritrea (N=3), Ethiopia (N=4), Guyana (N=1), Kosovo (N=3), Iraq (N=2), Serbia (N=1), Sierra Leone (N=1), Turkey (N=4) and Uganda (N=2).

Participants were divided into two groups. The first group consisted of participants with a history of sexual violence. Following Van Velsen et al.'s (1996) study, sexual violence was defined as (a) rape of men or women and (b) other tortures directed to the genital area. The second group consisted of participants with a history of non-sexual violence. This was broadly defined as having experienced or witnessed some form of psychological and/or physical maltreatment including torture. Fifteen participants (56%) experienced some form of sexual violence (male/female ratio: 4/11), including rape (N=12), sexual torture (N=3). Twelve participants (44%) experienced or witnessed some other form of violence (male/female ratio: 7/5), including torture (N=6), being shot (N=2), beatings (N=2), and witnessing killing of family members (N=2). Participants were not asked directly about their index trauma to avoid inducing distress. Instead this information was obtained, with consent, from the person's clinician, caseworker, or medical notes.

Quantitative Measures

Scores of symptom severity on the PSS-I ranged from 8 to 51 (median = 35, interquartile range = 21), with 18 participants (67%) receiving a diagnosis of PTSD.

Scores on the HSCL-25 led to 24 participants (89%) receiving a diagnosis of depression. Total scale scores ranged from 16 to 57 (median = 41, interquartile range = 15). There was substantial comorbidity between PTSD and depression; all 18 participants with a diagnosis of PTSD returned above-threshold scores for depression on the HSCL-25. These findings are in line with the literature showing increased prevalence rates for PTSD and depression in refugees and asylum seekers (Holliefield et al., 2002) as well as high comorbidity (Blanchard et al., 1998).

The total shame scores, as measured by the ESS, ranged from 28 to 97 (median = 50, interquartile range = 29). There are no cut-off scores for this measure, but a higher score indicates greater feelings of shame. The mean dissociation score on the PDEQ-SRV was 29 (interquartile range = 26.3), with scores ranging from 10 to 46. Again, there are no cut-off scores for this measure, but a higher score indicates greater dissociation.

Comparison of Participant Group Characteristics

The groups differed significantly in terms of age (Mann-Whitney $U = 47.0$; $p = .04$). No significant group differences existed for sex ($\chi^2 = 2.77$; df = 1; $p = .10$), or asylum status ($\chi^2 = 1.91$; df = 2; $p = .39$).

Table 1 shows the median scores for the two groups. There was a significant difference in overall PTSD severity (Mann-Whitney $U = 41.0$; $p = .02$) and in PTSD avoidance symptoms (Mann-Whitney $U = 24.5$; $p = .001$); those with a history of sexual violence showed greater overall PTSD severity and avoidance symptoms. There were however no significant differences in PTSD re-experiencing symptoms

(Mann-Whitney $U = 76.5$; $p = .49$), or arousal symptoms (Mann-Whitney $U = 63.0$; $p = .19$). There was also a significant difference in total shame scores (Mann-Whitney U = 25.0; $p = .001$), total dissociation scores (Mann-Whitney $U = 41.5$; $p = .03$), and difficulty in disclosure (Mann-Whitney $U = 21.5$; $p < .001$); those with a history of sexual violence reported greater feelings of shame, and they also showed greater dissociation symptoms and found it more difficult to disclose personal information during their Home Office interview. There were no significant differences between the two groups in depression scores (Mann-Whitney $U = 57.0$; $p = .11$).

To control for the effects of age, a Multivariate Analysis of Covariance (MANCOVA) was carried out with age as the covariate and PTSD total scores, PTSD avoidance scores, total shame and dissociation scores and difficulty in disclosure as the dependent variables. The results showed that after controlling for the effects of age, the groups still differed significantly on PTSD avoidance scores (F (1,23) = 12.3, $p = .002$) total shame scores (F (1,23) = 10.8, $p = .003$), total dissociation scores (F (1,23) = 5.0, $p = .04$), and difficulty in disclosure (F (1,23) = 16.3, $p = .001$), but not on PTSD total scores (F (1,23) = 2.5, $p = .13$).

Furthermore, to explore whether the groups still differed when controlling for PTSD severity, another MANCOVA was run with PTSD total scores as the covariate and total shame and dissociation scores and difficulty in disclosure as the dependent variables. The results showed that after controlling for the effects of PTSD severity, the groups still differed significantly on total shame scores (F (1,23) = 6.3, $p = .02$), and difficulty in disclosure (F (1,23) = 13.8, $p = .001$), but not on total dissociation scores (F (1,23) = 3.6, $p = .07$).

Table 1: Comparison of groups by measures.

	Sexual Violence (N = 15)	Non-Sexual Violence (N = 12)	Mann-Whitney *U*
	Median (Interquartile Range)	Median (Interquartile Range)	
Age	35 (15)	46.5 (21.3)	47.0*
PSS-I			
- Overall severity	38 (12)	26.5 (18.3)	41.0*
- Re-experiencing	10 (5)	12 (7)	76.5
- Avoidance	17 (3)	5.5 (8)	24.5**
- Hyperarousal	14 (7)	10.5 (7.3)	63.0
HSCL depression total	46 (16)	39 (19.5)	57.0
ESS total	64 (29)	42 (14.5)	25.0**
PDEQ-SRV total	34.5 (10.8)	12.5 (21.5)	41.5*
Difficulty in Disclosure	4 (1)	1 (1)	21.5***

Note. PSS-I, PTSD Symptom Scale - Interview; HSCL, Hopkins Symptom Checklist; ESS, Experience of Shame Scale; PDEQ-SRV, Peritraumatic Dissociative Experiences Questionnaire- Self-Report Version.

*$p < .05$; **$p < .01$, ***$p < .001$. (All tests were two-tailed).

The Relationship of Shame to PTSD Symptoms

There was a significant association between total shame scores and PTSD total scores (Spearman's rho = 0.75; $p < .001$), PTSD avoidance symptoms (Spearman's rho = 0.79; $p = .001$), and PTSD arousal symptoms (Spearman's rho = 0.52; $p = .006$), indicating that those with higher levels of shame also had higher PTSD scores and showed increased avoidance and arousal symptoms. No significant relationship existed between total shame scores and PTSD re-experiencing symptoms (Spearman's rho = 0.26; $p = .19$).

The Relationship of Dissociation to PTSD Avoidance Symptoms and Shame

There was a significant association between total dissociation scores and PTSD avoidance symptoms (Spearman's rho = 0.44; $p = .03$), and between total dissociation scores and total shame scores (Spearman's rho = 0.61; $p = .001$), showing that those with increased dissociation scores were higher on levels of shame and showed greater PTSD avoidance symptoms. These effects were still significant after partialling out the effects of age using partial correlations.

Since age was significantly related to PTSD total scores (Spearman's rho = -0.44; $p = .02$) and PTSD avoidance symptoms (Spearman's rho = -0.47; $p = .02$), the above correlational analyses involving these variables were run again, holding age constant. Partial correlations showed that there was still a significant association between total shame scores and PTSD total scores ($r = 0.69$; $p < .001$), between total shame scores and PTSD avoidance symptoms ($r = 0.74$; $p < .001$), and between total dissociation scores and PTSD avoidance symptoms ($r = 0.49$; $p = .01$) after partialling out the effects of age.

The Relationship of Disclosure to the Dependent Variables

There was a significant association between difficulty in disclosure and age (Spearman's rho = -0.40; $p = .04$), gender ($\chi^2 = 12.4$; df = 3; $p = .006$), PTSD total scores (Spearman's rho = 0.55; $p = .003$), PTSD avoidance symptoms (Spearman's rho = 0.63; $p < .001$), total shame scores (Spearman's rho = 0.69; $p < .001$), total depression scores (Spearman's rho = 0.51; $p = .007$), and total dissociation scores (Spearman's rho = 0.78; $p < .001$). No other significant associations were found. These results indicate that difficulty in disclosure increased with age, that women found it more difficult to disclose than men, and that the more difficult people found it to disclose the higher they were on measures of overall PTSD scores, PTSD avoidance symptoms, shame, depression and dissociation.

For information, all the correlational analyses can be found in table 2.

Table 2: Correlations among variables

	Age	PSS-I Overall	PSS-I Reexperiencing	PSS-I Avoidance	PSS-I Arousal	ESS	HSCL Depression	PDEQ-SRV
PSS-I Overall severity	-.44*							
PSS-I Reexperiencing	-.13	.66***						
PSS-I Avoidance	-.47*	.82***	.26					
PSS-I Arousal	-.28	.84***	.68***	.45*				
ESS total	-.24	.75***	.26	.79***	.52**			
HSCL Depression total	-.35	.80***	.65***	.59**	.74***	.58**		
PDEQ-SRV total	-.23	.36	.06	.44*	.15	.61**	.25	
Difficulty in Disclosure	-.40*	.55**	.07	.63***	.37	.69***	.51**	.78***

Note. PSS-I, PTSD Symptom Scale - Interview; HSCL, Hopkins Symptom Checklist; ESS, Experience of Shame Scale; PDEQ-SRV, Peritraumatic Dissociative Experiences Questionnaire- Self-Report Version.

*$p < .05$; **$p < .01$, ***$p < .001$. (All tests were two-tailed).

Qualitative Results

Method of Analysis

The data were analysed using a thematic analysis approach, which focuses on identifiable themes and patterns of personal experiences. The thematic analysis approach taken was that described by Aronson (1994), following the steps of transcription, listing patterns of experiences, and combining patterns into themes: After transcription and familiarisation with the material, the data were grouped by interview question and each question was analysed separately. These questions were then arranged under the pre-existing categories outlined in the method section. For each interview question patterns of experiences were listed from direct participant quotes. Major response themes were then drawn out from these patterns. For a minority of questions the data were combined due to similarity. Additional and more detailed quotes can be found in Appendix 12.

Following recommendations by Elliot, Fischer and Rennie (1999), credibility checks were provided in several ways: To provide checks on reliability, a second marker audited the data from each question, looking at the themes created. Any differences in opinion were discussed and rectified. Furthermore, triangulation was used by comparing the outcome of the qualitative data with the results of the quantitative data and drawing parallels between the two (see Discussion). The validity of the conclusions drawn from the interview data was enhanced in several ways. First, by presenting direct quotes from the interviews to demonstrate to the readers the relationship between themes and the source data. Second, to indicate how representative the themes were of the sample as a whole, the proportion of

participants for each theme was outlined. Third, the analysis included a negative case analysis, which means reporting on minority as well as majority responses.

Disclosure of Sensitive Personal Information

Q1: When was the first time you talked about the traumatic event? After the event? After your arrival in the UK? Who did you talk to? Q2: Was there anything you initially did not tell this person? What were the reasons for that? Twenty participants (74%) out of 27 reported that the first time they talked about the traumatic event was after their arrival in the UK; the majority of those talked to Home Office officials (N=13), the rest talked to family members (N=3), health-care professionals (N=2), or their solicitor (N=2). Out of the 14 people who disclosed to others than the Home Office, 10 reported that they initially did not tell the person everything. Reasons cited included the impact of past traumatic events, such as feelings of confusion and shock (N=3), a need to build up trust and confidence before being able to talk about sexual issues (N=3); feeling scared that details might be passed on to their government or that they would not be believed (N=3), and not wanting to burden other family members (N=1).

Q4: What was the asylum interview like for you? Q5: To what extent did you feel you could open up and talk openly about what happened to you? Q17: How did it feel to be asked personal questions during the interview? Only 5 people (19%) had a positive attitude about the interview. They reported not being pressured too much by the interviewer and found it easy to answer questions in the hope that it might help their application. The majority of participants (81%, N=22) however felt that the interviews were difficult. Two different themes emerged from the participants'

answers: finding it too difficult to disclose, and wanting to disclose, but not given the chance to. Twelve people reported difficulties in disclosing personal details; 10 of those had a history of sexual violence. Reasons cited were feeling too traumatised, afraid and ashamed to talk about the past (N=10), and intrusive experiences, such as intrusive memories and flashbacks, which affected their ability to focus on the interview and give a coherent account (N=2):

It was the first time in my life that I had to speak about what happened to me. I only told the interviewer about ten per cent, I could not talk, it was too difficult. I felt so traumatised and ashamed. [P2]

Ten (37%) people reported that they wanted to tell the Home Office what happened to them, but that they were not given the opportunity to do so; the interviewer apparently was more interested in factual details about their home country and how they got to the UK than what happened to them or their families (see also Appendix 12, quote 1):

I wanted to explain properly, but they just stopped me. They ask you to make it short, and give yes or no answers. You don't get a chance to say much or explain to them. Therefore I did not go into much detail. But that affected me later when I was asked why I did not tell them in the interview. [P16]

Five of the people who wanted to disclose also reported that they were asked similar questions repeatedly, which increased their stress levels and impacted negatively on their ability to disclose (see also Appendix 12, quote 2).

Q21: Are there any things you have not yet told the Home Office about? If yes – Could you tell me what some of the reasons might be that you have found it difficult to do that? Fifteen people (56%) reported that there are still things they have not told the Home Office about; 10 of those were men and women with a history of sexual violence and most of them reported feelings of shame as a reason for non-disclosure (N=7):

I wanted to keep things from my past private. I was scared that they would look at me badly and make me feel ashamed. I could not tell everything at the interview, but later on I was able to tell the court. They were nice at the court and made me feel more relaxed. [P21]

Other reasons included forgetting some details, which they were not able to mention in later interviews for fear it would affect their credibility (N=2), being unsure whether they could disclose details they were not directly asked about (N=3), and that they were not given the opportunity and the time to talk openly about their past traumatic experiences (N=2).

Reactions towards People in Authority

Q7: How did you imagine the officials would react to hearing your story? What did you think would happen? Nine (33%) of the 27 respondents imagined that the interviewer would react positively when hearing their story and 10 (37%) imagined a negative reaction. Imagined positive reactions included believing that the interviewer would be understanding and sympathetic, have pity, protect and believe

them. People who imagined a negative reaction worried that the interviewer would not believe them, would not be interested in their case, send them back or to prison, or pass information on to their government. One person imagined that the interviewer would not want to hear his story for fear of getting upset, and a woman with a history of rape worried about shaming reactions from the men in the room, fearing that they might leave if she disclosed that she was raped.

Q8: How did the officials react? Three themes emerged from the participants' responses: positive, neutral, and negative reactions. Only five people (19%) reported that the interviewer reacted positively, such as showing feelings of sympathy and making the person feel understood. Six people (22%) said that the interviewer did not show any emotions and three thought that this was due to them doing a routine job and hearing many stories every day. One woman did not know how the male interviewer reacted, as she was too ashamed to look him in the eye. The majority of people (N=14, 52%) however thought that the officials reacted negatively, which impacted on their ability to disclose (see Appendix 12, quote 3). Reasons included: the interviewer did not understand, show pity or interest, was ignorant, insensitive, angry, cold, and did not listen properly or take the person seriously:

When I started talking I felt like I was dying. You tell them everything, you feel naked. But once I saw that they were not really interested and ignorant I stopped talking. [P9]

Q9: How did the officials make you feel? Eight people (30%) felt that the interviewer was nice and polite and made them feel comfortable and relaxed. The

majority (70%, N=19) however had negative experiences (see Appendix 12, quote 4). Eight people said the officials reminded them of police or officials from their home country, which increased their anxiety and interfered with their ability to disclose. Four people reported feeling like criminals and that the interviewer did not believe them, and one was openly accused of being a liar. Others felt that the interviewer looked at them 'funny' and that they felt watched (N=4). One woman reported that the interviewer made her feel low, dirty and ashamed, accusing her that it is wrong not to tell her husband that she was raped. One person felt that he could not trust the person, no matter how the person behaved.

Q10: Were you afraid the officials would judge you negatively? Eighteen people (67%) reported that they were afraid the interviewer would judge them negatively. Reasons included: disclosing a history of rape or other past traumatic experiences, being a refugee, not being able to express oneself properly and physical appearance. For example, one person had a scar in his face from a shot wound and he was worried that the interviewer thought he looked cruel and therefore refused him. One woman described an actual incidence of being openly judged by the interviewer, which increased her feelings of shame.

Q12: I wonder whether the sex of the interviewer had any impact on you? Eight people (30%) reported that the sex of the interviewer had an impact on their ability to disclose; six of those were men and women with a history of rape. All agreed that it would be easier to speak to a member of the same sex, especially when talking about sexual experiences. Women in particular (N=5) expressed shameful reactions when talking about rape to men they did not know. For people who said that the sex did not

matter, the attitude of the interviewer and the way they were treated was seen as more important (N=5).

Situation- and Context-Specific Factors

Q11: Did you get a chance to meet the interviewer before the interview? If no – Would you have felt more comfortable if you met the interviewer before? None of the 27 participants got a chance to meet the interviewer before the interview. Sixteen (59%) said that they would have liked for the interviewer to introduce him/herself and give them some information about what's going to happen in the interview, which would have helped them to feel more relaxed. Some expressed that the attitude and personality and how one is treated is more important than meeting the interviewer beforehand (N=6).

Q13: Was there anything about the setting/place of the interview that made it difficult for you to open up? Eight people (30%) reported that the setting made it more difficult for them to open up. Seven felt that the room was too small. Two women reported feeling uncomfortable as they were sitting too closely to the male interviewer, and two others said that the room reminded them of their prison cell. One person reported that she was interviewed in an open area, which made it difficult for her to open up as she found it hard to concentrate and feel confident.

Q15: Were you interviewed alone of with other members of your family? If alone - Would you have preferred to have family members/others with you? If with family/others - Would you have preferred to be interviewed alone? Out of the 22 people interviewed alone, 18 reported that they would have liked a family member or

a friend in the room, which would have made them feel more relaxed, secure and confident. Five people specifically would have liked their solicitor to be there, who was seen as a person they could trust and who knows about their case. Four people said that they preferred to be interviewed alone as they did not want to bother their family with their problems or did not want others to know what they went through. One woman was interviewed with her husband initially and was unable to disclose that she was raped in front of him.

Q16: Did you feel that the procedures were well explained to you? Eighteen people (67%) felt that the procedures were not well explained; they did not know what was expected of them or what was going to happen during the interview. Most agreed that they would have liked some advice or information before the interview to know better what to say and what not to say. Two people felt that they should have received this information from their solicitor.

Q18: Did you feel safe during the interview? Nineteen people (70%) reported that they did not feel safe during the interview. Eleven commented that they were scared about being refused, sent to prison or being accused of lying. Some also commented that the effects lasted long after the interview (N=12); 11 of those had a history of sexual violence. They reported the interview gave them nightmares and caused them physical problems and mental health difficulties, such as anxiety, depression and paranoia, for which they had to seek professional help.

Culture-Specific Issues

Q20: Are there things you have not talked about because in your culture it is considered wrong? Eight participants (30%) reported that there were things they have not talked about because in their culture it is considered wrong; all of them were men and women with a history of sexual violence. Most of them stated that in their culture sexual issues are not talked about, especially rape, which is seen as a 'disgrace'. Two specifically mentioned feelings of shame associated with rape and that shame prevented them from talking about it in the interview. A quote from a woman highlights the impact of shame on disclosure (see Appendix 12, quote 5).

Other Issues and Recommendations

Q22: Is there anything else that you would like to tell me that I have not asked you about? One major issue that was raised by 15 people (56%) was difficulties with interpreters. Seven reported that the interpreter spoke a different dialect, which made it hard for them to understand everything that was said in the interview. Six raised the issue that the interpreter was from a different tribe or political group, which made it hard for them to feel safe, have trust and disclose in the interview. Many reported that in their country these different tribes were at war with each other. Another six felt that the interpreter did not interpret everything word-by-word (see Appendix 12, quote 6). Two people reported that the interpreter at times ran the interview, or stopped the person from talking.

Another issue that was raised repeatedly was regarding the interview statement that is presented to the asylum seeker at the end of the interview for signing. Many non-English speaking refugees and asylum seekers reported that they had to sign the

statement, which is in English, without knowing what they were signing. They complained that there were incorrect details on their statement, which they only found out afterwards when they translated the statement after being refused (see also Appendix 12, quote 7):

The interview protocol was wrong. I tried to show him my scar in the interview, but he asked me to stop undressing. In the report he wrote, "She tried to show me her vagina". [P12]

Finally, many also reported difficulties with the screening interview and/or court interviews, however, this was not explored further due to the limitations of this study, which focused only on the main Home office interviews.

Q6: Is there anything that would have made it easier for you to open up? Q14: What would be a better setting/place to be interviewed in? Q19: How could the interviews be changed to make it easier for people to open up? Participants were asked at various points throughout the research interview to make recommendations. When asked specifically whether there was anything that would have helped the person to open up more, the most frequently cited factor was the attitude of the interviewer (N=11). A quote summarises this:

During the interview try to be more understanding. Show the person more that you feel sorry for them, but not judge them in any way. It makes a big difference how you are spoken to, some people make you nervous and scared and some don't.

And remember that for some people it is hard to speak. Make them feel more welcome and give them time and a chance to talk about the past. [P26]

Recommendations regarding the setting included using bigger rooms (N=2), sitting in a circle rather than behind a desk (N=1), making the room look more homely (N=1), and make people feel more welcome when entering the Home Office building by having signs up in different languages (N=2).

Other recommendations included: use female interviewers and interpreters for women, especially in the case of rape (N=4), allow someone in the room the person can trust (N=4), have more knowledge about the person's country of origin (N=3), provide some information about the interview procedure (N=2), have an interview protocol (N=2), make the interviews less formal (N=2), and take the person's psychological symptoms into account (N=1). In addition, recommendations regarding interpreters were mentioned by four people: use interpreters with the same dialect and who are from the same background, and make sure the interpreter's role is solely to translate everything that is being said. Finally, four people also mentioned that the immigration system has to change to make a difference, not only the interviews. However, this was not explored further.

DISCUSSION

Late disclosure, or the addition of new statements in later interviews, has been cited as evidence against an asylum seeker's credibility (Asylum Aid, 1999). This common, and understandable, assumption however fails to take into account other

reasons for not disclosing from the outset. The current study is the first attempt to systematically investigate the factors involved in refugees' and asylum seekers' disclosure during Home Office interviews. It is also the first to consider the relative contributions of shame and dissociation in the same study and to investigate their role in the link between trauma types and PTSD symptoms.

Group Comparisons

Comparing participants with sexual and non-sexual violence, the results suggested that, after controlling for age and PTSD severity, people with a history of sexual violence scored higher on PTSD avoidance symptoms and shame, and they also found it more difficult to disclose sensitive personal information during these interviews. In line with the initial hypothesis, there was a significant association between sexual violence and PTSD avoidance symptoms. These findings replicate previous results by Ramsey et al. (1993) and Van Velsen et al. (1996) and add weight to their suggestions that PTSD may not be a homogeneous condition and that specific trauma types may lead to different patterns of responses.

The Relationship of Shame to Psychopathology

The current study also refined and extended previous findings by the above authors by considering the relationship between shame, dissociation and avoidance behaviours. The current results confirmed the initial hypothesis that there is a significant association between shame and PTSD avoidance symptoms. Shame was also significantly associated with overall PTSD severity, and PTSD arousal symptoms, which provide further evidence that shame might be linked to the course

and onset of PTSD (Andrews, Brewin, Rose & Kirk, 2000; Leskela, Dieperink & Thuras, 2002; Wong & Cook, 1992).

Furthermore, the analysis also revealed a significant relationship between dissociation and shame, suggesting that those who experience higher levels of dissociative experiences during the Home Office interviews showed higher levels of shame. This presents further evidence for the role of shame in psychopathology. Shame has been linked to a variety of psychological problems such as depression (Andrews, 1995), social anxiety (Gilbert & Trower, 1990) and eating disorders (Frank, 1991). However, to the author's knowledge, this is the first study to link shame to dissociative experiences and it is hoped that future research will confirm and extend these results. For example, it would be interesting to explore the mechanisms by which shame interacts with dissociative experiences.

The Relationship of Dissociation to PTSD

The significant relationship between dissociation and PTSD avoidance symptoms confirms the initial hypothesis and speculations by Van Velsen et al. (1996) that dissociation is related to PTSD avoidance symptoms. The results are also in line with the literature showing that dissociative experiences are commonly reported by individuals with a diagnosis of PTSD (Ehler & Clark, 2000; Foa & Hearst-Ikeda, 1996a). It is possible that this has an implication on people's ability to disclose and provide a coherent account during their Home Office interview.

Disclosure Findings

The relationship between difficulty in disclosure and the experimental variables was also investigated. Correlational analyses showed that difficulty in disclosure was significantly associated with a variety of factors, including age, gender, PTSD total and avoidance symptoms, shame, depression, and dissociation during Home Office interviews. These results indicate that difficulty in disclosure increased with age, that women found it more difficult to disclose than men, and that people who found it more difficult to disclose also scored higher on measures of PTSD, shame, depression, and dissociation. This suggests that disclosure is influenced by a variety of factors. Future research could conduct a study to examine the relative contribution of these variables to difficulty in disclosure, however, due to the small sample size this was not possible in the present study. The current results indicate that late or non-disclosure during Home Office interviews does not necessarily mean a lack of honesty on the asylum seeker's part, and highlight that a variety of factors need to be taken into account when judging asylum seekers' credibility based on the information they disclose during these interviews. The findings also suggest that people experience psychological symptoms during their Home Office interview, which seems to impact on their ability to disclose.

The data from the qualitative interviews provide further evidence for the above findings. Perhaps one of the most striking findings of the interview data was that 74 per cent of refugees and asylum seekers talked for the first time about their pre-migration trauma after entering the UK and of those, 65 per cent talked to Home Office officials. These findings suggest that traumatised people tend to avoid talking

about their traumatic experiences, which supports the significant relationship between disclosure and PTSD avoidance behaviours reported in this study. Furthermore, the findings that a high proportion of people with a history of sexual violence still have not disclosed everything to the Home Office is in line with the quantitative results showing a higher rate of difficulties with disclosure in this group.

Factors Impeding Disclosure

The majority (81%) of participants experienced the Home Office interviews as difficult. Many (44%) reported difficulties with disclosing personal details, and frequently cited reasons for this were negative emotions, such as feeling too traumatised by past experiences and feelings of shame, especially for people with a history of sexual torture. This supports the findings of the quantitative analyses that this group is higher on measures of shame and that shame is associated with difficulty in disclosure. It is possible that there were avoidance behaviours at play, such as avoiding thoughts or feelings associated with the trauma and not being able to remember details, which is in line with the findings that PTSD avoidance behaviours are linked to shame and difficulty in disclosure.

The interview data also showed that disclosure was not just based on personal decisions and intra-psychic processes, but also related to interpersonal-, situational-, contextual-, and culture-specific factors, with interpersonal factors emerging as the strongest factor. Sixty-seven per cent said they were afraid the interviewer would judge them negatively, which relates to Gilbert's (1998) concept of external shame. These findings are also in line with those of Finkenauer, Rime and Lerot (1996) demonstrating that non-disclosure of emotional experiences was related to a desire

to avoid shame and the negative judgments of others. The majority of people (70%) also reported that the interviewer did not make them feel very good, and reminded them of police or officials from their home country, which they reported affected their ability to disclose. Furthermore, 70 per cent reported that they did not feel safe during the interview and 12 felt that these negative emotions lasted long after the interview was over; 11 of those were people who disclosed sexual violence in the interview. The findings are in line with results by Brown, Russell and Thornton (1999) showing negative affect post-disclosure in their sample and they are also consistent with Mc Nulty and Wardle (1994) who suggested that disclosing sexual abuse may be a cause of primary psychological distress in itself.

Culture specific factors were cited by 30 per cent of people, all of them had a history of sexual violence. Many of those reported that in their culture sexual issues are not discussed with others and that this prevented them from disclosing sexual issues during their Home Office interview. Most of them also expressed feelings of shame associated with rape and the impact of this on their ability to disclose. These findings are in line with the quantitative results showing a link between shame, difficulty in disclosure and PTSD avoidance symptoms. They are also consistent with the previous research of Hill et al. (1993) and Kelly (1998), demonstrating that sexual issues remain difficult to discuss, even in therapy, as the person often considers these issues shameful. They are also in line with suggestions by Farber and Hall (2002) that non-disclosure of sexual issues might be a reflection of cultural-specific norms of what should be spoken about.

Factors facilitating disclosure

Participants were also asked to make recommendations of what would facilitate disclosure during Home Office interviews and the attitude of the interviewer was cited by the majority of participants. This is in line with previous research by Brown et al. (1999) showing that therapists' qualities of concern, acceptance and non-judgemental listening were cited by their sample of eating disordered inpatients as important factors facilitators of disclosure. Situation- and context-specific factors that were cited as aiding disclosure included meeting the interviewer before, have a trusting person in the room, explaining the interview procedures, and using female interviewers and interpreters for women, especially when the woman has a history of rape. Another issue that came up repeatedly is the poor quality of interpreters. Finally, many also reported difficulties with the screening interview, which they felt had an impact on their mental state and affected their ability to disclose during the main Home Office interview. However, this was not explored further in this paper, but could be a focus for future research.

Finally, it should be noted that, although the difficulties with disclosure seemed to be persistent, many participants did express a willingness to talk about their experiences. However, they were not given the opportunity to do so or were prevented by the interviewer from discussing their experiences. This is an interesting finding and raises questions. One explanation could be vicarious traumatisation of the interviewers, which is a common phenomenon in people working with trauma survivors (Figley, 1995). Indeed, a multidisciplinary analysis of the decision-making process of the Canadian Immigration and Refugee Board showed that coping with vicarious traumatisation and uncontrolled emotional reactions was one of the factors

impacting negatively upon the board member's ability to evaluate credibility and upon the overall conduct of hearings (Rousseau, Crepeau, Foxen & Houle, 2002). However, this needs to be clarified by further research.

Limitations

Several methodological aspects of the current study warrant consideration. The small sample size increased the chance of type II errors, although the highly significant findings suggest that the study had enough statistical power despite the small sample size. With regards to the two experimental groups (sexual vs. non-sexual violence), there is concern about whether some participants in the non-sexual violence group might in fact have not disclosed sexual violation, given the reported difficulties in disclosure in people with a history of sexual trauma. Another limitation was that the sample was not randomly selected and due to the limited availability of a homogeneous sample there is also the chance of a potential sampling bias. However, this study is an applied study of a real life situation, representing the diverse population of refugees going through asylum interviews in the UK. Furthermore, Van Velsen et al. (1996) suggest that sampling biases generally pose a problem in research studies on refugees and asylum seekers, as this population is already exposed to various selection biases. Nevertheless, the above issues restrict the generalisability of the findings and the tentative conclusions outlined in this paper should be considered with this in mind. It is hoped that the findings can be confirmed in a follow-up study.

Although the data were not normally distributed a parametric MANCOVA was used, as there was no non-parametric equivalent. The results of this test therefore need to

be interpreted with caution due to the small sample size. Another shortcoming was that the use of correlational analyses did not allow cause-effect relationships to be investigated. A future study should assess the cause and effect relationship between shame, PTSD and dissociative symptoms by examining whether shame is a primary emotion arising at the time of the traumatic event (peritraumatic shame; see Gilbert, 1997; Gilbert & McGuire, 1998; Nathanson, 1992), or whether shame is a secondary emotion occurring in the aftermath of an event when the individual seeks to understand the meaning and cause of the event through cognitive appraising processes (Brewin, Dalgleish & Joseph, 1996). There is evidence in the literature that secondary shame may be associated with the symptoms of PTSD, which may be perceived as a sign of weakness or an inability to cope (Ehlers & Steil, 1995).

Finally, the lack of a control group restricts the present findings. It would be desirable to find a comparison group of refugees and asylum seekers who had not experienced any kind of violence. The present comparisons were limited as the base rates of PTSD, shame, depression, dissociation and difficulty in disclosure are unknown in this group. Whether there are refugees and asylum seekers who fit these criteria requires further discussion and depends largely on the definition of violence.

Implications of Findings

The above findings have implications for the asylum process. Asylum seekers often come from countries where they experienced or witnessed torture and organised violence, which means that they are in a vulnerable position when entering the UK. Most asylum seekers in the current study experienced the immigration process, including the Home Office interviews, as stressful and anxiety provoking, as many

fear deportation. As seen above, disclosure is a difficult issue in this group; many need time to process past traumatic events and to establish a sufficient level of trust and confidence to reveal the potentially painful and shaming details of their experiences. This needs to be taken into account by an immigration system that requires asylum seekers to make a claim shortly after arrival. It is therefore of paramount importance that sensitivity is used when processing refugee claims and that immigration officials are aware of the needs of asylum seekers in order to avoid inducing further distress in this already highly traumatised group.

The findings also have implication for the current immigration policy. The desire for policies that identify asylum seekers who are fabricating their story and deter immigrants that have left their country for economic reasons seems understandable. However, the current study suggests that legitimate asylum seekers may be punished and retraumatised by the enforcement of them. Furthermore, these policies need to take into account the special needs of victims of sexual violence, particularly since there is a high incidence of shame in this group. Given the significant associations between shame, PTSD avoidance symptoms and difficulty in disclosure, one might speculate that being forced to talk about a traumatic event could potentially activate shame reactions, and that people experiencing more shame are engaging in strategies to avoid this feeling, such as non-disclosure of sensitive personal information. This also highlights the importance of recognising and dealing with asylum seekers' shame in an empathic way. It seems that the immigration officials could benefit from supervision and training about traumatic experiences, such as sexual violence, and the impact of these on people's psychological mental health, affective states, and ability to disclose.

The current results also have clinical implications for working with people with high levels of shame, such as victims of sexual violence. They support that clinical experience of shame in therapy may lead to avoidance behaviours and interfere with the person's ability to disclose if these feelings are not dealt with in a sensitive manner. Lee, Scragg and Turner (2001) highlighted the need to address emotional responses such as shame and guilt when assessing and treating PTSD as the activation of shame and guilt can lead to intrusions and avoidance reactions and interfere with certain treatment techniques for PTSD such as imaginal exposure. Furthermore, feelings of shame may contribute to early treatment dropout or may be the reason why some people never present for treatment in the first place.

Conclusion

The current study has provided some preliminary answers to the research questions of what prevents refugees and asylum seekers exposed to violence from disclosing trauma in the Home Office interviews, and has pointed to areas for future research. The results indicate the importance of shame and psychopathology in disclosure and support the need for immigration procedures sensitive to these issues. The current findings also demonstrate that late or non-disclosure in a Home Office interview does not necessarily signal a lack of honesty, but that disclosure is influenced by a multitude of factors, which can outweigh any individual's requirement to reveal personal details in their Home Office interview.

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PART 3: CRITICAL APPRAISAL

The Challenges of Researching Refugees and Asylum Seekers

ABSTRACT

This critical appraisal will concentrate on the challenges of conducting research with refugees and asylum seekers. The first section looks at methodological issues, such as language and cultural barriers, measurement and sampling issues, and ethical considerations. Section 2 looks at systemic issues, such as post-migratory factors that need to be considered when carrying out cross-cultural research. Section 3 takes a closer look at whether participation in trauma research is potentially harmful for refugees and asylum seekers and presents some preliminary data collected to assess this. It also raises the issue of whether researchers should take a political stance. The arguments presented throughout this paper will be supported by findings from the empirical literature and the current author's experiences.

1. METHODOLOGICAL ISSUES

Language and Cultural Barriers

Language and cultural barriers present an obstacle for cross-cultural research and research with refugees and asylum seekers, as they make the collection of accurate data more difficult, especially if the sample includes participants from diverse language groups. Translated measures and interpreters are typically employed by

researchers to overcome language barriers. However, both approaches have their limitations and need careful consideration.

The process of translating questionnaires is complex and often underestimated by researchers (Bradley, 1994). Translators not only need to be native speakers of the language concerned, but also need to understand the purpose and design of the questionnaire and the individual items, as literal translations often do not guarantee equivalence of meaning, and thus the translator is required to construct a new version of the item. Bradley (1994) also highlights the need for doing back-translation and retranslation: A second translator, who has not seen the original scale, should conduct the back-translation. Discrepancies in the translations then need to be discussed between the two translators and retranslated as necessary. Ideally, any retranslated items should be sent to a third translator for back-translation and then discussed again until there are no further discrepancies. Finally, the translated questionnaire should be treated as a new instrument and the psychometric properties should be assessed to ensure validity and reliability.

The use of interpreters limits the amount of information that can be collected. Presenting measures orally is time-consuming, especially when using scales with multiple-choice answers, which take longer to translate and place more demands on the participant's ability to remember information. A pilot study therefore is vital to check the feasibility of translating measures and the overall length of the interview. The present author found that questionnaires with a simpler Likert scale are better suited when using interpreters, as the interpreter can translate the scale beforehand and then present it visually to the participant during the interview. Another way of

simplifying scales would be through the use of pictorial representations that are meaningful to the individual in terms of their background and culture. This approach is widely used in the learning disability field where numerical rating scales are, for example, replaced with cartoon representations and visual analogue scales aided by descriptive histograms (see Lindsay, 1991).

In line with current participants' recommendations, Tribe and Sanders (2003) point out that the interpreter's own dialect and cultural background must be taken into account as this can influence communication. They also highlight that the interpreter has to gain the refugee's trust first and that a professional interpreter should not take sides for any reason as this can compromise the refugee's trust in the interpreter and the interviewer. Furthermore, there are similar linguistic problems as described above in terms of translating concepts. Tribe (1999) argues that the language of mental health and psychology is based on Western vocabulary and concepts, and that words relating to issues such as trauma and mental health may not have the same 'valence' in another language, or may not even exist. For example, there reportedly is no word in Polish for 'counselling'; the closest approximation translates as 'advice giver' or 'adviser'. She also claims that meaning sometimes cannot simply be translated across languages and she uses the example that there apparently seems to be no easy way to ask someone in Turkish whether they feel depressed. The issue of language and culture also presented a challenge for the current study and required close collaboration with participants and interpreters. Participants were encouraged to let the researcher know when a word or a concept was unclear. For example, many requested an explanation for the questionnaire item 'feeling blue'. Furthermore, both interpreters and participants were asked whether the word 'shame' existed in the

person's native language, as there was some concern that shame might not be a universal concept. However, the majority of participants reported that the concept of shame existed in their culture and many used it as part of their vocabulary. The difference between words and meaning across languages is further demonstrated by a participant quote from the current study:

The word 'rape' in my language sounds so bad and horrible, I would never say it. That's why I did not request an interpreter; I did not want to hear the word 'rape' spoken in my language. It's ok in English but so horrible in my language, it makes me sick when I hear it. [P14]

Tribe and Sanders (2003) highlight the need of providing adequate training for interpreters, specifically when interpreting in the mental health field. To the author's knowledge, there are currently no National Health Service (NHS) guidelines or national qualification frameworks for interpreters, which makes it difficult to determine their level of expertise. The Institute of Linguists accredits a Diploma in Public Sector Interpreting (DPSI), which includes the areas of health, law and local government. There is no equivalent training for mental health though. Working with refugees and asylum seekers also places greater demands on the interpreter; apart from possessing the necessary linguistic skills, interpreters sometimes act as consultants or link workers for service users and clinicians, which means that they need adequate training in mental health. Thus, when working with this group experienced interpreters should be employed. Arranging a pre- and post-consultation meeting with the interpreter may also enhance the quality of the consultation. It is crucial to briefly meet with the interpreter before the session to clarify the nature of

the interview and its objectives, for example whether it is a clinical or research interview, and to provide the interpreter with some background details of the client. Following the interview, it is important to debrief the interpreter and this might also be a good opportunity to find out the interpreter's impression of the meeting or to clarify issues.

Despite the above-mentioned methodological limitations and challenges of using interpreters, there is clinical research showing that the involvement of an interpreter has a positive impact. For example, a study by Hillier, Loshak, Rahman and Marks (1994) found that the use of an interpreter led to a higher return rate of clients following assessment, which was confirmed by participants' self-reports. Anecdotally, the author found a similar trend in the current study in that all participants initially approached with an interpreter subsequently agreed to participate in the study. However, no firm conclusions can be drawn from these findings. These findings suggests that research participation may be enhanced if potential participants are approached initially with the help of an interpreter, even for people whose English is relatively good. Involving an interpreter would also help in explaining the research purpose and process as well as difficult concepts, such as consent and confidentiality. As will be demonstrated below, refugees and asylum seekers often struggle with such concepts, as their understanding of research is often limited.

Measurement Issues

It has been argued that only limited conclusions can be drawn from the literature on refugee research, as many evaluation measures have not been adequately translated

into the refugees' native languages and are not sensitive to their cultural norms (Hollifield et al., 2002). It is indeed debatable whether quantitative measures designed for Western cultures should be used in cross-cultural research, and whether the outcome data from such measures are valid and meaningful. There are several reliable and culturally sensitive screening instruments of trauma exposure and psychiatric distress that have been validated in a variety of refugee communities and across a wide variety of cultures, and many have been translated into several different languages. The Hopkins Symptom Checklist-25 (HSCL-25; Derogatis, Lipman, Rickels, Uhlenhuth & Covi, 1974) is one of these. Researchers should use culturally sensitive measures, where available. When not available, there is a dilemma of whether to use standard measures that have not been validated across cultures, or to develop more appropriate measures first? There are no doubt valid arguments for both sides. However, one risk of taking the latter stance is that less or no research will be conducted, as the development of new measures is complex and time-consuming. A possible solution might be to use triangulation of research findings to ensure validity and reliability, such as combining qualitative and quantitative measures in the same study.

In terms of the current study, an attempt was made to address these issues by using, where available, measures that have been used in similar populations and by using triangulation of data. The PSS-I was chosen as it requires less assessment time and has been used with several refugee populations. The HSCL-25 was selected due to its high cross-cultural validity. The present study also used a shame scale (ESS) that was developed in the UK and standardised on university students, which might not adequately measure shame in other cultures. Similar issues apply to the measure of

dissociative experiences (PDEQ-SRV), which has been standardised on predominantly Caucasian populations. However, the qualitative data confirmed that some participants experienced high levels of shame and some reported dissociative experiences, which lends support to the outcome data from these two scales. Nevertheless, the issue of applicability of measures is still a valid one and restrict the validity of the outcome data.

Ethical Considerations

The current research study also raises some ethical considerations. Refugees and asylum seekers are often not familiar with the concept of research or the research process. Those who have been persecuted by authorities in the past may be understandably suspicious of researchers inquiring into their backgrounds. This has a potential impact on the validity of the research findings as participants may be reluctant to tell researchers about their experiences, or they might portray their experiences in a certain light in the hope that it might somehow help them. In the present study, some people became very suspicious when hearing the word 'Home Office' and they were afraid that the researcher was working for the Home Office, whereas others hoped their participation would have a favourable impact on their asylum application. This shows the need for taking time to clearly explain issues, such as confidentiality and consent, in language participants understand well.

The current study also found that procedures initially designed to protect participants, such as signing a consent form and conducting interviews in a separate room to protect their confidentiality, often had the opposite effect. For example, many of the participants were reluctant to sign the consent for fear that they might be

identified, and some wanted to be interviewed as a group, which made them feel more relaxed and confident. Several also did not want their interview to be taped, which made collecting the interview data more difficult. This demonstrates that researchers need to be flexible when conducting research with refugees and asylum seekers and that there needs to be a greater awareness that research procedures that are taken as granted in Western culture may not apply cross-culturally.

Furthermore, the vulnerability of this group needs to be considered when designing research. Many refugees and asylum seekers are isolated, experience many psychosocial problems, and may have limited contact with professionals. This may lead to the researcher being seen as a friend or mistakenly identified as someone who could help them in the future. For example, the current researcher had an experience where a highly distressed participant, who was informed earlier that day that her asylum application had been declined, called her at one o'clock in the morning. She said her reasons for calling were that she had felt listened to and understood by the researcher when interviewed previously, and she hoped that the researcher could influence the court decision. This incident hopefully shows that research procedures, such as handing out personal phone numbers, need to be re-evaluated when conducting research with refugees and asylum seekers to protect both the researcher and the participants. The author feels that this is a particular issue for the Doctorate in Clinical Psychology where students are under increased pressure to complete a research study within a particular time-frame and often receive very little support in the data collection. This means that common research procedures, such as not handing out personal phone numbers to participants, sometimes need to be adapted. The incident described above also shows the need for providing participants with

more information on the role of the researcher and whom they can contact if they need help.

Sampling Issues

It has been argued that research studies on refugees and asylum seekers have an increased chance of sampling and selection biases, especially when the sample consists of participants from different cultural backgrounds. Please refer to page 114 of the empirical paper for a fuller discussion.

The above paragraphs stress that there are a variety of methodological difficulties that need careful consideration when conducting research with refugees and asylum seekers. Researchers need to carefully think about the feasibility of certain methods. For example, is it feasible to properly translate measures and check for reliability and validity following the above recommended guidelines? Or to produce new measures that are culturally valid? They also need to be aware that this research is time-consuming and costly, requiring funding. This is in stark contrast with the pressures from research bodies and services for quick and cost effective research that helps to improve services. This also raises questions for the research process, such as how research should be conducted and how it can be improved. The following paragraphs will discuss these issues further.

2. SYSTEMIC ISSUES

Research studies on mental health issues in refugees and asylum seekers often fail to take into account the wider systemic context in which refugees and asylum seekers find themselves, such as the effects of post-migratory factors on psychological well-

being. It is still a common assumption that refugees' and asylum seekers' distress is caused by the traumatic experiences they suffered in their country of origin, and other factors, such as refugeedom itself, have largely been neglected by the research literature (Summerfield, 1995). This is highlighted by the fact that symptoms of Posttraumatic Stress Disorder (PTSD) have been widely used in the research literature to measure traumatisation in refugees and asylum seekers. However, Summerfield (1995) argues:

In summary, traumatic experience needs to be conceptualised in terms of a dynamic, two-way interaction between the victimised individual and the surrounding society, evolving over time, and not only as a relatively static, circumscribable entity to be located and addressed within the individual psychology of those affected.

There is a growing literature pointing to the cumulative effects of both pre- and post-migration factors on psychopathology. Silove, Sinnerbrink, Field, Manicavasagar and Steel (1997) concluded that post-migratory living stressors might interact and potentially exacerbate psychiatric symptoms in asylum seekers. They also showed that the prolonged process of determination of asylum applications has a significant impact on the asylum seeker's mood state and maintenance of traumatic stress symptoms. It is vital that factors of exile are taken into account by researchers when planning and conducting a study, but also when interpreting and evaluating research findings. Research that limits the causal factors for refugees' well-being to pre-migratory events essentially ignores the context of the person's suffering and therefore the validity of the results is questionable.

With respect to the current study, it was not possible to account for post- migratory factors because of the limitations in data collection, such as the small number of participants that could be interviewed and the time taken to interview participants using interpreters. This limited the power of the statistical analyses that could be undertaken. There is a possibility that the experiences of trauma, depression, shame and dissociation could have been related to post-migratory factors as well as trauma-event factors, and this remains an open question. With regard to the issue of applicability of PTSD concepts, whilst the concerns of a universal and Western concept of trauma certainly need to be considered, many people in the current study clearly did suffer from acute psychological reactions, including the symptoms of PTSD, which need to be recognised and worked with. We need to be sure, however, that we are not just recognising the symptoms, but also evaluating their significance with reference to the refugee's sense of what matters. This is highlighted by a letter the present researcher received from a group of participants, which was written following their participation in the research interview. They were concerned that the study on disclosure during Home Office interviews potentially ignores wider issues, such as factors of exile and governmental policies:

The problem with the [interview] questions is that they make it seem as if by just making some small changes, it would be possible for our cases to have a fair hearing. But we know and all the women in our group know, that the problem is that the government has its target numbers to return people. Even if the interviewers were more polite it wouldn't change the fact that the instructions they have from the government is to find a reason to turn us down no matter what we have suffered. They always say we are "bogus" and they don't want to know anything

about what happened to us. The way we are treated - the questions they ask, the disbelief, the hostility, the lies and abuse in the media, being left destitute, being fearful to go out at night, imprisoned in our home even if we have a roof over our head - all this is torture but its not recognised as that. If your recommendations ignore the context of the inhumane laws and policies you will be misrepresenting our experience. How can we trust a government to give any of us a fair hearing when it doesn't care whether we live or die?

The above quote shows the need for explaining the research process and the limitations of the research to people. It also raises questions, such as whether refugees and asylum seekers should be more involved in research, and whether researchers have a responsibility to ensure that their research promotes the interests of those they are researching, which leads to the more general question of whether research should be value-free or a political exercise. These issues will be discussed in more detail in the following section.

3. RESEARCH PARTICIPATION

There is concern expressed in the literature about potential harm to trauma survivors through involvement in psychological research. Emotional distress has been cited as a potential risk factor for trauma survivors participating in research, especially when the trauma is of a sexual nature, with further concerns raised about the impact of this distress on people's ability to give informed consent (Draucker, 1999; DuMont & Stermac, 1996; Templeton, 1993). Another main concern raised is participants' ability to decline research participation (Castor-Lewis, 1988), which is explained by power differences between researchers/therapists/physicians and potential

participants (Draucker, 1999). However, these concerns have not been widely investigated or supported by empirical research. There is evidence that trauma survivors find participation in trauma research a positive experience and are able to cope with the distress that arises, even for those participants who experience a high number of PTSD symptoms (Griffin, Resick, Waldrop & Mechanic, 2003; Newman, Walker & Gefland, 1999; Walker, Newman, Koss & Bernstein, 1997).

There is even less data on the participation of traumatised refugees and asylum seekers in research, with some authors warning about the potential harmful effects (Hundeide, 1995; Knudsen, 1992) and others suggesting beneficial effects, as shown in a study by Dyregrov, Dyregrov and Raundalen (2000) on refugee families' experience of research participation. Their sample rated participation as positive, with this positive effect seemingly related to being given the opportunity to tell their story and assign meaning to their experiences.

Concerns about the possibility of the current study causing distress were first raised by the ethics committee, and approval was only granted under special circumstances mentioned below, which suggests that research with refugees and asylum seekers raises more concerns than other types of research. The following quote was taken from a letter addressed to the researcher by the ethics committee:

The Committee would like to have more regular feedback about the study than is usually required and would like to be notified about how the study is progressing on a six monthly basis. If significant problems arise on a more regular basis, the Committee would also like to be informed of this.

The above concerns were also reflected in the attitude of many refugee workers, who were reluctant to give the current researcher access to their sample, or in some cases, denied access completely for fear of retraumatising their clients (despite the fact that the study had gained ethical approval and these concerns had already been addressed). Below is a quote from a professional working with refugees that highlights these concerns:

The concerns that arise from the subject of your research are indeed linked to the well-being of the client. Which is why our caseworkers are concerned that the interview might induce re-traumatisation which they want to avoid in the first place and also they feel they may not be in a position to provide the adequate clinical support if necessary.

It was the current researcher's experience that some professionals took on the role of the client's protector assuming that they knew what was best for them, without asking the person's opinion. This attitude is supported by Bracken, Giller and Summerfield (1997):

Because of their knowledge, doctors and other professionals have become the prime authenticators of suffering and legitimators of the sick-role and now stand as 'gatekeepers' to many of these victim groups.

In light of the above, refugees' and asylum seekers' experiences of being involved in research were assessed in the current study by means of a questionnaire that was

completed at the end of the research interview. This questionnaire was designed by Professor Chris Brewin and colleagues and has been used to assess people's opinions and experiences of being involved in trauma research (Research Participation Questionnaire, unpublished reference). Participants rated their answers on a 5-point scale, ranging from 1 (strongly disagree) to 5 (strongly agree), with items assessing experience of research participation, distress, informed consent, and ability to decline or terminate participation. These data were not included in the empirical paper. A copy of the questionnaire can be found in Appendix 13.

Twenty-six people completed the questionnaire. Findings show that the majority of participants were glad to be in the study (N=21, 81%), felt it was their choice to participate and that they could have said no (N=25, 96%), felt good about being in the study (N=15, 58%), felt good about helping others by being in this study (N=22, 85%), and knew that they could skip questions, stop or take a break (N=22, 85%). When asked whether participation made them feel upset or sad, 10 (38%) agreed/strongly agreed, 10 (38%) disagreed/ strongly disagreed, and 6 (24%) were in the middle. 24 (92%) disagreed/strongly disagreed when asked whether they regretted taking part in the study. These findings are in line with those by Dyregrov et al. (2000) showing that participants rated their involvement as positive, despite some feeling upset or sad. The findings that participants reported that they felt able to stop or refuse participation do not support the concerns raised by Castor-Lewis (1988) that people who have been sexually violated may be less likely to discontinue or refuse research participation.

The previous and current findings show that the involvement of refugees and asylum seekers in research can have some beneficial effects for the participants and is not as harmful as sometimes perceived. It would be misguided to argue that research involving refugees and asylum seekers should not be conducted because of the potential harm to the participants. Refugees and asylum seekers are vulnerable groups, who often have suffered torture and organized violence, and it is understandable that professionals working with refugees sometimes feel overprotective towards them. However, one could argue that this attitude might prevent them from making their own choices and potentially disempower them to an even greater extent. It also fails to consider that many refugees and asylum seekers might want to tell their story.

The above findings raise interesting questions. Is there something about refugee and asylum seeker research in particular that causes such wide concerns, or are there the same concerns when researching Western populations who have experienced lives of hardship and trauma? For example, the literature has shown that people with severe mental illness, such as schizophrenia, have high rates of trauma exposure, including childhood sexual or physical abuse and other types of victimisation, which puts them at increased risk for PTSD (Mueser, Rosenberg, Jankowski, Hamblen & Descamps, 2004). One could argue that this makes them a vulnerable group requiring protection. However, there is a lot more research conducted on psychosis than refugees and asylum seekers: a search on the complete PsychInfo databases has rendered 2121 results for refugees, 145 for asylum seekers and, in contrast, 26898 results for psychosis, which might suggest that there are less concerns regarding research participation of this group. Furthermore, in other areas of psychology there is an

emphasis on service user involvement in research. For example, UK learning disabilities researchers are actively striving to enhance the involvement and empowerment of 'vulnerable people' (Clements, Rapley & Cummins, 1999a), especially following the 2001 White Paper *Valuing People* (see Oliver, 1992; Zarb, 1992). Perhaps greater involvement of refugees and asylum seekers in research would help to minimise the potential for inducing distress.

Walmsley (2005) argues for changing relationships between researchers and participants and the development of research within user organisations. He proposes that this change could be accomplished by changing the role of the researcher to that of an expert advisor to client groups and organisations. This expert consultant would ensure that the standard research procedures are followed, but also that users are educated and taught about research skills, which would enable them to take a more active role in research and give them the tools to critically evaluate existing research. The current author goes one step further by arguing that the service users can also teach the researcher about important issues, such as cultural matters, and this interchange of ideas would be an important step in producing more culturally valid research.

Walmsley (2005) furthermore raises the question whether researchers have a responsibility to promote the interests of their sample in terms of acting as their advocates, ensuring that the results reach them, and carrying out research that is relevant and applicable. This also raises the issue whether research can be value free, a currently hot topic within the social sciences, and whether psychologists and researchers should take a political stance. Some argue that psychology is an unbiased

profession and that science should be apolitical with the data standing alone, whereas others suggest that research aimed at improving people's lives and circumstances can never be apolitical. The author agrees with the two following quotes:

Whatever the likes and intentions of the researcher, cross-cultural psychological research is never a value-free, apolitical exercise. (Warwick, 1980: 324).

Researchers cannot change the world, but they can make small incremental changes, and they can, and should continue to debate ways in which the voices of those who are usually excluded can speak loud and clear within the research community, to argue that what matters to them is what researchers should attend to. (Walmsley, 2005: 23).

The above paragraphs suggest that there are a number of difficulties in cross-cultural research and that there are no easy answers in solving these. However, it is the author's view that refugees and asylum seekers have a right to be involved in research and that it is unethical to exclude them from it. Not doing this research means that we might miss out on important information that could help this group. Sensitivity is important when approaching traumatised individuals with research interviews and questionnaires, and it is paramount that the researcher has appropriate training to conduct research with this vulnerable population.

4. CONCLUSION

Cross-cultural research presents with a variety of challenges and requires time, funding, flexibility and careful consideration to adequately deal with these challenges. It is important to acknowledge the difficulties of this research and explain to participants the limitations of what can be done. The author feels that there needs to be a greater debate within the research community on how to conduct research with refugees and asylum seekers and how this research might differ from other types of research. At the moment, this area raises more questions than answers. Do we lower our research standards to accommodate the needs of this group? Should the limitations stop us conducting research? Or would there still be an acceptable way of conducting research without essentially compromising the reliability and validity of the results? If anything, the author hopes that this critical appraisal has demonstrated that, despite the various challenges and limitation, research in this field is imperative and that there is room for improvement.

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APPENDICES

Appendix 1: Ethical approval letter

Camden & Islington Community
Local Research Ethics Committee
Room 3/14
Third Floor, West Wing
St Pancras Hospital
4 St Pancras Way
London
NW1 0PE

13 October 2004

Ms Diana Bogner
Trainee Clinical Psychologist
University College London

Dear Ms Bogner,

Full title of study: What Prevents Asylum Seekers from Disclosing Trauma
REC reference number:
Protocol number:

Thank you for your letter of 05 October 2004, responding to the Committee's request for further information on the above research.

The further information has been considered on behalf of the Committee by the Chair, Matthew Lewin and Dr Sonia Johnson.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation.

The favourable opinion applies to the following research site:

Site: Camden and Islington Mental Health and Social Care Trust

Principal Investigator: Ms Diana Bogner

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

You are also asked to comply with the conditions specified in the Committee's letter of 16 September 2004 and agreed to in your letter of 05 October 2004. Specifically, that you will ensure the participant information sheet is translated into additional

languages as necessary, and submit copies to the Committee when this occurs and that you will provide feedback to the Committee on a six-monthly basis or, if significant problems arise, more frequently.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document Type: Application
Version: 1
Dated: 07/04/2004
Date Received: 07/04/2004

Document Type: Investigator CV
Version:
Dated: 30/03/2004
Date Received: 07/04/2004

Document Type: Protocol
Version:
Dated: 30/03/2004
Date Received: 07/04/2004

Document Type: Letter from Sponsor
Version:
Dated: 19/03/2004
Date Received: 07/04/2004

Document Type: Peer Review
Version:
Dated: 03/12/2003
Date Received: 07/04/2004

Document Type: Participant Information Sheet
Version:
Dated: 31/03/2004
Date Received: 07/04/2004

Document Type: Participant Information Sheet
Version: Albanian
Dated: 26/08/2004
Date Received: 26/08/2004

Document Type: Participant Consent Form
Version:
Dated: 31/03/2004
Date Received: 07/04/2004

Document Type: Response to Request for Further Information
Version: 1
Dated: 24/08/2004
Date Received: 26/08/2004

Document Type: Response to Request for Further Information
Version:
Dated: 05/10/2004
Date Received: 05/10/2004

Document Type: Other
Version:
Dated: 31/03/2004
Date Received: 07/04/2004

Management approval

The study may not commence until final management approval has been confirmed by the organisation hosting the research.

All researchers and research collaborators who will be participating in the research must obtain management approval from the relevant host organisation before commencing any research procedures. Where a substantive contract is not held with the host organisation, it may be necessary for an honorary contract to be issued before approval for the research can be given.

Notification of other bodies

We shall notify the R&D Department of the North Central London Research Consortium that the study has a favourable ethical opinion.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

REC reference number:	**Please quote this number on all correspondence**

Yours sincerely,

Stephanie Ellis
Chair

Enclosures Standard approval conditions

Appendix 2: Consent form

Camden and Islington NHS
Mental Health and Social Care Trust

CONSENT FORM

Title of Project: What Prevents Asylum Seekers from Disclosing Trauma?

1. **I agree to take part in this study.**

(Participant's mother tongue, will be filled in by the interpreter before the start of the interview)

2. **I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.**

(Participant's mother tongue, will be filled in by the interpreter before the start of the interview)

3. **I confirm that I understand what the above study involves and have had the opportunity to ask questions.**

(Participant's mother tongue, will be filled in by the interpreter before the start of the interview)

Name of Participant	Date	Signature
Researcher	Date	Signature

Appendix 3: Patient Information Sheet

Camden and Islington NHS
Mental Health and Social Care Trust

Study title: Refugees' and Asylum Seekers' Experiences of Legal Interviews.

We are currently asking people if they would like to participate in a research study. Before you decide whether you would like to take part I will explain a little bit about the study to you, why the research is being done and what it will involve. Please ask if there is anything that is not clear or if you would like more information.

What is the purpose of the study?
We are interested in your experience of the asylum interviews. A lot of refugees and asylum seekers attending our service frequently report that they found it difficult to answer personal questions during their asylum interviews. We would like to know more about what specifically made it difficult for you in these interviews to open up and what could have been done differently to make it easier for you. We are also aware that you have had some traumatic experiences in the past and would like to find out whether this had an impact on your interviews. We are therefore approaching refugees and asylum seekers to invite them for a one-off interview.

Do I have to take part?
It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect your current treatment or any treatments you will receive in the future.

What will happen to me if I take part?
The interview will be held at a location convenient for you and last for approximately an hour. You will be interviewed by a female team member together with an interpreter about your experience of the asylum interviews. There will also be a few questionnaires that need to be filled out. These will be translated by the interpreter and help us to find out more about how your past experiences are affecting you now. The interview will be recorded on tape, which helps us to remember and write down afterwards exactly what you said. You can stop the interview at any time.

Benefits and Risks
We are hoping that with this research we will be able to find out more about the asylum interviews and how to improve them, which will hopefully benefit other asylum seekers entering the UK. **You will not be expected to talk about any of your traumatic experiences directly.** However, if the interview caused you distress in any way you can come and talk about this with your therapist or caseworker.

Will my taking part in this study be kept confidential?
All information which is collected about you during the course of the research will be kept strictly confidential. Any information about you will have your name and

address removed so that you cannot be recognised from it. Only the researchers and a representative of the Research Ethics Committee will have access to the data collected during this study.

What are the arrangements for compensation?
The Camden & Islington Local Research Ethics Committee has approved this project. If you are harmed by taking part in this research project, there are no special compensation arrangements. If you are harmed due to someone's negligence, then you may have grounds for a legal action but you may have to pay for it. Regardless of this, if you wish to complain, or have any concerns about any aspect of the way you have been approached or treated during the course of this study, the normal National Health Service complaints mechanisms should be available to you.

Who do I speak to if problems arise?
If you have any complaints about the way in which this research project has been, or is being conducted, please, in the first instance, discuss them with the researcher. If the problems are not resolved, or you wish to comment in any other way, please contact the Chairman of the Research Ethics Committee by post via the Camden & Islington Local Research Ethics Committee administration, Room 314, Third Floor, West Wing, St Pancras Hospital, 4 St Pancras Way, London NW1 0PE, or if urgent, by telephone on 020 7530 3799.

What will happen to the results of the research study?
You will be informed about the results of the study once it is written up. We are trying to publish these results and you will obtain a copy if this happens. Please also be advised that you will not be identified in any publication.

Contact for further information
Please feel welcome to ask questions or discuss any worries you have about the study with your therapist. You can also contact us via telephone and we will be happy to answer your questions.

Diana Bogner
Trainee Clinical Psychologist
University College London

Tel: [researcher's mobile phone number]

Thank you very much!

Appendix 4: Covering letter

Camden and Islington NHS
Mental Health and Social Care Trust

[Date]

Diana Bögner
Traumatic Stress Clinic
73 Charlotte Street
London W1T 4PL

Dear [participant's name]

My name is Diana Bögner. I am a trainee clinical psychologist and currently doing a research study at the Traumatic Stress Clinic. Dr Jane Herlihy is my supervisor there and oversees the study.

I am presently contacting refugees and asylum seekers attending the Traumatic Stress Clinic to ask them whether they would like to participate in my study. I have included an information sheet, which will explain to you what the study is about. I would appreciate it if you could spare a few minutes and read through the enclosed sheet. Please note that participation is completely voluntary.

I will be contacting you in a few weeks time to see whether you would like to get involved. You will also have a chance to ask me any questions you might have then.

Alternatively, you are welcome to contact me on [researcher's mobile phone number] if you would like to participate or simply to ask me any further questions.

Thank you very much for your time!

Yours sincerely,

Diana Bögner

Appendix 5: Translated patient information sheet (Albanian version)

Ju jeni të përfshirë të merrni pjesë në një studim hulumtus. Para se të vendosni se a do të merrni pjesë unë do t'ju shpjegoj pak më shumë për këtë studim. Pse do të hulumtojm dhe qka do të përfshijme. Ju lutem pyetni nëse diçka nuk është e qartë ose keni nevoj për më shumë informacione.

Çka është qëllimi i këtij studimi? Dhe pse jamë zgjedhur unë?
Ne jemi të interesuar për eksperiencën e juaj të intervistës se azilit. Shumë refugjate vijn tek ne, në sherbimin tonë frekuentojn-reportojn, sa veshtirë është të përgjigjen në pyetje personale gjatë intervistes për azilin e tyre. Ne kemi deshirë të dijmë më shumë përse veqanerisht është veshtirë për ju në këto intervista të qeleni (apo hapeni) dhe çka është deshtë të bëhet ndryshe që të jetë më lehtë për ju. Ne gjithashtu jemi të vetëdijshm se ju keni pas një eksperiencë traumatike në të kaluaren dhe kemi deshirë të dijmë se a ka ndikim kjo me intrevisten e juaj. Dhe për këtë arsye i ftojmë refugjatet që janë të pranishme në kliniken tonë për një intervistë.

A duhët unë me marrë pjesë?
Ky është vendimi i juaj, a merrni pjëse apo jo. Në qoftë se vendosni të merrni pjesë do t'ju pyesim ta nënshkruani një form me pelqimin e juaj. Nëse mendoni të merrni pjesë ju jeni ende të lirë të tërhiqeni në gjdo kohë gjatë këtij studimi dhe pa dhënë asnjë arsyetim. Vendimi të tërhiqeni në gjdo kohë ose vendimi të mos vazhdoni më nuk ka kurfarë efekti në trajtimin e tanishëm ose në trajtimet e tjera që do t'ju afrojmë në të ardhmen.

Çka do të ndodh me mua në qoftë se unë marrë pjesë.
Intervista do të mbahët në klinik këtu dhe do të zgjatë përafërsisht një orë. Intervista do të mbahet me ndonjëren nga kolleget e mija femra, së bashku me përkthysen për experiencen e juaj ne lidhje me intervisten e azilit. Gjithashtu janë edhe disa forma të tjera që duhet të mbushen. Kjo bëhet me ndihmen e perkthyeses / perkthyesit të na ndihmon neve të dijmë më shumë se si experienca e se kaluares ju mundon/efekton tani. Intervista do të regjistrohet në një kasetë e cila do të na ndihmon neve të mbajmë në mend dhe ta shkruajmë saktësisht se çka keni thanë. Ju mund të nderpreni/ndaloni intervisten në gjdo kohë.

Perfitimi dhe Rreziku?
Ne shpresojmë se ky hulumtim do t'na mundeson të zbulojm me shumë për intervistat e azilit, dhe si ti permirsojmë ato, me shpres që t'ju ndihmojm azil kërkuesve apo refurgjatve të tjerë të cilët hyjen në Angli. Nuk pritet nga ju që të folni për eksperiencen traumatike direkt. Mëgjithatë, në qoftë se intervista ju shkakton mërzi në gjdo aspektë ju mundeni te vijeni tek unë më biseduar për këtë në sesionin e juaj.

A do të jetë pjesëmarrja ime në këtë studim sekretë?
Të gjitha informacionet të cilat do ti mbledhim gjatë këtij hulumtimi do të mbahen rreptsisht sekret. Gjdo informacion rreth juve që del jashtë nga klinika do t'ju shlyhet emri dhe adresa, që të mos njiheni nga kjo.

Çka do të ndodhë më rezultatet e studimeve hulumtuese?
Do t'ju informojmë për rezultatet e hulumtimit mbasi që ti shkruajem.
Ne po mundohemi ta provojmë ti botojm/publikojm këto rezultate dhe ju siguroj një kopi në qoftë se kjo ndodhë. Ju lutem të jeni të këshilluar se ju nuk do të jeni të identifikuar në publikim ose botim.

Kontakto për informacione të më tutjeshme.

Ju lutem ndjëhuni të mirëseardhur të pyetni për gjdo pyetje ose shqetësim në lidhje me studimet. Ju mundeni gjithashtu të me tregoni herën tjeter, kur të takohemi së bashku nëse deshironi të merrni pjesë apo nuk deshiron të merrni pjesë.

Ju faleminderoj shumë!

Appendix 6: Translated patient information sheet (Turkish version)

Arastirma Basligi
Multeciler ve iltica basvurusu yapanlrin hukuki gorusmelerdeki tecrubeleri

Biz bu klinige gelen herkesin bu arastirmaya katlilimini bekliyoruz. Kararinizi bildirmeden once ben konu basligimizi kisa olarak acikliyayim. Bu arastirmayi nicin gerekli gorduk ve kimleri ilgilendiriyor. Lutfen anlamadigniz veya anlasilmayan herhangi bir sey varsa veya daha fazla bilgi istiyorsaniz sorunuz.

Arastirmanin amaci
Biz sizin yasamis oldugunuz hukuki gorusmeler sirasindaki tecrubeyi ogrenmek istiryouz. Bircok multici ve iltica basvurusu yapanlarin bizim kliniginize geldikleri zaman soyledikleri, hukuki gorusmeler sirasinda sorulan ozel sorulari veveplandirmada zorlandiklari ve biz bu konuda daha fazla bilgi sahahibi olmak ve ozellikle zorlandigiginiz bolumlerde duzeltme yapilmasi icin daha fazla ne yapilabilir.

Biz biliyoruzki gecmiste travmatik tecrublerden gecmis ve bunun sizi gorsmeler sirasinda etkileyip etkilemedingini anlamak istiryouz. Bu sebepten dolayi klinigimize gelmekte olan multeci ve iltica basvurusu yapanlarin katilimini ve bir gorusme yapmamizi rica ediyoruz.

Katilmam gerekli mi?
Tamamiyla katilip katilamamak size kalmistir. Eger katilmaya karar verirseniz bir izin kagidi imzalamaniz rica olunacaktir. Eger katildiktan herhangi bir zaman sonra gerekce gostermeksizin ayrilabilirsiniz. Bu karaninizi oncesi veya sonrasi icin kullanabilirsiniz ve kararinz sizin almakta oldugunuz veya ilerde alacaginiz tedaviyi hicbir sekilde etkilemeyecektir.

Katildigim taktirde bana ne olacak
Gorusme bu klinikte olmak uzere tahminen bir saat kadar surecektir. Gorsmeler bayan gorevli ve onun tercumani aracigiyla basinizdan gecen hukuki tecrubeleri dinleyecektir. Gorusmeler sirasinda birkac anket sorusu formumlari doldurmaniz istenecektir. Bu cevaplariniz tercuman trafindan cevrilecek ve bizim sizin gicmisinizle ilgili daha genis bilgi sahibi olmamizi ve sizi su anda nasil etkildeigini anlamaniza faydasi olacaktir. Gorusmeler radyo kasete cekilip daha sonra yazmimda kullanilmak icin aynen sizin ifadenizi hatirlamami saglayacaktir. Gorusmeyi herhangi bir zamanda durdurabilirziniz.

Faydalari ve riskleri
Biz umit ediyoruzki arastirmalar saysinde signmacilarin hukuki gorusmeleriyle ilgili daha fazla bilgi toplar ve bununla ilgili nasil duzeltme yapilabilecegini ve bununda ingiltereye gelen signmacilarda faydasi olacaktir. Direk olarak gecmisinizdeki travmatik tecrubenizle ilgili konusmaniz beklenmiyor. Bu gorusmeler sirasinda herhangi bir sikintiniz olusa terapistinize gelip konusabilirsiniz.

Arastirmaya katildigim takitirde konusulanlar gizli kalacak mi?
Arastirma icin sizden alinan butun bilgiler kesinlikle gizli tutulacaktir. Alinan herhangi bir bilgide sizin isminiz veya adresiniz varsa silinecek ve buda sizin

taninmamanizi saglayacaktir. Sadece arastrmaci ve arastirmaya katilan beli kisiler trafindan bakilmasina izin veilecektir.

Tazminatlik anlasmasi neler?
Camden ve Islington Local Research Ethics Commitee bu projeye destek sunmustur. Eger bu arastrumaya katlmanizdan dolayi bir zarar gorurseniz bununla ilgili herhange bir tezminat veya bedel anlasmasi yapilmamistir.

Eger konuyla ilgile kanuni islem yapilmasini isterseniz? Yapabilirziniz fakat odemeleri sizin yapmaniz gerekiyor. Eger arastirmalar sirasinda bir sikayetiniz olursa veya herhangi bir konuyla ilgili endiseniz olursa sikayet edebileceginiz yer: National Health Service makanismalari sizin ici hazir olacaktir.

Herhangi bir sorun karsisinda tanisabilecegim kisi?
Eger herhangi bir sikayetiniz arastirmalar sirasinda olursa lutfen bunu oncelikle arastirmaci kisi ile konusun. Eger sourn cozulmes ve herhangi bir elestiriniz varsa lutfen komite sorumlusu onlan kisiyle yazili olarak temasa geciniz.
Chairman of the Research Ethics Committee
Camden & Islington Local Research Ethics Committe adinistration
Room 314, Third Floor
West Wing
St Pancras Hospital
4 St Pancras Way
London NW1 0PE

0207 530 3799 telefon acabilirsiniz.

Arastirma sunucu ne olacak?
Yazim islemleri bittikten sonra siz arastirmayala ilgili bilgilendirleceksiniz. Arastirma sonucunu yayinlamya calisacagiz ki siz de bir kopyasini alabilirsiniz. Yaginlarimizda isminizin belirtilemsini istemiyorsaniz lutfen belirtiniz.

Bilgi icin ulasabileceginiz yerler
Lutfen sormak istediginiz veya endisenizle ilgili konusmak isterseniz veya herhangi bir konuda konusmak isterseniz terapistinizle konusabilirsiniz. Bunun yani sira telefonla ulasmak isterseniz, ulasabilegeginiz kisiler:

Diane Bogner
Trainee Clinical Psychologist

Dr Jane Herlihy
Clinical Psychologist

The Traumatic Stress Clinic
73 Charlotte Street
London W1T 4PL
Tel: 0207 530 3666

Katilan herkese tesekurlerimizi sunariz!

Appendix 7: PTSD Symptom Scale

For each item listed below, ascertain whether the individual experienced the symptoms during the past two weeks. Probe all positive responses in order to determine the severity of the symptoms (e.g., in the past two weeks, how often have you had bad dreams or nightmares), then rate the severity on the scale presented below.

Rating Scale (ratings made over the last 2 weeks)

0 = Not at all
1 = Once per week or less / a little bit / once in a while
2 = 2-4 times per week / somewhat / half the time
3 = 5 or more times per week / very much / almost always

Re-experiencing Symptoms (need one)

___ 1. Have you had recurrent or intrusive distressing thoughts or recollections about the traumatic event?

___ 2. Have you been having recurrent bad dreams about the traumatic event?

___ 3. Have you had the experience of suddenly reliving the assault, flashbacks of it, acting or feeling as if it were re-occurring?

___ 4. Have you been intensely emotionally upset when reminded of the traumatic event?

Avoidance Symptoms (need three)

___ 5. Have you persistently been making efforts to avoid thoughts or feelings associated with the traumatic event?

___ 6. Have you persistently been making efforts to avoid activities, situations, or places that remind you of the traumatic event?

___ 7. are there any important aspects of the traumatic event that you still cannot remember?

___ 8. Have you markedly lost interest in free time activities since the traumatic event?

___ 9. Have you felt detached or cut off from others around you since the traumatic event?

___ 10. Have you felt that your ability to experience emotions is less?

___ 11. Have you felt that any future plans or hopes have changed because of the traumatic event?

Arousal Symptoms (need two)

___ 12. Have you been having persistent difficulty falling or staying asleep?

___ 13. Have you been continuously irritable or having outbursts of anger?

___ 14. Have you been having persistent difficulty concentrating?

___ 15. Are you overly alert since the traumatic event?

___ 16. Have you been jumpier, more easily startled, since the traumatic event?

___ 17. Have you been having intense physical reactions when reminded of the traumatic event?

Appendix 8: Hopkins Symptom Checklist – Depression

Listed below are symptoms or problems that people sometimes have. Please read each one carefully and describe how much the symptom bothered you or distressed you **in the last week, including today.** Place a check in the appropriate column.

No.	Depression Symptoms	1 Not at all	2 A little	3 Quite a bit	4 Extremely
1	Feeling low in energy, slowed down				
2	Blaming yourself for things				
3	Crying easily				
4	Loss of sexual interest or pleasure				
5	Poor appetite				
6	Difficulty falling asleep, staying asleep				
7	Feeling hopeless about future				
8	Feeling blue				
9	Feeling lonely				
10	Thoughts of ending your life				
11	Feelings of being trapped or caught				
12	Worry too much about things				
13	Feeling no interest in things				
14	Feeling everything is an effort				
15	Feeling of worthlessness				

Appendix 9: Experience of Shame Scale

Everybody at times can feel embarrassed, self-conscious or ashamed. These questions are about such feelings if they have occurred **at any time in the past year**. There are no 'right' or 'wrong' answers. Please indicate the response which applies to you with a tick.

	Not at all	a little	moderately	very much
1. Have you felt ashamed of any of your personal habits?	( )	( )	( )	( )
2. Have you worried about what other people think of any of your personal habits?	( )	( )	( )	( )
3. Have you tried to cover up or conceal any of your personal habits?	( )	( )	( )	( )
4. Have you felt ashamed of your manner with others?	( )	( )	( )	( )
5. Have you worried about what other people think of your manner with others?	( )	( )	( )	( )
6. Have you avoided people because of your manner?	( )	( )	( )	( )
7. Have you felt ashamed of the sort of person you are?	( )	( )	( )	( )
8. Have you worried about what other people think of the sort of person you are?	( )	( )	( )	( )
9. Have you tried to conceal from others the sort of person you are?	( )	( )	( )	( )
10. Have you felt ashamed of your ability to do things?	( )	( )	( )	( )
11. Have you worried about what other people think of your ability to do things?	( )	( )	( )	( )
12. Have you avoided people because of your inability to do things?	( )	( )	( )	( )
13. Do you feel ashamed when you do something wrong?	( )	( )	( )	( )
14. Have you worried about what other people think of you when you do something wrong?	( )	( )	( )	( )
15. Have you tried to cover up or conceal things you felt ashamed of having done?	( )	( )	( )	( )
16. Have you felt ashamed when you said something stupid?	( )	( )	( )	( )
17. Have you worried about what other people think of you when you said something stupid?	( )	( )	( )	( )
18. Have you avoided contact with anyone who knew you said something stupid?	( )	( )	( )	( )
19. Have you felt ashamed when you failed at something that was important to you?	( )	( )	( )	( )
20. Have you worried about what other people think of you when you fail?	( )	( )	( )	( )
21. Have you avoided people who have seen you fail?	( )	( )	( )	( )
22. Have you felt ashamed of your body or any part of it?	( )	( )	( )	( )
23. Have you worried about what other people think of your appearance?	( )	( )	( )	( )
24. Have you avoided looking at yourself in the mirror?	( )	( )	( )	( )
25. Have you wanted to hide of conceal your body or any part of it?	( )	( )	( )	( )

Appendix 10: Peritraumatic Dissociative Experiences Questionnaire

Instructions: Please complete the items below by circling the choice that best describes your experiences and reactions *during the Home Office interview(s) and immediately afterward.* If an item does not apply to your experience, please circle "Not at all true."

1. I had moments of losing track of what was going on – I "blanked out" or "spaced out" or in some way felt that I was not part of what was going on.

1	2	3	4	5
Not at all true	Slightly true	Somewhat true	Very true	Extremely true

2. I found that I was on "automatic pilot" – I ended up doing things that I later realized I hadn't actively decided to do.

1	2	3	4	5
Not at all true	Slightly true	Somewhat true	Very true	Extremely true

3. My sense of time changed – things seemed to be happening in slow motion.

1	2	3	4	5
Not at all true	Slightly true	Somewhat true	Very true	Extremely true

4. What was happening seemed unreal to me, like I was in a dream or watching a movie or a play.

1	2	3	4	5
Not at all true	Slightly true	Somewhat true	Very true	Extremely true

5. I felt as though I were a spectator watching what was happening to me, as if I were floating above the scene or observing it as an outsider.

1	2	3	4	5
Not at all true	Slightly true	Somewhat true	Very true	Extremely true

6. There were moments when my sense of my own body seemed distorted or changed. I felt disconnected from my own body, or that it was unusually large or small.

1	2	3	4	5
Not at all true	Slightly true	Somewhat true	Very true	Extremely true

7. I felt as though things that were actually happening to others were happening to me – like I was being trapped when I really wasn't.

1	2	3	4	5
Not at all true	Slightly true	Somewhat true	Very true	Extremely true

8. I was surprised to find out afterward that a lot of things that happened at the time that I was not aware of, especially things I ordinarily would have noticed.

1	2	3	4	5
Not at all true	Slightly true	Somewhat true	Very true	Extremely true

9. I felt confused; that is, there were moments when I had difficulty making sense of what was happening.

1	2	3	4	5
Not at all true	Slightly true	Somewhat true	Very true	Extremely true

10. I felt disoriented; that is, there were moments when I felt uncertain about where I was or what time it was.

1	2	3	4	5
Not at all true	Slightly true	Somewhat true	Very true	Extremely true

Appendix 11: Interview schedule

I am interested in your experience of the asylum interviews and would like to ask you a few questions about it. Please try to be as honest as you can. I can assure you that the information you provide will be confidential and not be used against you in any way.

1. When was the first time you talked about the traumatic event? After the event? After your arrival in the UK? Who did you talk to?

2. Was there anything you initially did not tell this person? What were the reasons for that?

3. After your arrival in the UK, were you interviewed at any point with regards to your asylum application? When was that? Who was present?

4. What was the asylum interview like for you?

5. To what extent did you feel you could open up and talk openly about what happened to you?

6. Is there anything that would have made it easier for you to open up?

7. How did you imagine the officials would react to hearing your story? What did you think would happen?

8. How did the officials react?

9. How did the officials make you feel?

10. Were you afraid the officials would judge you negatively?

11. Did you get a chance to meet the interviewer before the interview?
If No – Would you have felt more comfortable if you met the interviewer before?

12. I wonder whether the sex of the interviewer had any impact on you?

13. Was there anything about the setting/place of the interview that made it difficult for you to open up?

14. What would be a better setting/place to be interviewed in?

15. Were you interviewed alone of with other members of your family?
If alone - Would you have preferred to have family members/others with you?
If with family/others - Would you have preferred to be interviewed alone?

16. Did you feel that the procedures were well explained to you?

17. How did it feel to be asked personal questions during the interview?

18. Did you feel safe during the interview?

19. How could the interviews be changed to make it easier for people to open up?

20. Are there things you have not talked about because in your culture it is considered wrong?

21. Are there any things you have not yet told the Home Office about?
    If yes – Could you tell me what some of the reasons might be that you have found it difficult to do that?

22. Is there anything else that you would like to tell me that I have not asked you about?

Thank you very much for sharing this information with me.

Appendix 12: Participant quotes

Quote 1:
The Home Office official told me right at the beginning: "You don't have to tell me what happened. I ask the questions and you answer. You also don't have to talk about details from your SEF statement." I was wondering then what she did want me to talk about. Even my lawyer representative asked her what then she wants me to talk about. The questions were mainly about factual details (about the president of my country) and how I escaped. But she did not ask what happened. My lawyer in the end advised me not to sign the interview protocol. [P14]

Quote 2:
When he asked me questions and I answered them he started cross-examining me and that got me into a difficult situation. He started coming with more questions. That put me under more stress. The more I said the more questions he asked me. It felt like he was trying to trick me. I felt nervous and stressed, which made it harder to talk for me. [P16]

Quote 3:
The Home Office officials are strangers and carry out a routine. Therefore you can tell them many heartbreaking stories and it does not affect them. And because they don't show any emotions or sympathy it is very hard to feel relaxed and open. Maybe if I was encouraged to talk more about and if they understood me better and I saw that they showed some sympathy, maybe I would have said more. The Home Office official I had was very cold. I felt she did a job, following a routine, asking questions. [P6]

Quote 4:
The Home Office officials have a 'diplomatic way' of torture. The Home Office interview was worse than the repeated rape and detention I suffered. The rape was physical, at least I could close my eyes while it happened and try to forget about it. I developed ways to deal with the physical torture. When you have a cut or a wound it heals after a while, but what the Home Office does and the government ensures that those wounds they inflict on you will never heal. They tell you: "We do this interview in your interest". You open up then, let down your mask and become fragile. But then they torture you inside, for example I was asked by a female interviewer: "How come you don't have any sexual diseases like syphilis or AIDS, but you tell me that you were raped?" I was thinking at the time, maybe if I had AIDS then they would accept my case. They take my fragile part and destroy it. They know how to do this well, they are trained in it. [P14]

Quote 5:
In my culture, nothing can be more shameful to a female, or a member of her family, like her husband, than rape. Women have no rights at all at home and there is a strong religion and tradition in my culture. Women in my country they just eat, work and sleep. They have to be slaves to their husband and his family. They can't decide anything for themselves. And then when those terrible things happen to you [rape] you are not a very strong person to survive. You are finished. You are dead in your head and heart. It is difficult for people from the Home Office to understand about our feelings and our lives. And we don't know exactly what they want to know about

it. Talking about your life for the first time, when you have never done it before, is just so difficult. You don't think at the time that you must tell them everything because your future depends on it. You think how ashamed you are and how you could possibly tell them. You wish to be dead. [P1]

Quote 6:

The Home Office interpreter was of English background. She could speak Turkish but had no background knowledge of Turkey. While she interpreted I had to explain things to her, for example about the political situation in Turkey. She interpreted very badly. Out of 10 words I said she only interpreted one, and that was not even related to things I was saying. She only really interpreted the gist of the story. I give you an example: I was detained and tortured and kept in a dark room. However, she only interpreted that I was kept in a dark room. And obviously if you don't interpret everything I have said then it does not make sense. My English is getting better now and so I am able to understand a lot more. [P10]

Quote 7:

What happened was that after my refusal my statement was translated into Turkish for me. My statement during the interview was written down in English. I could not read it, but I had to sign it. What happened then I had to go to court and the judge picked up on inconsistencies in my story between the Home Office interview and an earlier statement. When they read the statement that was produced during the interview at court I told the judge that I did not say these things. They actually apologised to me in the end for making a mistake. [P11]

Appendix 13: Research Participation Questionnaire

We want to know your opinions about what it was like *for you* to be in this study. What it was like for you to be interviewed about the types of intrusive images/memories you experience. Your answers will help us understand how people feel about being in studies like this one. We REALLY want to hear your opinions, even if there were things you did not like. For each item below, please circle the number under the answer that is true for you. There are no right or wrong answers.

	Strongly Disagree	**Disagree**	**Maybe (in the middle)**	**Agree**	**Strongly Agree**
1. Being in this study was boring.	1	2	3	4	5
2. I am glad that I was in this study.	1	2	3	4	5
3. It was my choice if I was in the study (I could have said no even if other people wanted me to say yes).	1	2	3	4	5
4. Being in this study made me feel upset or sad.	1	2	3	4	5
5. The things I said will stay private (no one else will know I said them).	1	2	3	4	5
6. I am sorry I was in this study.	1	2	3	4	5
7. Being in this study made me feel good about myself.	1	2	3	4	5
8. I was told the truth about the study before it started.	1	2	3	4	5
9. I feel good about helping other people by being in this study.	1	2	3	4	5
10. I knew I could skip questions or parts of the study if I wanted to.	1	2	3	4	5
11. I knew I could stop at any time.	1	2	3	4	5
12. I knew I could ask to take a break whenever I wanted.	1	2	3	4	5

DO YOU HAVE ANY COMMENTS OR SUGGESTIONS FOR THE RESEARCHERS? (Please write here or on the back of this sheet).