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Part I—The mental health impacts of migration: the law and its effects
Failing to understand: refugee determination and the traumatized applicant

Zachary Steel[a,*], Naomi Frommer[b], Derrick Silove[c]

[a]*Senior Lecturer, School of Psychiatry, University of New South Wales, Australia Center for Population Mental Health Research, Australia*
[b]*Asylum Seeker Mental Health Program, School of Psychiatry, University of New South Wales, Australia*
[c]*Professor, School of Psychiatry, University of New South Wales, Center for Population Mental Health Research, Australia*

1. Introduction

Large-scale, rigorous programs screening asylum seekers for eligibility for refugee status began with the Comprehensive Plan of Action (CPA) in the late 1980s in response to the unresolved Indochinese refugee crisis (Asia Watch, 1991). Reception countries of the West justified this step by asserting that many Indochinese refugee claimants had no substantive protection claims under the 1951 Convention relating to the Status of Refugees (the Refugee Convention) and that a portion of those leaving their homelands were motivated primarily by economic factors (Robinson, 1998). In the majority of situations of mass displacement and upheaval, application of such case-by-case refugee determination procedures remains problematic, not least because the sheer number of persons crossing borders exceeds the logistic capacity of both the United Nations High Commissioner for Refugees (UNHCR) and host countries to assess individual protection claims (UNHCR, 2000). Nevertheless, procedures for testing refugee claims continue to be applied by most countries of the West in order to manage and restrict the flow of persons displaced by conflict, political upheaval or poverty.

* Corresponding author. Tel.: +61 2 9828 4912; fax: +61 2 9828 4910.
E-mail address: Z.Steel@unsw.edu.au (Z. Steel).

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The UNHCR (UNHCR, 1997, 2000) and human rights organizations (Diller, 1988; Human Rights Watch, 1997) have raised concerns that procedural shortcomings in testing refugee claims could lead to the *refoulement* of bona fide refugees. Mental health issues are one important domain that could lead to erroneous decisions. The present article will consider the importance of psychological factors in the context of the fairness of the refugee decision-making process that has been established in Australia. In the early sections, we will outline the legal framework within which refugee determination takes place under Australian law and review relevant literature on the mental health status of refugee and asylum seeker populations, with particular reference to the impact of torture. This background will lead to a consideration of the key issue raised by the article, namely, the influence of psychological factors on the presentation of asylum seekers' accounts of their traumatic experiences. Specific focus will be placed on the impact of trauma on memory functions, recounting of traumatic experiences, and the effects of such disclosures on symptoms of psychological distress. We will draw on case studies to highlight issues surrounding the impact of trauma on asylum seekers' ability to present effectively their claims for protection, and the role of expert psychological evidence in assisting decision-makers in the assessment of applicants.

The refugee determination process represents a point of intersection between the domains of psychology and administrative law, a setting in which these frameworks may well collide. The breakdown of this intersection is dramatically illustrated by the following case cited by Aron (1992) involving Ms M, an 18-year-old from El Salvador:

> [Ms M] related her recent history to the court: her brother had been killed, her boyfriend mutilated and tortured to death, and her cousin had been detained and tortured. She had been present when another cousin was pulled out of the house and shot to death by Salvadorian security forces. After an attempt was made on her father's life, she was sent out of the country by her family and was now seeking political asylum in the United States. Ms M's application for asylum was denied for lack of credibility. The judge felt that no one who had truly lived through all that would be able to speak about it so calmly and without any expression of emotion. He interpreted her lack of affect as evidence that she had been coached and was lying (p.82).

The case illustrates several important issues. Most notable is the apparent lack of understanding on the part of this decision-maker of the psychological sequelae of trauma and the range and expression of this in individuals making claims for asylum. Expert psychological evidence would have indicated that such a detached presentation most likely represented dissociation, a common feature of a complex post-traumatic stress reaction. Dissociation is an extreme stress reaction involving numbing, withdrawal, and a narrowing of the focus of attention, features that to the untrained observer might appear to reflect nonchalance or lack of emotion. This case also highlights the importance of issues of credibility in assessing the veracity of the applicant's claim in the absence of other evidence. Given these tragic oversights, it seems likely that Ms M would have been returned to a situation where many of her relatives had been summarily executed. The life-and-death struggle implicit in the refugee claim process presents the mental health clinician with additional professional and ethical dilemmas. Clinicians working with asylum applicants often find themselves in a position where forensic demands—namely, the need to obtain trauma testimonies to support refugee applicants' claims—can be of such a pressing nature that they outweigh usual clinical caution in delving too quickly into traumatic material that could undermine the emotional well-being of their patients.

2. Legal framework for refugee determination in Australia

The determination of refugee status in Australia is conducted according to a two-tier administrative decision-making framework. Applications are considered first by officers of the Department of Immigration, Multicultural, and Indigenous Affairs (DIMIA), and then on review, by the Refugee Review Tribunal (RRT or the "Tribunal"). The process, as in other parts of the world, is designed to be non-adversarial and approximates an inquisitorial or investigative model (Kneebone, 1998; Macklin, 1998) where the decision-maker accepts submissions from, listens to, and assesses the applicant's claims on the basis of credibility and known fact. The High Court of Australia has determined that administrative decision-making should involve application of the test of whether the applicant faces "a real chance" of persecution. It is recognized that a person can have a well-founded fear of persecution even though the possibility of the persecution occurring is well below 50%. The dire consequences of error underscore the need for a decision-maker to give the applicant the benefit of doubt. Thus, in accordance with guidelines developed by UNHCR, the refugee decision-making process is not bound by the formal rules of evidence established under common law as it is recognized that "cases in which an applicant can provide evidence of all his statements will be the exception rather than the rule" (UNHCR, 1998).

The definition of refugee status that must be met by applicants to prove an individual fear of persecution is set out in Article 1A(2) of the Refugee Convention as:

> any person who . . . owing to a 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 unwilling to avail himself of the protection of that country; . . .

In spite of these provisions aimed at giving applicants the benefit of the doubt, asylum seekers nevertheless face major obstacles in substantiating their protection claims (Cohen, 2002; Durst, 2000; Kneebone, 1998, 2003; Taylor, 1994). The UNHCR Handbook (1998) acknowledges that asylum seekers often flee persecution without access to documentation of abuse, corroborating evidence or witnesses. Paragraphs 196–201 of the UNHCR's Refugee Handbook provide guidelines for decision-makers, reflecting the need to consider the intersection of evidentiary, psychosocial, cultural and linguistic issues when undertaking the complex and difficult task of assessment of claims (UNHCR, 1998).

Authorities in Australia (Aronson & Dyer, 2000; Dauvergne & Millbank, 2003; Kneebone, 1998, 2003) and elsewhere (Cohen, 2002; Durst, 2000; Houle, 1994; Macklin, 1998; Rousseau, Crépeau, Foxen, & Houle, 2002) have drawn attention to some of the problematic aspects of decision-making with regard to the assessment of refugee claims. Decisions, at both the primary and review stages, frequently turn on issues of the applicant's credibility, a concept that is inherently subjective (Kneebone, 2003; Macklin, 1998). In particular, decision-makers appear to encounter difficulties when evaluating the evidence of applicants who have experienced significant trauma. It has been observed (Kneebone, 1998, 2003) that adverse findings of credibility are frequently made against applicants on the basis of inconsistencies between initial and subsequent accounts, exaggeration of the facts, or because documentary records of human right abuses in a country held by the Department of Immigration are preferred to the applicant's evidence. It has been argued that legal and evidentiary understandings of what makes a witness credible (Anderson, Hunter, & Williams, 2002), developed in the context of an adversarial process, are of tenuous application in the context of the "difficulty of proof inherent in the

special situation that an applicant for refugee status finds [himself/herself]" (UNHCR, 1998, para 197; Aronson & Dyer, 2000; Dauvergne & Millbank, 2003). In particular, there has been criticism of DIMIA and the RRT in relation to the adequacy of their application of the investigative powers available to them (Aronson & Dyer, 2000; Dauvergne & Millbank, 2003; Kneebone, 1998). This issue has been raised in general by the UNHCR's Refugee Handbook (UNHCR, 1998) at paragraph 196:

> while the burden of proof in principle rests on the applicant, the duty to ascertain and evaluate all the relevant facts is shared between the applicant and the examiner. Indeed, in some cases, it may be for the examiner to use all the means at his disposal to produce the necessary evidence in support of the application.

In the absence of such a disposition on the part of a decision-maker, the burden of proof disproportionately rests on the refugee applicant. Irrespective of the particular merits of a refugee claim, the degree to which an applicant can meet this burden is dependent on multiple factors, some of which are self-evident, such as the adequacy of language interpreting, access to legal advice, or the provision and interpretation of individual and country documentation (Dauvergne & Millbank, 2003). Some challenges may be less evident, such as the impact of cultural misunderstandings, fear of authority figures, or the degree to which the experiences of an applicant (such as exposure to pre-migration, migration or post-migration loss, trauma and stress) affect their mental state in a manner that impedes the presentation of their claims. Given the overwhelming body of evidence that populations exposed to mass trauma and conflict are at heightened risk of ongoing psychological distress and psychiatric illness, the impact of such disturbances in mental state on refugee determination becomes particularly important when reviewing the adequacy of refugee decision-making processes (Rousseau et al., 2002).

3. Psychological traumatization

It is only since the late 1970s, following the mass return of US soldiers from Vietnam, that substantial research attention has been directed to the psychological consequences associated with exposure to trauma. The introduction of post-traumatic stress disorder (PTSD) in the third edition of the American Psychiatric Association's (1980) Diagnostic Manual consolidated previous descriptions appearing in the psychiatric literature. It remains a historical irony that the Vietnam conflict that precipitated the current international endeavor to understand the long-term consequences of conflict, trauma, and human right abuses also saw the beginning of the international refugee crisis and the subsequent decision by Western countries to instigate policies of deterrence against trauma-affected populations (Silove, Steel, & Watters, 2000; UNHCR, 1997).

3.1. Post-conflict, refugee and asylum seekers populations

A comprehensive body of research has documented elevated rates of mental illness, particularly PTSD and major depression, amongst post-conflict populations including refugees (Cardozo, Vergara, Agani, & Gotway, 2000; de Jong et al., 2001; de Jong, Mulhern, Ford, van der Kam, & Kleber, 2000; Modvig et al., 2000; Mollica et al., 1993, 1999; Turner, Bowie, Dunn, Shapo, & Yule, 2003). Similar mental disturbances are seen across formally recognized refugees and asylum seekers (Association pour les Victimes de la Repression en Exil, 1985; Reid & Strong, 1987; Silove, McIntosh, & Becker, 1993;

Silove, Sinnerbrink, Field, Manicavasagar, & Steel, 1997; Steel & Silove, 2000; Sultan & O'Sullivan, 2001; Thompson, McGorry, Silove, & Steel, 1998). High rates of PTSD and depression are also manifest amongst asylum seeker populations (Drozdek, Noor, Lutt, & Foy, 2003; Silove et al., 1997; Silove, Steel, McGorry, & Mohan, 1998), with there being a close relationship between the extent of trauma and the likelihood and severity of PTSD (the dose–response relationship) (Cheung, 1993; Mollica et al., 1998; Steel, Silove, Bird, McGorry, & Mohan, 1999).

3.2. Torture and its psychological sequelae

Particularly noteworthy is the consistently high rate of asylum seekers who present with a history of exposure to torture. Most studies document rates of between 20% and 40% (Association pour les Victimes de la Repression en Exil, 1985; Silove et al., 1993, 1997; Steel & Silove, 2000; Thonneau, Gratton, & Desrosiers, 1990). A number of these studies have been based on detailed clinical interviews (Silove et al., 1997), while others recorded supporting evidence of physical ill-treatment (Thonneau et al., 1990). Confined asylum seekers held in immigration detention have reported even higher rates of torture, with Thompson and colleagues (Thompson et al., 1998) finding that amongst 25 detained Tamil asylum seekers, two thirds reported exposure to torture, a rate that was three times that of compatriots residing in the community (Steel & Silove, 2000). Similarly, Sultan and O'Sullivan (2001) found that over half of 33 asylum seekers detained in Sydney reported a history of physical torture.

As one of the most extreme forms of trauma an individual can encounter, it is not surprising that torture represents a potent risk factor for a range of mental disturbances. The pattern of psychological sequelae that emerges from studies amongst torture survivors (Allodi & Cowgill, 1982; Basoglu et al., 1994; Goldfeld, Mollica, Pesavento, & Faraone, 1988; Holtz, 1998; Lunde, 1982; Morris et al., 1993; Petersen et al., 1985; Petersen & Jacobsen, 1985; Ramsay, Gorst-Unsworth, & Turner, 1993; Shrestha et al., 1988; Silove, Steel, McGorry, Miles, & Drobny, 2002; Somasundarum, 1993) is one of high rates of depression, anxiety, sleep disturbance, nightmares, impaired concentration and memory, as well as PTSD. Moreover, this pattern of sequelae appears to be remarkably consistent across torture victims from widely differing cultural backgrounds and historical circumstances. These effects have also been demonstrated to persist over long periods of time. Petersen et al. (1985) reported on torture survivors interviewed at 5 and 10 years following torture. The most common forms of torture experienced were general beatings, falanga (beating of soles of feet), subjection to long periods of isolation, head injury, threats and humiliation, and direct genital injury. Other forms of torture included electrical torture, suspension, mock execution, sleep deprivation, and deprivation of food and water. At both the 5- and 10-year follow-up periods, high levels of somatic symptoms were found, often directly related to the torture experience. These symptoms remained constant throughout both assessment periods. In addition, at the 5-year interview the majority continued to experience symptoms of irritability and aggressiveness, with over a third reporting anxiety and depressive symptoms, sleep disturbance, and impaired concentration. At the 10-year follow-up there was no reduction in psychological symptoms, with the level of depressive symptoms increasing.

3.3. Psychological deterioration associated with the refugee determination procedure

In addition to the effects of exposure to pre-migration torture and trauma, a growing body of evidence suggests that the asylum seeking process itself is associated with psychological

deterioration. Many asylum seekers residing in the community in Australia have limited or no access to health, welfare, and social services. Perhaps, not surprisingly, exposure to these stressors in combination with the stressors of the asylum seeking process has been found to be associated with deteriorating symptoms of depression and PTSD (Silove et al., 1997, 1998; Steel & Silove, 2000). Asylum seekers who have an extensive traumatic history appear to be particularly susceptible, manifesting a disproportionate deterioration compared to their non-traumatized counterparts (Steel & Silove, 2000).

Confinement in immigration detention centers during the refugee determination process is likely to result in deterioration in the mental health of asylum seekers. Sultan and O'Sullivan (2001) document a pattern of progressive deterioration in mental health amongst a cohort of 33 asylum seekers held in detention for an average of 2 years. In the final stage of deterioration documented by the authors, detainees are described as entering a psychological state that is

> dominated by paranoid tendencies, leaving them in a chronic state of fear and apprehension and a feeling that no one, including other detainees, can be trusted. Long periods of time are spent alone and some develop frankly psychotic symptoms, such as delusions, ideas of reference and auditory hallucinations (p. 595).

The authors note "there is a significant and chronic impairment in concentration, with detainees being unable to perform even simple tasks" (p. 595). These findings have in part been corroborated by research undertaken by Thompson et al. (1998) and independent observations made by various human right agencies (OHCHR, 2002a, 2002b) and governmental bodies (HREOC, 1998; Joint Standing Committee on Foreign Affairs Defence and Trade, 2001).

4. Implications for the refugee determination process

It is clear from the foregoing discussion that substantial numbers of asylum seekers presenting before refugee decision-makers are likely to be suffering from complex psychiatric disturbances. However, in Australia there are no clear guidelines for determining officers to follow in interpreting the various ways in which such psychological symptoms may manifest or how they may affect the presentation of the applicant or his or her evidence. There is no requirement for decision-makers to seek expert psychological evidence even in situations where applicants present with complex trauma histories. There seems little doubt, therefore, that the failure to obtain such evidence can profoundly undermine the ability of the decision-maker to interpret adequately an applicant's claim. Of equal concern is the willingness and/or capacity of decision-makers to make appropriate use of expert psychological evidence presented to them.

An in-depth qualitative analysis of 40 cases considered by the Canadian Immigration and Refugee Board (Rousseau et al., 2002), the equivalent of the RRT, identified legal, cultural and psychological factors that influence decision-makers, applicants, and other actors involved in the refugee determination process (lawyers, health professionals, and interpreters). In summary, Rousseau et al. made the following findings (pp. 57–60):

- Post-traumatic symptoms were frequently misinterpreted as evidence that claimants' stories were not credible;

- Confusion by asylum seekers about dates and time sequences was commonly treated by Board members with impatience and suspicion;
- Omissions of significant traumatic events from the original application statement filled in by applicants on arrival were commonly treated by Board members as evidence that the event did not occur, despite subsequent disclosure. Reasons for initial non-disclosure (e.g., shame or adverse social consequences) were poorly understood by some Board members;
- There was confusion about the expert medical and psychological evidence presented, with Board members frequently failing to understand the evidence presented or treat it appropriately;
- Vicarious traumatization (from overexposure to trauma) of Board members frequently resulted in a lack of empathy with applicants' experiences and in avoidant reactions, such as denial, cynicism, trivialization of extreme events, and officers evading or refusing to hear the details of traumatic incidents.

Our clinical experience supports the findings of Rousseau et al. (2002) that asylum seekers with extensive trauma histories experience substantial difficulties in the refugee determination process. This is particularly so in situations where independent corroborating evidence to support a protection claim is not available. Traumatized asylum seekers often are unable to present a coherent trauma narrative to the decision-maker. This is misinterpreted as evidence that they are unreliable witnesses and therefore lack credibility, the basis for rejecting the case. Before reviewing a number of the cases that we have encountered, it is pertinent to review the psychological evidence relevant to the impact of trauma on memory and memory encoding.

4.1. Evidence of the relationship between trauma, memory functioning and symptoms of psychological distress

Research on the organization and retrieval of memories indicates that traumatic experiences are encoded and processed in a different way to non-traumatic experiences (Ehlers & Clark, 2000; Foa & Riggs, 1993; Koutstaal & Schacter, 1997). Because traumatic memories are encoded while an individual is experiencing extreme anxiety, the normal processing and integration of these experiences is disrupted (Dunmore, Clark, & Ehlers, 2001; Halligan, Clark, & Ehlers, 2002). Instead of being encoded into memory in an organized, coherent and integrated manner, traumatic experiences are often encoded in a disorganized and fragmented manner (Brewin, Dalgleish, & Joseph, 1996; Foa, Molnar, & Cashman, 1995; Foa & Riggs, 1993; van der Kolk & Fisler, 1995). In the broader sense, clinical symptoms of chronic PTSD, including disruption to information processing, emotions and physiological functioning, result in a disruption to core adaptive systems and a progressive failure to integrate traumatic experiences into personal meaning frameworks (Silove, 1999). The failure to adequately elaborate and process the traumatic experience in memory is also manifest in the emergence of habitual avoidance strategies that impair the integration of trauma experiences into memory (Dunmore et al., 2001; Ehlers & Clark, 2000; Foa & Riggs, 1993).

Trauma experiences can also alter the perception of time and distort time sequencing (Terr, 1984); interfere with spatial perception (Pynoos & Nader, 1989); produce memory blocks, including, in extreme circumstances, amnesia for complete or partial details of an event (Kirmayer, 1996; Koutstaal & Schacter, 1997; McNally, Clancy, Schacter, & Pitman, 2000); produce

dissociative phenomena where the person is not fully in touch with reality such as flashbacks, derealization and depersonalization (Ehlers & Clark, 2000; Kirmayer, 1996; Koutstaal & Schacter, 1997); generate ongoing impairments in concentration; and create a tendency to hyper-arousal and startle when confronted by environmental cues and triggers reminiscent of or resembling the traumatic event.

Recent research suggests that as trauma memories are processed, the recall of events changes and stress symptoms subside (Amir, Stafford, Freshman, & Foa, 1998; Foa et al., 1995; Foa & Riggs, 1993; van Minnen, Wessel, Dijkstra, & Roelofs, 2002; Zoellner, Sacks, & Foa, 2003). Therapeutic interventions used to treat PTSD aim to reduce trauma-related anxiety through gradual, repeated experience of memories of the traumatic event (exposure techniques), thereby facilitating the processing of traumatic memories (Foa & Meadows, 1997). Successful treatment is directed towards greater organization and less fragmentation in trauma memories, and an associated reduction in PTSD symptoms (Foa & Meadows, 1997; Foa et al., 1995). The natural process of recovery from a trauma seems, in part, to involve the organizing of memories associated with the trauma, as well as the ability to access these memories in an intentional or strategic way, rather than experiencing memories in the form of intrusive flashbacks (Ehlers & Clark, 2000).

4.2. Psychological evidence concerning asylum seekers and accounts of traumatic experiences

Attention has only very recently been directed towards examining the ways in which disruptions to memory and the organization of traumatic experiences can impact upon the presentation of asylum seekers' claims for protection during the refugee determination process. In a study conducted amongst a sample of refugees in the U.K. (Herlihy, Scragg, & Turner, 2002), there were discrepancies in the accounts of the same traumatic event given on two different occasions by all the participants interviewed. In particular, significantly more discrepancies were observed in details regarded by participants as peripheral than details regarded as central. Amongst refugees with high levels of PTSD, the number of discrepancies increased as the length of time between interviews increased. Since participants were authorized refugees with secure residency status, there was no motivation to fabricate memories. Below are several case studies that are illustrative of many of the memory and cognitive problems documented in research reviewed and discussed above.

5. The case of Mr R

Mr R, a national of Iran, arrived in Australia in 1999. From the time of his arrival until the granting of a protection visa by the RRT some 4 years after this, Mr R was held in various immigration detention facilities. During this period, Mr R's application went through two RRT hearings, two applications to the Federal Court, an application to the full bench of the Federal Court, and an application to the High Court. At no stage was psychological evidence introduced into Mr R's proceedings although he was observed by a number of health professionals to be increasingly displaying signs of severe psychological disturbance. On the third presentation to the RRT, a psychological report was requested by the Tribunal Member. To our knowledge, this is one of the rare occasions that expert psychological evidence has been sought over the decade that the Tribunal has been operating.

Psychological assessment indicated that Mr R was suffering from a major depressive disorder with pronounced psychotic features, PTSD and panic disorder. Mr R's performance on the Wechsler Memory Scale (WMS-III) indicated extreme impairment, particularly in attention and concentration. Mr R's retention of information was also severely disorganized. The assessment found a close concordance between Mr R's clinical state, performance on the memory tasks, and inability to provide a coherent narrative of events that occurred both before and after arriving in detention. All these deficits were attributed to Mr R's depressive and psychotic symptoms.

The psychological evidence was accepted by the Tribunal member and Mr R was granted a protection visa. The Tribunal's decision stated that:

> Mr R's presentation at the [previous] Tribunal hearing (that is, the embellishments, corrections and inconsistent statements that he made on that occasion) is consistent with the onset of memory and confusional difficulties. The inconsistencies [that were alluded to in the past Tribunal decision] should not be unexpected for someone with the severity of symptoms that Mr R displays.

In a private communication following the hearing and handing down of the decision, the Tribunal member commented as follows in relation to the utility of the psychological report from a decision-maker's perspective:

> Overall I've found this exercise [of seeking a psychological report for the Tribunal hearing] very useful ... I found ... [the report] to be very helpful. It gave me a good idea of what to expect during the hearing and assisted me to work out what I could usefully ask and what wasn't going to work. [This is in contrast to] a report that does nothing more than recite applicant's claims and conclude that [he] has a well-founded fear of persecution, [which] is useless.

Given the limited grounds for judicial review of RRT decisions in Australia (Dauvergne & Millbank, 2003; Kneebone, 1998, 2003), this case highlights the importance of informing decision-making with appropriate psychological evidence.

6. The case of Mr P

The case of Mr P presents an example where psychological evidence was obtained, but was unable to be used to instigate a review of the applicant's protection claim. Mr P was born in Sri Lanka and was of Tamil ethnicity. Mr P arrived in Australia during 1995 and lodged an application for a protection visa. Mr P's application was unsuccessful at both the primary and review stages and he was detained in 2000. After a successful application for judicial review, Mr P was allowed to reapply for a protection visa but was again unsuccessful at both the primary and review stages. After 2 years in detention, legal advisors acting on the behalf of Mr P sought a psychological assessment pursuant to a ministerial application for humanitarian protection. The assessment found that Mr P had symptoms consistent with a diagnosis of PTSD, major depression and panic disorder. As with Mr R above, Mr P showed an extreme level of distractibility and highly disorganized thought processes during the interview. He experienced great difficulty providing a coherent narrative of his life in Sri Lanka. He became confused about the chronological order of events that had occurred and could only provide cursory information about events that took place. Formal assessment of memory functioning identified profound memory impairment on all Wechsler Memory Scale domains.

The observations made by relevant decision-makers were consistent with the clinical presentation of Mr P. For example, at the primary interview the delegate of the Minister for Immigration stated:

> At interview I found his description of first aid training and practice to be unconvincing, he was vague about when and where he did this work, claiming he did not remember. He described battle conditions but could not remember where or when the fighting occurred.
>
> At interview he could not satisfactorily explain what he did between 1992 and 1995 yet on his visitor application he provided documentation that he was living and working in Colombo at the time.
>
> He stated that he travelled from Jaffna to Colombo in July or August 1995 by bicycle and did not encounter any difficulties. It was only after repeated requests to describe his journey that he mentioned he had to cross water.

Upon review of this decision by the RRT, the Tribunal member made the following observation about the testimony provided by Mr P:

> The applicant was asked about the whereabouts of his family. He said that he did not know where his mother and older sister were, and that they were somewhere in Jaffna. However, in response to a later question, the applicant said that his older sister was married in 1991 and is living in Canada.

Such confusion in the presentation of basic testimonial evidence was interpreted by all decision-makers as evidence that the applicant was unreliable and lacked credibility. However, the scattered and confused nature of his testimonial evidence was consistent with his clinical presentation as a traumatized and psychologically affected individual. Failure to be consistent in the presentation of such simple, albeit peripheral, information is not compatible with someone who has carefully rehearsed a narrative in order to deceive a decision-maker. Nevertheless, at the second primary application the delegate of the Minister concluded:

> I consider that the problems with his claims are in no way attributable to ill health. The inconsistencies conflict with known information, and the applicant has consistently displayed a lack of knowledge about the Jaffna area throughout the processing of the case.

At no point was appropriate psychological or psychiatric evidence provided to the delegate of the Minister of Immigration or the member of the RRT to assist in the interpretation of Mr P's presentation. It is important to note, however, that as with many traumatized individuals who display such impairments, there was a consistency in Mr P's core testimony across all of the interviews. This consistency remained evident despite repeated suggestions to Mr P that he elaborate or provide additional details about the "real" basis for his claims. Mr P was ultimately returned to Sri Lanka.

6.1. Delayed disclosure of traumatic events

Another difficulty in testimony occurs when an applicant makes delayed or only partial disclosure of a relevant traumatic event. The decision-maker may seize on such an inconsistency to deduce that the applicant has fabricated additional instances of persecution to strengthen his or her claim, particularly after they have had an opportunity to discuss their case with other asylum seekers or advisors. Yet there may be sound psychological reasons for such late disclosures, an

issue noted by Rousseau et al. (2002). Shame and humiliation may inhibit early disclosure, as may periods of traumatic amnesia that resolve over time.

7. The case of Mr P

Following the decision by the primary delegate, Mr P (referred to above) disclosed to his legal counsel that he had been raped while held for questioning by police in Sri Lanka. However, the Tribunal member concluded that despite the applicant giving "every appearance of being genuinely distressed when he gave evidence about the alleged rape … the Tribunal cannot be satisfied that this assault actually occurred". It was noted by the Tribunal member that "during the past two weeks there had been at least three other Sri Lankan cases before the Tribunal, all with the same advisor, where the same very serious mistreatment was alleged to have occurred," raising questions "as to whether this was in fact the applicant's own experience". This inference contrasted with Sri Lankan country information which suggested that the rape of male detainees in Sri Lanka was commonplace (Peel, Mahtani, Hinshelwood, & Forrest, 2000). In addition, analysis of Mr P's original statutory declaration indicated that in the description of his period of detention he had been unable to speak to his relative who collected him from the police station because he "was in a crying mood, crying a lot and very upset, [and] when [he] came out [his] father's friend asked [him] what had occurred". Mr P's clinical presentation was also consistent with a traumatizing event such as the occurrence of sexual assault. He met diagnostic criteria for PTSD, with the triggering incident being the rape. He also described a range of clinical reactions that are observed amongst victims of sexual violations such as an aversion to being touched, loss of the ability to express feelings of affection, psychosexual dysfunction, and intense feelings of shame regarding the rape. While it is acknowledged that the assessment of the veracity of such a claim is difficult even for an experienced clinician, the failure to obtain psychological evidence may have been in part responsible for the adverse outcome of Mr P's protection claim.

7.1. Partial disclosure of traumatic events

An even more common problem relates to when applicants make only partial disclosure of traumatic experiences. This problem is of grave import since it may bias a decision-maker towards a lesser judgment of harassment or discrimination rather than of persecution, thereby diminishing the need for offering protection to the asylum seeker. The problem is compounded if the legal representative and/or the decision-maker fail to inquire further into the matter, a point also noted by Rousseau et al. (2002). An illustration of this problem is afforded by the case of Ms L.

7.2. The case of Ms L

Ms L, a 24-year-old Burmese citizen, applied for protection from persecution on the basis of race and political opinion. Ms L's family is ethnic Chinese. Ms L's father was involved in the democracy movement in Burma, and following the demonstrations staged by the movement in 1988, he was imprisoned by the Burmese military for 4 months. Following this, Ms L's father was arrested, tortured and beaten before disappearing in 1991. After this the family continued to experience ongoing harassment and on several of these occasions Ms L was questioned and sexually assaulted at the local

police station. The statutory declaration accompanying Ms L's protection visa application made brief reference to the sexual assaults that took place, and to Ms L's fear of repeated assaults if she were returned to Burma. In the primary decision record no mention was made of the alleged sexual assaults, but rather only of the possibility that she would be subject to questioning which was not regarded by the decision-maker as sufficient grounds to indicate that there was a real chance of persecution occurring should Ms L be returned to Burma. The psychologist assessing Ms L then obtained a detailed history of Ms L's experiences of sexual assault in Burma, and this was done over a number of interview sessions in a careful therapeutic manner. When the interviewer questioned Ms L during the preparation of this report about why she did not disclose details of the assault to her solicitor during the preparation of her application statement, Ms L stated that she felt very ashamed and fearful about what had happened. She indicated that as she had not been questioned in detail about the incident that took place in the police station by either her solicitor or the decision-maker, she did not voluntarily revisit these painful memories. The provision of a detailed report of Ms L's sexual assaults did lead the Tribunal member to accept that the applicant had "suffered some molestation by military personnel soon after her return to Burma ... in 2001". However, the Tribunal member proceeded to find that the fear of sexual assault arising from these experiences was because Ms L was a young woman (rather than because of her imputed or actual political opinions), and concluded:

> despite claims made in the psychologists' reports ... about the reason for the molestation she suffered and the causes of [Ms L's] current state of depression and her emotional disorders, I do not give much evidentiary weight to these, as I find they are merely evidence of what the applicant told the psychologist was the reason for what occurred, rather than being evidence of the facts themselves.

7.3. The case of Mrs Y

Mrs Y, a Chinese national, applied for a protection visa on the basis being persecuted due to her adherence to the Falun Gong faith. In the statement in support of Mrs Y's protection visa, she stated that she had been arrested, detained and interrogated by the police and subsequently sent to a labor camp for a month where she was forced to engage in hard physical labor, was not provided with adequate food and was at times mistreated. Mrs Y was also able to provide a copy of the summons issued to her that resulted in her period of detention in the work camp, the document being accepted as a true copy. Mrs Y did not detail the nature of the abuse she suffered to her solicitor and further inquiry was not made about this during her interview with the primary decision-maker. Although the claims made by Mrs Y that she had been detained and sent to a work camp for 4 weeks were accepted, the primary decision-maker did not accept that she faced a real chance of persecution, concluding:

> the treatment [Mrs Y] has described as receiving from the authorities accords with that experienced by many low-level practitioners. There is no evidence before me that the claimant has experienced any harm or mistreatment of sufficient gravity as to amount to persecution.

In a subsequent detailed clinical interview, Mrs Y was diagnosed with PTSD and major depressive disorder. The psychologist obtained a detailed trauma history in which Mrs Y recounted being repeatedly subject to interrogation, beating and kicking by guards. She was also suspended by having her arms held behind her back. At other times she was electrocuted with an electric rod and on one occasion lost

consciousness when the rod was applied to her temple. These details were recorded in a psychological report. On review of her application before the RRT, the Tribunal member supported her protection claim and stated:

> I accept the applicant's evidence that she was sent to re-education, largely on the basis of the [psychological report] . . . and therefore accept the reports and find that the applicant did attend the [re-education] camp for 4 weeks and was harassed and tortured. I find that such harassment and torture amounts to persecution for a [Refugee] Convention reason.

In both of the cases cited above and in numerous others we have dealt with, clinical interviews with asylum applicants have revealed that many asylum seekers had either not been questioned about key trauma events by their legal representatives, or had only been asked for cursory details, such as the general nature of how, where, and for how long the torture or abuse had taken place. Applicants commonly revealed that it was only in the confidential context of the clinical interview, where it was apparent that their emotional distress was understood, that they felt comfortable enough to disclose details of the torture and/or abuse to which they had been subjected. Several legal representatives have also indicated to us a reluctance to obtain a detailed trauma narrative out of a fear that it will provoke an adverse psychological reaction in the asylum seeker that they feel ill-equipped to manage.

Moreover, this is consistent with the established pattern of non-disclosure by people who have suffered abuse of a humiliating nature (Rousseau et al., 2002). This paradox provides a very strong argument for the routine involvement of mental health professionals in the assessment of applicants who indicate a trauma history. However, this is also one of most difficult areas to traverse because of the competing priorities between the provision of supportive clinical care and the need to provide supporting documentary evidence for an applicant's claim. From a mental health professional's viewpoint, there is a need to weigh the probative value of revealing information obtained in a confidential therapeutic context against the risk of further traumatization that could result from the asylum seeker being required to retell the trauma experiences in the non-therapeutic determination process. The complexity of the situation is compounded by the fact that decision-makers do not necessarily understand or accept the reasons for non-disclosure of trauma-related information, and at times, as evidenced by interpretation of the sexual abuse claims in Ms L's case, treat the explanations provided by mental health professionals with incredulity.

8. Discussion and recommendations

In preparing this article, many parallels between the Canadian and Australian experiences have become apparent, and several of the issues identified by Rousseau et al. (2002) are directly relevant to the authors' experience of working with asylum seekers in Australia. As suggested by the preceding review and corresponding case studies, there is strong evidence that the complex clinical presentation of asylum seekers can adversely impact upon the ability of decision-makers to assess the protection needs of refugee applicants. Although decision-makers are in a position to request expert advice, this has rarely been undertaken with respect to psychological evidence. Similarly, it has been our experience that there is often a failure on the part of legal representatives to appreciate the value of psychological evidence or how it may assist in the documentation of the protection needs of their clients or the interpretation of

their behavior. The central argument of this article has been that decision-makers should be prepared to use their investigative powers in cases where asylum seekers present with reports of substantive traumatic histories, and that the threshold for seeking such advice should be set relatively low given the range of individual responses to traumatic exposure documented. Additionally, there is a need to ensure the appropriate use of psychological evidence, from both the perspective of the mental health professional providing assessment and advice and from the perspective of the refugee decision-maker charged with the task of determining the protection needs of the applicant.

Decision-makers regulating refugee admission have indicated to us that there have been cases where the submission of a report by a psychiatrist, psychologist, or other mental health professional has been viewed as an attempt to usurp the role of the decision-maker. The mental health professional is not in possession of the range of country information, relevant case law, or other information that should be considered in determining the likelihood of future persecution of an applicant. However, we have also encountered situations where decision-makers have criticized mental health professionals for making findings of fact that we believe were appropriate. For instance, in circumstances where an individual has made certain claims about having been a victim of torture and/or other serious human right violations and this testimony is supported by expert psychological, psychiatric or physical assessment, it is warranted for the mental health professional to make a finding that the clinical assessment confirms the authenticity of alleged events. It remains for the decision-maker to determine if the abuse experienced by the applicant constituted persecution or, in combination with appropriate country information, provides grounds to believe that a "real chance" of future persecution exists.

When considering psychological evidence, it should be noted that while international research indicates that a significant proportion of individuals exposed to severe trauma will go on to experience disabling psychiatric symptoms, it is equally true that many individuals demonstrate a high degree of resilience and manage to resume their lives with no significant ongoing psychological or psychiatric disturbance (Steel, Silove, Phan, & Bauman, 2002; Turner et al., 2003). For this reason, it is important that each case is treated on its own merits, and the absence of psychological symptoms should not be taken as evidence that the alleged experiences have not occurred. This underscores the complex nature of psychological assessment within this forensic setting, and the need for the provision of such assessment to be viewed as a specialist area of mental health inquiry. The professional requires significant experience in working with people from refugee backgrounds as well as experience in working within a forensic setting. It is only with this confluence of skills that appropriate evidence and interpretation can be provided to the refugee decision-maker to inform the process and advise the decision-maker of the factors that should be considered when assessing the applicant's claim.

9. Conclusion

The submission, assessment, and correct use of psychological evidence as part of the refugee determination process poses significant challenges for the mental health professional and the refugee decision-maker. Complex traumatic presentations can easily be misunderstood by decision-makers, leading to adverse findings about the protection needs of an applicant. In adhering to the principles of natural justice, decision-makers must be aware of the role and import of expert mental health advice and, if such information is not available to them, should apply a low threshold in exercising their investigative powers to obtain such advice. The mental health professional must balance the clinical needs of their

clients against the imperative to obtain appropriate testimony or pertinent clinical findings that can assist the decision-maker in assessing the applicant's refugee claim. The aim of all parties should be to ensure that correct and fair decisions are made that will result in the provision of protection to those who face persecution. The consequences of a failure to understand the protection needs of traumatized asylum seekers are grave and place a high moral burden on us all.

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