Mental Disorders in Asylum Seekers

The Role of the Refugee Determination Process and Employment

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Abstract: The refugee determination process (RDP) and social factors putatively impact on the psychiatric morbidity of adult asylum seekers (ASs) living in the community. Clinical and sociodemographic data relevant to AS experience in the RDP were collected using self-report measures to assess posttraumatic stress (Harvard Trauma Questionnaire–Revised) and depressive and anxiety symptoms (25-item Hopkins Symptom Checklist), and the Mini-International Neuropsychiatric Interview 6.0 psychiatric interview was used to establish a cut-off for caseness. The prevalence of major depressive disorder (MDD) and posttraumatic stress disorder (PTSD) was 61% and 52%, respectively. Unemployment and greater numbers of both potentially traumatic events and RDP rejections were predictors of symptom severity. Unemployed ASs were more than twice as likely to have MDD (odds ratio, 2.61; 95% confidence interval [CI], 1.11– 6.13; $p = 0.03$), and ASs with at least one RDP rejection were 1.35 times more likely to develop PTSD for each additional rejection (95% CI, 1.00–1.84; $p = 0.05$). Reducing the asylum claim rejection rate and granting work rights are likely to reduce the rate of PTSD and MDD in community-based ASs.

Key Words: Asylum seekers, refugee determination, posttraumatic stress, depression, employment status

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Refugees and asylum seekers living in Western countries experience a high prevalence of mental disorders, particularly posttraumatic stress disorder (PTSD), major depressive disorder (MDD), and other anxiety disorders (Fazel et al., 2005; Steel et al., 2009), with asylum seekers being more vulnerable than settled refugees (Macleod and Reeve, 2005; Silove et al., 1998; Steel et al., 2009). However, most research on mental health in asylum seeker populations has focused on the prearrival context and refugees whose status was established before arrival in the host country (Ryan et al., 2008). Less consideration has been given to the circumstances encountered in host countries (Gerritsen et al., 2006; Watters, 2001) and to those living in the community, which is the case for most asylum seekers in Australia (Department of Immigration and Border Protection, 2014). Most asylum seekers in Australia are ultimately granted protection visas and permanent residency; however, low rates of successful primary determination (*e.g.*, 33% for nonirregular maritime arrivals) result in a protracted refugee determination process (RDP) for most asylum seekers (Department of Immigration and Border Protection, 2013).

Few studies have investigated the association between mental health and the RDP itself. Internationally, a long asylum process has been found to be associated with psychiatric disorders (Hallas et al., 2007; Heeren et al., 2012; Laban et al., 2004; Mueller et al., 2010; Ryan et al., 2008), with one study finding that a long RDP waiting time combined with rejection of asylum claims to be associated with suicidality (Staehr and Munk-Andersen, 2006). In an Australian study (Silove et al., 2007), posttraumatic stress, depressive, and anxiety symptoms in a small cohort of asylum seekers were measured 3.8 months after their initial application. Only those whose applications were successful showed a reduction in symptom severity, whereas those whose applications were rejected continued to demonstrate a high level of psychiatric morbidity and functional impairment. Similar findings were reported in a prospective Canadian study of asylum claimants (Davis, 2006), with prevalence of PTSD decreasing from 100% to 10% for those who received a positive RDP decision; conversely, 89% of those who received a negative decision retained a PTSD diagnosis. PTSD has also been associated with self-reported delays in processing refugee applications in asylum seekers and greater exposure to premigration trauma (Silove et al., 1997). Thus, it has been suggested that Australia's procedures for processing asylum claims may contribute to high levels of stress and psychiatric symptoms in people who are already traumatized (Silove et al., 1997).

Research Aims

The present study aimed to cross-sectionally investigate the association between psychiatric morbidity in community-based asylum seekers and number of asylum claim rejections and time in the RDP. Sociodemographic variables were also explored as potential predictive factors for psychiatric morbidity.

METHODS

Participants

A convenience sample of 98 adult asylum seekers were recruited through the casework program of the Asylum Seeker Resource Centre (ASRC) in Melbourne, between September 2008 and October 2010. Because of database inaccuracies and the transient population, it was not possible to randomly sample participants, and thus, a convenience sample reflecting the current asylum seeker trends based on country of origin was used. All participants had lodged an application for asylum and were residing in the community while their cases were being determined. An opt-in approach was applied to potential participants who were not from clinical services and came to the ASRC for non-health reasons (*e.g.*, for legal support or material aid). Caseworkers canvassed the study with eligible clients to determine their interest in participating and obtained verbal consent for the researcher to contact them directly.

Ethics

Approval for the research study was granted by the Victoria University Human Research Ethics Committee.

Instruments

Two questionnaires were used to assess levels of depression, anxiety, and posttraumatic stress.

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TABLE 1. Sociodemographic Characteristics of the Sample ($n = 98$[a])

	n	%
Sex		
Male	87	88.8
Female	11	11.2
Mode of arrival		
Plane	87	94.6
Boat	5	5.4
Speaks English		
Yes	12	12.2
No	86	87.8
Country of origin		
Sri Lanka	39	39.8
Pakistan	30	30.6
Zimbabwe	12	12.2
Iraq	8	8.2
Afghanistan	6	6.1
Iran	2	2.0
Lebanon	1	1.0
Immigration detention		
Yes	8	8.2
No	89	91.8
Number of PTEs[b]		
<5	2	2.2
5–10	34	37.0
11–26	56	60.9
Number of RDP rejections		
0	51	52.6
1–2	23	23.7
≥3	23	23.7
Education		
Tertiary	59	60.8
Finished secondary	26	26.8
Other	12	12.4
Previous occupation		
Professional	31	31.6
Administration/self-employed	27	27.6
Skilled/trade	16	16.3
Unskilled/student/unemployed	24	24.5
Employment status		
Not working/nil work rights	55	57.3
Working/students	41	42.7
Health cover		
Yes	61	65.6
No	32	34.4

[a]Totals less than 98 are because of missing data.

[b]Refers to different categories of PTEs, not the number of individual PTEs experienced.

The Harvard Trauma Questionnaire–Revised (HTQ) (Mollica et al., 2004) is a cross-cultural instrument designed to assess trauma and torture and their sequelae. A 16-item subscale of the HTQ measured PTSD symptoms, whereas anxiety and depressive symptoms were measured by the 25-item Hopkins Symptom Checklist (HSCL) (Mollica et al., 1987). The range for both instruments is 1 to 4, with higher scores indicating greater severity, and the scaled score is ascertained by dividing the total score by the number of items.

The HSCL and HTQ have demonstrated efficacy in the identification of mental illness and psychological distress in culturally diverse populations. Both instruments have widespread acceptance in the assessment of traumatized populations (Mollica et al., 1987) and are the most widely used instruments in populations of forced migrants who have experienced premigration and postmigration trauma (Steel et al., 2009). Back-translated versions of the HTQ and HSCL were used for participants who were not conversant in English. Interpreters were used for interviews as necessary.

The *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition* American Psychiatric Association, 2000) diagnoses of MDD and PTSD were established using cutoff scores from the HSCL (2.29) and HTQ (2.50) (Mollica et al., 2004), respectively, using the Mini-International Neuropsychiatric Interview 6.0 (MINI) (Lecrubier et al., 1997). The cutoff for MDD was higher than that previously reported (1.75; Mollica et al., 2004) and was based on our follow-up study (Hocking et al., submitted for publication).

Data were also collected on a range of sociodemographic variables and information relevant to participants' status in the RDP, Medicare (free public health care) access, work rights, and employment status.

Because of symptom measures being scales for neurotic disorders, three cases with psychotic disorders as assessed by the MINI were excluded from analyses examining anxiety, depressive, and posttraumatic stress symptoms.

Statistical Analyses

Data were analyzed using the Statistical Package for the Social Sciences for Windows, Version 20.

Because of the data being nonnormally distributed, Spearman's rho analyses were performed to examine the associations between demographic variables and symptom scores. Post hoc nonparametric tests (Mann-Whitney and Fisher's exact test) investigated relationships between diagnoses of MDD and/or PTSD and categorical sociodemographic variables. For multiple regression analyses, the number of RDP rejections was logarithmically transformed ($\log_{10}$) to establish normality. Logistic and multiple regression analyses were conducted to determine RDP and sociodemographic predictors of psychiatric diagnoses and symptom severity, respectively.

RESULTS

The sociodemographic characteristics of the sample are shown in Table 1. The sample had a mean (SD) age of 34.6(10.63) years, with the mean (SD) time spent in the RDP being 29.4(49.3) months. The mean (SD) number of RDP rejections and potentially traumatic events (PTEs) experienced was 1.64 (2.39) and 13.1 (5.48), respectively.

Most of the sample (52.6%) had yet to receive a refugee status decision, whereas 23.7% had received one or two rejections. The same number (23.7%) had received between 3 and 11 rejections. The time spent in the RDP was positively skewed, with a median of 6 months (interquartile range, 2–19 months).

TABLE 2. Depression, Anxiety, and PTSD Symptom Scores and Caseness

	n	Symptom Score, Median (IQR)	Caseness, % (*n*)
Depression	95	2.67 (1.93–3.13)	61.1 (58)
Anxiety	95	2.10 (1.50–2.80)	N/A
Posttraumatic stress	94	2.50 (1.88–3.00)	52.1 (49)

IQR indicates interquartile range.

The prevalence of psychiatric morbidity is shown in Table 2. Sixty-one percent of the sample met the cutoff score for a diagnosis of MDD (≥2.29) and 52% for PTSD (≥2.50), as validated against the MINI.

Correlations were performed between symptom scores and sociodemographic variables (Table 3). There was a significant association between number of PTEs and anxiety, depression, and posttraumatic stress. In addition, there was a moderate negative association between employment status and both anxiety and depressive symptoms. Mann-Whitney tests confirmed that being employed was associated with reduced severity of anxiety ($U = 793$, $p = 0.03$, $n = 95$) and depressive ($U = 807$, $p = 0.04$, $n = 95$) symptoms. Those who were not employed were 2.61 times more likely to be diagnosed with MDD (95% confidence interval [CI], 1.11– 6.13; $p = 0.03$, $n = 95$).

No other significant relationships were observed between the psychiatric indices and the remaining sociodemographic variables.

A logistic regression was performed to explore whether a diagnosis of PTSD and MDD could be predicted by the number of RDP rejections for those who had received at least one rejection. This was significant for PTSD (χ^2_1, $n = 44 = 4.56$, $p = 0.03$), indicating that the model was able to distinguish between asylum seekers who did and asylum seekers who did not incur a diagnosis of PTSD. One or more RDP rejections explained between 9.8% (Cox and Snell R^2) and 13.2% (Nagelkerke R^2) of the variance in PTSD status and correctly classified 63.6% of cases. The odds ratio for one or more RDP rejections indicated that asylum seekers were 1.35 (95% CI, 1.00–1.84; $p = 0.05$) times more likely to develop PTSD for every additional rejection received. One or more rejections did not predict a diagnosis of MDD ($\chi^2_1 = 0.51$, $p = 0.48$, $n = 44$).

Lastly, three multiple regression analyses were conducted with the 11 sociodemographic variables (see Table 1) entered simultaneously as predictors of anxiety, depressive, and posttraumatic stress symptoms, with missing values deleted pairwise.

An initial regression analysis for each of the symptom scores as outcome variables indicated that the 11 sociodemographic variables accounted for 21.5% of variance in anxiety symptoms ($F_{11, 72} = 1.79$, $p = 0.07$), 23.5% of variance in depressive symptoms ($F_{11, 72} = 2.02$, $p = 0.04$), and 26.9% of variance in posttraumatic stress symptoms ($F_{11, 72} = 2.41$, $p = 0.01$).

Because of the large number of independent variables for the sample size, a second regression analysis was performed for each symptom scale. Predictor variables that resulted in a p value below 0.1 for the initial analyses were included in subsequent regression analyses. These final results are presented in Table 4.

TABLE 3. Correlation Between Symptom Scores and Sociodemographic Variables

	Anxiety	Depression	Posttraumatic Stress
Sex	−0.03	−0.15	−0.03
Mode of arrival	0.08	0.00	0.02
Speaks English	−0.10	−0.07	0.05
Country of origin	−0.08	−0.10	0.11
Detention	−0.04	−0.14	−0.17
Number of PTEs	0.27*	0.26*	0.31**
Education	0.00	−0.08	−0.03
Previous occupation	−0.07	−0.03	−0.04
Employment status	−0.23*	−0.22*	−0.15
Medicare	−0.08	0.04	−0.10

*Significant at the 0.05 level.
**Significant at the 0.01 level.

TABLE 4. Sociodemographic Predictors of Anxiety, Depression, and PTSD Symptoms

Symptoms	R^2	Statistic	Part Correlation
Anxiety	0.150	$F_{4, 82} = 3.62$**	
Number of PTEs		$t = 2.72$*	0.28
Employment status		$t = -2.01$*	−0.20
Number of RDP rejections		$t = 1.88$	0.19
Speaks English		$t = -1.42$	−0.14
Depression	0.195	$F_{5, 81} = 3.94$**	
Number of PTEs		$t = 2.82$**	0.28
Employment status		$t = -2.79$**	−0.28
Detention		$t = -1.61$	−0.16
Number of RDP rejections		$t = -1.51$	0.15
Sex		$t = -1.51$	−0.15
PTSD	0.231	$F_{4, 82} = 6.17$***	
Number of PTEs		$t = 3.31$**	0.32
Number of RDP rejections		$t = 2.84$**	0.28
Employment status		$t = -2.38$*	−0.23
Detention		$t = -2.20$*	−0.21

*Significant at the 0.05 level.
**Significant at the 0.01 level.
***Significant at the 0.001 level.

Twenty-three percent of the variance in posttraumatic stress symptom scores was accounted for by number of RDP rejections, number of PTEs, employment status, and experience of immigration detention. Number of PTEs, employment status, number of RDP rejections, detention experience, and sex accounted for 19.5% of depressive symptom scores, and number of PTEs, employment status, number of RDP rejections, and an inability to speak English accounted for 15% of anxiety symptom scores.

Number of PTEs was the most important predictor of anxiety, depression, and posttraumatic stress symptom scores, independently accounting for up to 10% of the variance for each symptom scale. Unemployment and number of RDP rejections both contributed to the models for all symptom scales and made unique contributions to posttraumatic stress symptoms of 5.3% and 7.8%, respectively.

Curiously, an experience of immigration detention ($n = 7$) was associated with lower symptom scores on depression and posttraumatic stress.

The only psychosocial predictor of psychiatric symptoms was employment status. Unemployment (with or without work rights) accounted for 4% to 7.8% of all symptom scores and was the equal biggest predictor of self-reported depressive symptoms.

DISCUSSION

The present research represents a large Australian cross-sectional study of community-based asylum seekers. This is pertinent given the comparatively large numbers of asylum seekers currently residing in the community on bridging visas (approximately 24,000 in Australia) (Department of Immigration and Border Protection, 2014). We sought to investigate the influence of time and number of rejections in the RDP, as well as a range of psychosocial factors on the mental health of community based asylum seekers.

Psychiatric morbidity was high, in keeping with other studies of asylum seeker populations (Hallas et al., 2007; Maier et al., 2010; Silove et al., 2006), with the prevalence of PTSD and MDD being 52.1% and 61.1%, respectively. The RDP was a significant predictor of PTSD for those with one or more rejections, with increased odds of 1.35 of developing PTSD for each additional rejection received. This is a preventable risk factor given that the majority of asylum seekers are

ultimately granted protection (Department of Immigration and Citizenship, 2011, 2013).

No relationship emerged between duration in the RDP and psychiatric symptoms. There have been mixed findings with respect to length of time in the RDP and psychological distress, with some studies reporting an association (Hosking et al., 1997) and others finding no relationship (Silove et al., 1997, 2007). A Swiss study (Toscani et al., 2007) considered a reduction in posttraumatic stress symptoms of Kosovar asylum seekers living in the host country for more than six months to be suggestive of an adaptation to the stress of asylum seeking. Although recuperative living conditions during asylum seeking may influence the degree to which symptoms remit over time, the vicissitudes inherent in the RDP—particularly asylum claim rejections—may impede or disrupt adaptation.

RDP rejections may trigger fears of repatriation and, hence, a recapitulation of traumatic memories (Aron, 1992). Thus, RDP rejections may themselves function as a trauma that reaches disorder proportions as the number of rejections increase. It is well established that a central requisite for recovery from PTSD is a safe and secure environment (Herman, 1992), which appears to be undermined by RDP rejections. As noted by others (Silove et al., 2000), this finding raises important questions about the degree to which the RDP may compound stress and distress for asylum seekers caused by past trauma. Furthermore, this has particular significance for individuals exposed to high levels of trauma in their homeland, given that such individuals may be more sensitized to the effects of postmigration stress (Silove et al., 1998). Thus, our data indicate that RDP decisions have far greater relevance to PTSD than does time alone and that posttraumatic stress symptoms are likely mediated by rejections.

In contrast to RDP rejections potentially increasing an individual's vulnerability to posttraumatic symptoms, employment ameliorated psychiatric symptoms and thus served a protective function. This finding is consistent with previous research demonstrating the protective role of employment on psychological health through work's capacity to reduce stress and anxiety and increase a sense of self-agency (Paul and Moser, 2009). Furthermore, it may provide financial capacity to continue with RDP appeals and thus maintain hope. This finding is also consonant with employment potentially being more effective in restoring the mental health of asylum seekers than psychological interventions (Eastmond, 1998). It must be noted, however, that the association between unemployment and MDD may be due to impairment secondary to MDD, which may preclude sufferers from being able to work. Nevertheless, this finding has implications for policy changes associated with asylum seekers being denied work rights (Beiser and Hou, 2001; Hollander et al., 2013).

There are a number of limitations to the present research. First, being a cross-sectional study, causality of findings cannot be assumed. Second, regarding recruitment, asylum seekers are a difficult population to research, with sampling posing a particular challenge. The recruitment process attempted to maximize external validity by recruiting participants through the ASRC to reflect the broader asylum-seeking population by country of origin. The nationalities represented by the total sample comprised 37% of the total ASRC population by nationality. Between 52% and 90% of asylum seekers from the largest five "country" groups were recruited, reflecting a good representation of these five nationalities within the broader ASRC population. The ASRC member base by sex was approximately 70:30 (male:female), which was not reflected by the study sample, being 89% men. This may have introduced a sex bias into the findings.

Third, potential bias may have been introduced by individuals who agreed to participate in the hope that doing so would assist their legal case. This is unlikely given that all participants were informed from the outset that the research was independent of legal processes and that participating would neither help nor hinder their asylum case. Fourth, although it is possible that selection bias may have resulted in a higher rate of mentally ill individuals participating in the study, the prevalence of PTSD found in this sample is similar to that reported in other studies (Hallas et al., 2007; Mueller et al., 2010; Silove et al., 2006), and comparable or higher rates of MDD in cross-sectional studies have been found elsewhere (Gerritsen et al., 2006; Mueller et al., 2010; Silove et al., 2006). Furthermore, the MINI was used because of the risk of self-report measures inflating psychiatric prevalence (Steel et al., 2009), although it is acknowledged that symptom scores were not directly validated against the MINI.

Finally, unfortunately, corroborating information regarding the number of rejections and timeframes of these was not available in every case. Although a rigorous attempt was made to verify all responses in relation to RDP status and visa conditions, data were not comprehensively vetted through immigration lawyers.

Future studies should address the aforementioned limitations through prospective study designs incorporating random sampling and psychiatric interviews to establish caseness. Samples should include equal numbers of men and women where possible.

CONCLUSION

The relationship between mental health, time in the RDP, and number of rejections is complex. This is the first study to highlight the association between cumulative RDP rejections and sustained levels of psychiatric symptoms in community-based asylum seekers. The findings indicate that negative asylum decisions may be a better predictor of mental health than duration of the RDP. Although previous research has shown that an asylum claim rejection at the primary stage is associated with persisting high levels of psychiatric morbidity, no study has demonstrated the cumulative deleterious impact of RDP rejections on mental health beyond the primary stage and into the appeals process. The protective role of gainful employment was demonstrated by the reduced symptom severity in anxiety, depression, and posttraumatic stress in those who were working and a decreased risk of developing major depression. Hence, these data indicate that the high prevalence of psychiatric morbidity in asylum seekers may be potentially reduced through the granting of work rights and reducing the RDP rejection rate.

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DISCLOSURES

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The authors declare no conflict of interest.

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