

Development and policy

Mental illness in asylum seekers and refugees

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ABSTRACT

Symptoms of psychological illness are much more common in asylum seekers and refugees as compared to the general population and other migrants. They do not, however, necessarily signify mental illness. Asylum seekers and refugees have been the subject of much negative political and media attention in recent months. This paper reviews current literature regarding the mental

health of asylum seekers and refugees. Factors increasing vulnerability of these groups to mental illness, and compounding social factors are discussed.

Keywords: asylum seekers, mental illness, refugees

Introduction

This paper's objective is to review the relevant literature regarding mental illness in asylum seekers and refugees. The factors that affect the vulnerability of asylum seekers and refugees to mental illness, including torture, bereavement, loss of family, language and cultural difficulties, unemployment, poverty and discrimination are discussed, as well as compounding factors and appropriateness of diagnoses of mental illness.

Background

Refugees from many parts of the world have been seeking refuge in other countries since Roman times. Current estimates range from 21 to 50 million refugees worldwide.¹ In 2000, Summerfield reported that approximately 1% of the world's population were fleeing around 40 violent conflicts.¹ In 2002 there were 159 236 refugees and 40 800 asylum seekers in the UK alone.²

Asylum seekers and refugees have been the subject of much recent media and political attention, but they are often misrepresented and stigmatised. The terms 'asylum-seeker' and 'refugee' are often used in a derogatory manner, and associated with words such as 'free-loader' and 'sponger'. The United Nations High Commission for Refugees (UNHCR) gives the actual definitions of refugee status (see Box 1).

Since 1951, any country that has signed the UN Convention on Refugees is obliged to consider the application of anyone who claims refugee status and grant that person refuge on the basis of the evidence.³ Each individual case is decided on its merits, and failed applicants are generally deported. Furthermore, the UK has signed the European Convention on Human Rights,⁴ which forbids torture, inhuman or degrading treatment or punishment, and the UN Convention against Torture,⁵ which forbids expulsion to a territory where people may be tortured. Amnesty International currently estimates that torture takes place in two-thirds of all countries worldwide.⁶

Box 1 Definitions of refugee status³

Refugee: a refugee is a person who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership in a particular social group, or political opinion, is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country (1951 United Nations (UN) Geneva Convention).

Asylum seeker: asylum seekers may describe themselves as refugees, but remain asylum seekers while awaiting a decision on their application for refugee status.

Displaced person: a displaced person is usually someone who has been forced to flee his or her home owing to civil war or persecution, often on religious or political grounds, but has been displaced within their country of origin, rather than a different country.

Box 2 shows the top five countries of origin of refugees in Britain in 2003.¹ Many wars are played out on the terrain of subsistence economies, and most conflict involves regimes at war with sectors of their own society. Most refugees flee from developing countries across the border to other developing countries.¹ Less than 17% flee to the developed West, to European countries such as the UK and Germany.⁷ The UK ranks ninth in Europe for asylum applications per head of population.⁸ Most of those seeking asylum in the UK come from countries that are in conflict, often fuelled by arms sold by richer countries.⁹

Box 2 Top five countries of origin of refugees in Britain

- Somalia
- Former Yugoslavia
- Afghanistan
- Iraq
- Sri Lanka

Experiences of refugees and asylum seekers as factors contributing to mental illness

Asylum seekers and refugees differ from other migrants as they have not chosen to migrate but rather

have been forced to flee their country, family, friends, community, job and culture. They have not been able to plan their move practically, psychologically and systematically over time.¹⁰ Well-documented vulnerabilities of migrants to mental health problems also apply to asylum seekers and refugees, but to a greater extent.^{11,12} Anxiety, depression, stress and post-traumatic stress disorder (PTSD) were found to be the most common types of psychological problems in asylum seekers and refugees.¹³⁻²² Such psychological symptoms may, however, be normal reactions to stress rather than diagnoses of mental illness. This is further discussed in 'Application of Western models of psychiatric illness to culturally diverse populations' below.

Gerritsen *et al* (2004) examined the prevalence of specific psychological disorders in refugees living in a Western country.²³ They found that the prevalence of depression, anxiety and PTSD is often high.²⁴⁻⁴⁶ The mean prevalence of depression in refugees was found to be 36%, anxiety 28%, and post-traumatic stress disorder 43%.

The huge range in reported prevalence rates may be, in part, due to the heterogeneous nature of the study population (e.g. selection of the study population, country of origin, duration of residence in the country of resettlement, refugee status) and measurement instruments. For example, the prevalence rates for PTSD range from 4% to 70%; similar percentages are reported for the prevalence of depression (3% to 88%) and anxiety (2% to 80%).

Application of Western models of psychiatric illness to culturally diverse populations

The wide ranges of reported mental illness in refugees and asylum seekers may also prompt the question of the appropriateness of applying Western models of psychiatric illness universally. Ballenger *et al* (2000) suggested that variations in the prevalence of mental illness across cultures may be due to differences in classification and lack of culturally appropriate instruments.²⁴

Different cultures vary in their perceptions of mental illness,²⁵ which can affect their utilisation of orthodox psychiatric services, and their classification of illness.²⁶⁻²⁸ Culture can influence mental illness by defining the normal and abnormal, by influencing aetiological factors, by influencing clinical presentation and by determining help-seeking behaviour.^{28,29} Ethnic identity has a role in individual's self-esteem and affects the social causes and course of psychiatric disorders.³⁰ Cultural mechanisms can provide social support, socially

acceptable emotional outlets and cathartic strategies.²⁸

Mental illness may not be an acceptable form of presentation in some cultures, and may present as psychosomatic symptoms, often with non-specific body pains, headaches, dizziness and weakness.² This reflects both culturally ordained modes of help seeking, and their view of appropriate medical presentation.² The cultural background is likely to determine whether depression will be expressed in psychological and emotional terms, or in physical terms.³¹

Several authors have reported a higher prevalence of depression in ethnic minority groups in the UK than in the dominant population.³² Although core depressive or psychotic symptoms are often regarded as universal, some see these constructs as disorders consistent merely with a Western conceptualisation of distress.²⁸ It has been argued that DSM-IV and ICD-10 'Western' classifications of depression represent Western concepts of illness, and might not be easily applicable to other cultures.^{24,33,34}

Deep psychological reflection common in Westernised cultures appears to be relatively uncommon among more traditional cultures.²⁸ In Japan, China and India, internal psychological explanations of suffering are neither sought nor seen as credible.³⁵⁻³⁷ Gaines (1995) suggested that somatic experiences and delusions may be more common in societies that do not psychologise distress, such as traditional societies.³⁸ A culture-bound syndrome is a combination of psychiatric and somatic symptoms that are considered to be a recognisable disease only within a specific society or culture. Symptoms of such syndromes may not be readily recognised using Western models.

Behaviour which appears odd to the assessing clinician may have a culturally sanctioned role (e.g. speaking in tongues, extreme religiosity, trance and possession).³⁹ It is clear that hallucinations and delusions must be judged in relation to the patient's cultural background.²⁸ Mukherjee *et al* (1983) found that hallucinations were more frequent in their African-Caribbean sample than in their Caucasian sample.³⁹ Partly because of this, African-Caribbeans were more likely to be erroneously diagnosed as having schizophrenia in spite of a preponderance of affective symptoms.³⁹ Hallucinations and paranoid thought may be understandable where victimisation and persecution in everyday life are reflected in a cautious approach and suspicious attitude to strangers, including mental health professionals.³⁹

PTSD has frequently been used by many psychiatrists to describe the reactions of refugees to war or atrocities that they have suffered.⁴⁰⁻⁶³ PTSD is an anxiety disorder caused by the major personal stress of a serious or frightening event, such as an

injury, assault, rape, or exposure to warfare or a disaster involving many casualties.^{64,65} Many refugees and asylum seekers will have been exposed to these experiences. It is important to note that PTSD was a measure that originally formalised war trauma reactions in American Vietnam war veterans, and as such is a Western concept.⁶⁶

There is currently contention regarding the validity of PTSD as a diagnosis. It is important not to turn normal expressions of grief and distress concerning highly abnormal experiences into a medical problem.⁶⁵ The difficulty with the use of PTSD is that it may turn common reactions to traumatic events into medical problems and assume a universally valid and applicable model.^{65,67} The symptoms of PTSD do not necessarily mean the same in different cultural and social settings.⁶⁸ Symptoms need to be understood in the context in which they occur – distress and suffering are not in themselves pathological conditions.⁶⁹

Persecution in their country of origin

An asylum seeker flees from war and/or persecution in their country of origin. War and human rights abuses often have a lasting psychological impact that may contribute to the development of mental illness or psychological distress. Although symptoms of psychological distress are common among refugees, they may not necessarily signify mental illness.^{12,21,63}

Human rights abuses

Refugees' past experiences often include witnessing genocide, detention, beatings and torture, rape and sexual assault; witnessing the death and torture of others including family members, destruction of home and property and forcible eviction.⁷ Sexual violence and rape have been used throughout history as a weapon of warfare to degrade and humiliate an enemy.⁶⁹ Abuse is often carried out by those in authority, so victims are often fearful of authority figures in the host country.⁷⁰ Estimates of the proportion of asylum seekers that have been tortured vary from 5% to 30%, depending on the definition of torture used and their country of origin.^{71,72} The actual numbers may be even higher, as many people do not initially admit to their experiences of torture.⁶⁹

Children may have been conscripted into the army, while women and girls may have been forced into sexual slavery. Other examples of long-term persecution include political repression, deprivation of human rights and harassment. In refugee camps, there is often prolonged detention, squalor,

malnutrition and lack of education. In addition to these experiences, social, economic and cultural institutions are damaged, often intentionally.^{73,74}

Some refugees and asylum seekers experience atrocities such as torture without developing any serious psychological sequelae apart from a natural increase in anxiety and occasional nightmares.⁷⁰ Others show more marked signs of anxiety, depression, guilt and shame, as a result.^{70,71} Fundamental to peoples' processing of atrocious experiences is the social meaning assigned to it, which may include attributions of supernatural, religious and political causation.² Members of a terrorised social group who find their experiences incomprehensible, and whose traditional ways of handling crises are inadequate, are particularly likely to feel helpless and uncertain what to do.⁷⁴

Many asylum seekers may be reluctant to admit to torture and sexual violation. This may be through shame or unwillingness to disclose sensitive information to an immigration officer of the opposite sex, especially if a friend or family member is acting as their interpreter.⁷⁵ Furthermore, medical consultation for such atrocities may not be part of all cultures' health-seeking behaviours.

The experience of escape

The journey to a country of potential asylum may itself be traumatic, hazardous and stressful.¹⁰ By definition, refugees are fleeing persecution, hence they usually have to be helped by traffickers, who often demand extortionate payment.⁷ The journey itself may be long and difficult, filled with constant fear of discovery.¹⁹ Asylum seekers are particularly vulnerable, and may be subjected to inhumane conditions and sexual and physical abuse by the traffickers themselves.⁷⁶ These stressors all act as contributory factors for mental illness.⁷⁶

Experiences in the host country

Although many refugees have suffered trauma in their home country, it is often their experiences in the country of resettlement that have a much greater impact on their mental wellbeing. In the host country, they face the effects of loss, poverty, unemployment, dependence and lack of cohesive social support.⁷⁷ Such factors undermine both physical and mental health, and are associated with anxiety and depression. Additionally, language difficulties and racial discrimination can result in inequalities in health and have an impact on opportunities in and quality of life. Detention of refugees is especially associated with a high incidence of

mental illness.¹⁴ Each factor is discussed in more detail below.

Loss of family, friends, country, culture and profession

Asylum seekers and refugees face multiple changes needing much psychological and practical adjustment. Once refugees have arrived in the country of resettlement, they may initially feel immense relief at finding a place of refuge, but this usually gives way to feelings of grief for what has been left behind.¹⁹ The asylum seeker may have left members of their family and friends behind, or they may have been killed. Many refugees, including children, have no other relatives in the UK.¹⁸ Their country, culture and community have been lost, as well as adults' profession and status.

Eisenbruch (1990) used the term 'cultural bereavement' to describe Cambodian refugees in the United States.⁷⁸ He found that cultural bereavement was characterised by a tendency to live in the past, to be visited by supernatural forces from the past when awake or asleep, to feel guilty about leaving and to be distressed both by intrusive traumatic images and by the fading of positive memories from the past and a yearning to complete obligations to the dead.⁷⁸ For those Cambodian refugees, and for many asylum seekers in Britain today, antidotes to cultural bereavement reside in the comfort of religious belief and participation in religious gatherings rather than an inappropriate use of Western psychiatric technologies.⁷⁹

Socio-economic status and unemployment

The belief that most asylum seekers come to Britain for welfare benefits is at odds with the fact that many are highly skilled, and previously enjoyed a high standard of living.⁷ Forty percent of a sample of asylum seekers in Australia had worked in professional or managerial roles in their countries of origin, and similar figures have been found in Britain.^{15,80} Many have university degrees and other qualifications for skilled work. Many pay the equivalent of several thousand pounds to a trafficker to reach a country of potential asylum. Refugees often come from a high social standing, as it is often only the more affluent who can afford to pay traffickers to escape to other countries.⁷

Refugees come from a variety of cultural backgrounds, and although often perceived as an economic and social burden, they may also prove to be an asset. Refugees have made significant contributions around the world; in the UK, refugees have included the inventor of the contraceptive pill and the first Governor of the Bank of England.¹⁰

The skills of health professionals, teachers and other workers could benefit the UK, especially in view of the recent shortage of doctors and other healthcare workers, but it is difficult for their qualifications and experience to be recognised.⁸¹ Many UK refugees are doctors who are not allowed to work in the UK unless examinations are passed; and usually after long delays. From 3 April 2006, the Home Office no longer allowed non-European Economic Association (EEA) or non-resident doctors to be covered by 'permit-free' training status.⁸² Instead, trusts must now apply for a work permit before employing candidates not covered by any other leave to remain in the UK, and must demonstrate, via the resident labour market test, that there are no suitable EEA nationals to take up the post in their stead. In Britain it costs an estimated £200 000 to train a new doctor, while refugee doctors can be accredited to practise at an average cost of only £3500.⁸³

In the UK, unemployment is associated with early death, divorce, family violence, accidents, suicide, higher mortality rates in spouse and children, anxiety and depression, disturbed sleep patterns and low self-esteem.⁸⁴ Such problems of unemployment may be even more acute when asylum seekers are prevented from working, and there is often little prospect of continuing in their original profession even after refugee status has been obtained. Sinnerbrink *et al* (1997) found that asylum seekers reported a marked decline in socio-economic status on resettlement.¹⁵

Men are often more acutely affected by a drop in status. However, men granted refugee status are less likely to find work than women.⁴⁰ This leads to a further drop in status within the family. Economic independence has been linked to recovery of psychological distress – work has always been central to the way that refugees have resumed their everyday rhythms of life and re-established a viable social and family identity.⁸⁵

In Sweden, Eastmond (1998) compared two cohorts of families of survivors in of a particular Bosnian concentration camp.⁸⁶ The camp families were originally from the same town in Bosnia and had similar socio-economic backgrounds. By chance, half the families had been sent to a place where there was temporary employment but no psychological services, the other half to a place where no employment was available but there was a full range of psychological services. At a follow-up at one year, a clear difference had already emerged. The group given work appeared to have fewer psychological difficulties, but most adults in the second group were on indefinite sick leave.

Currently in the UK, an asylum seeker or refugee may only work once they have been granted asylum

or had their refugee status confirmed. Although the fast-track system has decreased the wait for a decision, there has been recent controversy over the quality of decisions made. Allowing asylum seekers and refugees to work, albeit temporarily whilst awaiting the outcome of this process, might minimise negative socio-economic effects on mental health of such vulnerable people. Most people would rather be active independent citizens than recipients of benefits.⁷⁰ Alternatively, a faster asylum application would be cheaper and reduce the period of unemployment.

The skills of many refugees and asylum seekers mean that many should be able to find a job and economically contribute to society. This might also alleviate some of the prejudices directed towards them due to their media portrayal as 'scroungers and would-be terrorists'.⁸⁷ Training schemes could be implemented, and would be especially helpful for those whose current skills need minimal adjustment in order to be used in the host country. This would have a positive economic effect for the host country, rather than using resources to pay unlimited unemployment benefits.

Poverty and hardship

Poverty and hardship have a well-documented compounding negative impact on mental health, and it is of deep concern that asylum seekers are being forced to live below the poverty threshold.⁸⁸⁻⁹⁰ Asylum seekers in the UK currently receive 70% of normal income support, which amounts to approximately £38 per week.¹³ Until April 2002, most of this money was in vouchers, for which supermarkets could not give any change.⁸⁵ In the UK, poverty and dissatisfaction with housing is widespread amongst refugees and asylum seekers.⁹⁰ The Oxfam and Refugee Council's report in 2002 reported that asylum seekers were suffering from poverty levels and hardships unacceptable in a civilised society, and that their basic needs were not adequately met by state provisions.⁹⁰

Adequate social support such as suitable housing and benefits may help to reduce the vulnerability of asylum seekers to mental illness.

UK dispersal policy

Under the 1999 Immigration and Asylum Act, many asylum seekers are dispersed throughout Britain to areas that have previously had little experience of refugees. These areas are often impoverished and lacking in appropriate refugee services.⁷⁶ Asylum seekers have no choice about where they are located. They have previously tended to go to London where there are established support networks including

other asylum seekers and refugees.⁸⁵ In a study of Iraqi asylum seekers in London, poor social support was more closely related to depression than was a history of torture.⁹¹

Extreme racism, which may include assaults and even murder, has occurred when refugees are moved to dispersal areas.⁹² Victims of racist discrimination have been shown to be at increased risk of anxiety, depression, and psychosis.^{93,94} People who leave their allocated accommodation for any reason, including racist abuse or to be nearer their family or community, lose their entitlement to income support.⁷ In spite of this, many asylum seekers leave the outlying areas to go to London where there are communities of people from comparable backgrounds.⁷⁶ The asylum seekers are thereby removed from the asylum support system and add to the number of destitute people in the capital.⁷

Awaiting asylum applications

To be granted refugee status, an asylum seeker must fulfil certain criteria under the terms of the UN Geneva Convention,³ and must show that he or she is personally at risk, which may be difficult to prove. The asylum process may be complicated and intrinsically stressful, with the continual fear of deportation.^{10,62} This process leads to exacerbation of psychological distress, causing anxiety, depression and frustration.^{10,62}

Language difficulties

Language difficulties are a common problem for all migrants, but especially for refugees and asylum seekers who have usually been forced to flee rather than choose their host country carefully. A 1998 study of Iraqi refugees in the UK reported that 29% were unable to speak any English.⁹¹ This may prevent them from seeking health care, obtaining employment and becoming socially integrated, and further highlight differences between refugees and the host population. If the asylum process is inefficient, and integration into the host society is poor, asylum seekers are more likely to become depressed.⁶² However, if they integrate well, and use health services, they are less likely to be depressed.⁶²

Detention

Australia is the only Western country that enforces a policy of mandatory detention for asylum seekers arriving without entry documents, although in March 2005 the UK was also currently detaining 1625 asylum seekers.^{95,96} Asylum seekers in the UK and abroad may have been held in prisons or detention centres for months or years pending their asylum

applications.⁹⁷ Many medical studies have reported on serious psychological effects that detention may have on asylum seekers' health.^{14,95-97}

The British government maintains that it uses detention sparingly and only when it is essential to prevent absconding, to check identity or make it easier to remove people from Britain. However, of approximately 750 asylum seekers detained in November 1996, approximately one-third had spent six months or more in detention.⁹⁸

The detainees have committed no crime, do not understand why they have been detained, and realise that detention may be indefinite. For those who have been detained in their own country, the experience of subsequent detention can be devastating, provoking powerful memories.⁶³ Survivors of torture often describe the feelings of fear and powerlessness caused by the clanging of cell doors, footsteps in the corridor and uniforms, which re-stimulate their distress.^{98,99}

Keller *et al* (2003) reported that 77% of detained asylum seekers in the US were found to have clinical symptoms of anxiety, 86% symptoms of depression, and 50% symptoms of PTSD.⁹⁷ All symptoms were significantly correlated with length of detention, and at follow-up, participants who had been released had marked reductions in all psychological symptoms. Those still detained were more distressed than baseline levels.

Racism and stigmatisation

Refugees and asylum seekers are generally misrepresented in the media, and these terms themselves are associated with stigmatisation. This can be demonstrated by headlines in *The Daily Mail* such as 'Tories will be tough on bogus asylum seekers', and in *The Daily Telegraph*: 'Secret Amnesty lets in bogus asylum seekers'.^{100,101} Thus fear of racial, ethnic and religious difference dominates popular attitudes to both asylum and immigration.

Racism is common: in one national survey in the UK, 25-40% of participants said they would discriminate against ethnic minorities; an estimated 282 000 crimes were racially motivated in 1999; and one-third of people from ethnic minorities constrain their lives through fear of racism.^{102,103} Disparities between ethnic minority and majority groups in housing, education, arrests, and court sentencing are believed to be due to racism, not simply to economic forces.¹⁰⁴

Racial discrimination has been shown to undermine mental health. In a UK study, victims of discrimination were more likely to have anxiety, depression, and psychosis.¹⁰⁵ People who believed that most companies were discriminatory were also at increased risk of mental illness.¹⁰⁶ Overt or

institutional racism and stigmatisation can result in lack of social integration, harassment, and loss of opportunities, not only for employment but also for health care.

Compounding effect of factors on mental illness

Whilst the above factors are important in isolation, other studies have demonstrated a compounding effect in combination. Social isolation, poverty, hostility and racism have been shown to have compounding negative effects on mental health.⁸⁸ In a study by Murphy *et al* (2002) examining refugees in inner London, depression was often connected with social isolation, racism, lack of occupational opportunities and losses sustained in the host country.¹⁰⁷

Sinnerbrink *et al* (1997) reported that common ongoing factors of severe stress included fears of being repatriated, lack of occupational opportunities and social services, separation from family, and issues related to the process of pursuing refugee claims. These results suggested that aspects of the asylum-seeking process may compound the stressors suffered by an already traumatised group.¹⁵

Silove *et al* (1997) interviewed 40 asylum seekers in Sydney, Australia.⁵² Anxiety scores were associated with female sex, poverty and conflict with immigration officials, while loneliness and boredom were linked with both anxiety and depression. Seventy-nine percent had experienced a traumatic event such as witnessing killings, being assaulted, or suffering torture and captivity, and 37% met full criteria for PTSD. A diagnosis of PTSD was associated with greater exposure to pre-migration trauma, delays in processing refugee applications, difficulties in dealing with immigration officials, obstacles to employment, racial discrimination, loneliness and boredom.

Asylum seekers and refugees are in the high-risk category for suicidal intention, and many succeed in taking their own lives. They are most often aged between 20 and 40 years, male, frequently alone, and isolated because of language difficulties or depression and a sense of not belonging, reinforced by experiences of racism or neglect.

Refugees rarely view their problems in terms of mental illness. In a survey of Kosovan refugees in the UK, almost everyone nominated work, schooling and family reunion as their major priorities, rather than psychological distress.⁷⁶ For many refugees, restoration as far as possible of their normal life

can be an effective promoter of mental health. Recovery over time is intrinsically linked to the reconstruction of social networks, achievement of economic independence, and making contact with appropriate cultural institutions against a background of respect for human rights and justice.¹⁰⁸

It is important to acknowledge the resilience of individuals and not label them with diagnoses that may add to their stigma and powerlessness.²³ While efforts must be made to improve mental health services, the longer-term fortunes of most asylum seekers and refugees depend primarily on what happens in their social, rather than their mental, world.¹²

Conclusion

There is an acute need for health professionals to understand mental health problems in the context of the individual's experiences and cultural backgrounds, rather than assume and impose diagnoses of mental illness. This is reflected in the wide range of prevalence of mental illness in different refugee populations, which may be due to over-diagnosis of mental illness rather than normal psychological reactions to stress.

Factors increasing the vulnerability of asylum seekers and refugees to mental illness derive from their experiences in their country of origin, their journey to refuge, and subsequent psychological, social and emotional stressors in their host country. Social factors have been suggested to be one of the most important factors in determining mental health, and have the potential to be addressed and greatly improved. Furthermore, there needs to be an understanding that individual factors affecting mental health may combine to compound the effect on individuals.

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CONFLICTS OF INTEREST

None.

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