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Mueller, J ; Schmidt, M ; Staeheli, A ; Maier, T

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Mental health of failed asylum seekers as compared to pending and temporarily accepted asylum seekers

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Abstract

Background: Asylum seekers and refugees often suffer from severe psychopathology in the form of posttraumatic stress disorder (PTSD). As PTSD impacts memory functions, and as asylum applications rely on personal accounts, AS with PTSD are at more risk of being rejected than refugees.

Methods: We studied the mental health of failed asylum seekers (FAS, $N=40$) and a matched sample of asylum seekers (AS, $N=40$). Participants were administered structured interviews on sociodemographics, flight, exile, and standardised questionnaires on PTSD, anxiety, depression and pain.

Results: Both samples were severely affected; over 80% exhibited at least one clinically significant condition.

Conclusion: Given the great vulnerability of these individuals, long and unsettling asylum processes as practised in western host countries seem problematic, as does the withdrawal of health and social welfare benefits. Finally, high rates of psychopathology amongst FAS indicate that refugee and humanitarian decision-making procedures may be failing to identify those most in need of protection.

Keywords

Asylum seekers, rejection of asylum, mental health, credibility

Introduction

In response to the increasing numbers of immigrants, typical host areas such as Europe, North America and Australia have in recent years tightened their immigration laws and asylum procedures. Only a small proportion of those seeking asylum in such countries are recognised as refugees (1). Those rejected face repatriation to their countries of origin, where they believe themselves to be at risk of harm or persecution (2). Consequently, growing numbers of failed asylum seekers (FAS) are deciding to remain illegally in the “host” countries (3). Only rough estimations on the numbers of these “undocumented migrants” exist. As many as 22,500 to 58,000 “sans papiers” (French: without papers) whose application for asylum was declined are estimated to live in Switzerland (3).

Asylum seekers and refugees are at high risk of ongoing mental health problems (4,5). As many of them are traumatised by war, political/ethnic oppression and torture, it is not surprising that Posttraumatic Stress Disorder (PTSD) rates of up to 70% have been found in community samples of asylum seekers and refugees (5,6). Amongst those, especially individuals without secure residency status - be it pending cases (7-9) or rejected asylum seekers (10) - appear to be at high risk to suffer from ongoing mental health problems. In this context it is especially alarming that the presences of traumatic experiences and PTSD directly influence refugee status decision-making (11,12) as both variables severely impact various memory functions known to give personal accounts credibility (13,14). Consequently, asylum seekers with PTSD are more likely to be refused refugee status (11).

Additionally to their pre-migration trauma, individuals without secure residency visa suffer substantial post-migration stress (7-9,15), insecurity regarding their legal status (10,16,17) and ongoing fear of repatriation and persecution (10,18). These stressors may be particularly harsh in FAS for several reasons. In many host countries, FAS are supposed to leave the country within a defined period, and welfare benefits are discontinued immediately. Those who stay in the country lose their accommodation, are not permitted to work, and receive no economic support. Finally, their health insurance coverage is discontinued, they are no longer entitled to free non-urgent primary or secondary care (19,20).

A dearth of data exists on the general and especially mental health conditions of rejected asylum seekers who decide to stay on in western countries. Despite discussion of these issues by General Practitioners (21,22), only one study so far has investigated the short-term impact of asylum claim decisions on the trajectory of traumatic stress and other psychiatric symptoms (10). Individuals living in illegality are by nature hard to locate and to study. From a moral perspective, however, we cannot ignore their fate. Aims of our study were therefore to investigate actual living conditions, trauma load, and mental health of rejected asylum seekers with long histories of living in illegality and to compare their outcomes with those of non-failed asylum seekers.

Methods

Design of the study

The study compares failed asylum seekers (FAS) with asylum seekers whose claim was still pending or temporarily accepted respectively at the time of the study (AS). All data were collected through direct interviews and standardised questionnaires. The FAS-sample was recruited from December 2008 to February 2009 – a time when around 150 “sans papiers” had occupied a church in Zurich fighting for better asylum policies and provisions for hardship cases. Contacts were made with the help of Bleiberechts-Kollektiv Zurich (an organisation defending the rights of undocumented migrants), and Meditrina Zurich (an outpatient health service for migrants without medical insurance or income). Interviews took place either in the squatted church, in the café of the Bleiberechts-Kollektiv Zurich or in shelters for sans papiers. Inclusion criteria were illegal residency status following a rejected asylum claim. The AS-sample was recruited with the help of the Swiss Federal Office for Migration, which provided us with names and addresses of unselected individuals who were applying for asylum during a defined period and who were assigned to the canton of Zurich. Recruitment and assessment took place between July 2008 and April 2009. AS (total sample size: $N=142$) were interviewed in their domiciles or at our department, at their convenience. Inclusion criteria were having applied for asylum in Switzerland, and having a valid visa. Each FAS was matched with an AS from the full AS-sample. Matching variables were sex, age and years of education and the number of traumatic events experienced. The latter variable was considered a matching variable firstly because it likely mediates mental health as well as the asylum status. Secondly, compared to the FAS the randomly recruited total AS sample was similarly severe

traumatised indicating to have experienced $M = 5.20$ ($SD = 4.27$) traumatic event types (23). Cohen's effect size $d = .34$ indicates the absence of essential group differences between the total sample AS sample and the FAS. Consequently, to control that due to the matching no differences in trauma-load occurred it was necessary to consider trauma the variable as a matching variable. In cases of more than one possible match, matching partners were chosen by randomisation.

Before assessments, potential participants were informed in detail about the aims of the study and assured that participation was voluntary and that all data would be treated confidentially. All participants gave their consent to the study. The approximately 45-minute assessment consisted of an interview conducted by trained psychologists from our department. If necessary, trained interpreters assisted the interviewers. All mental health questionnaires were translated and back-translated into the 11 main languages spoken by AS and refugees in Switzerland, using established translation/back-translation procedures (24). Most participants were thus able to answer the questionnaires by themselves. Individuals who did not understand any of these languages or who did not have the necessary level of literacy completed the questionnaires in interpreter-assisted face-to-face interviews. The Ethics Committee of the canton of Zurich approved the study.

Sample

The first sample consisted of $N=40$ asylum seekers whose claim for asylum in Switzerland had been rejected, but who had decided to stay on illegally. Most of these mainly male participants were single. They originated from 18 countries with an average duration of stay in Switzerland of 5.8 years and a mean duration of living in

illegality of $M=34$ months (range=1-108 months). Over one third (36.4%) had lived in Switzerland illegally for more than 2 years.

In the second sample, 78% of participants' asylum claims were still pending, whereas 23% had been rejected asylum status but obtained temporary visas. As a result of the matching procedure, most of the $N=40$ participants in this sample were also male. More than one third of them were married. They originated from 17 countries and their average duration of stay in Switzerland was nearly 4 years. For sociodemographic characteristics see Table 1.

Measures

By means of a structured interview we assessed the demographic characteristics (such as sex, age, ethnicity, religion, education), the reason for the participants' migration, as well as characteristics of the situation in Switzerland (such as duration of stay in Switzerland, but also variables targeting integration such as working, contacts to Swiss or satisfaction with life in Switzerland). Variables for this part of the assessment were adapted from previous research (25,26). Mental health variables were assessed by standardised questionnaires. Traumatic events were assessed using part one of the Harvard Trauma Questionnaire (27), a common instrument assessing 17 types of traumatic life events known to affect refugee populations (range 0–17). In this article, we refer solely to the number of traumatic event types that participants indicated having experienced themselves.

The Posttraumatic Diagnostic Scale (28) is a DSM-IV-based 17-item self-report assessing the PTSD symptom severity experienced by the respondent in the month

prior to assessment. Each item is rated on a 4-point scale (range: 0–51). The PDS has demonstrated validity and reliability and is recommended as a particularly useful tool for screening and assessing PTSD (28).

The Hopkins Symptom Checklist-25 (HSCL-25, 29) assesses symptoms of anxiety (10 items) and depression (15 items) on a 1–4 scale. Individuals with a mean score greater than 1.74 are considered to be symptomatic. The scale has very good validity and reliability and has been adopted for use in refugee populations (29).

The intensity of pain experience during the past month was measured by the 1-item Verbal Rating Scale (VRS, from SF-36, 30) that is rated on a 6-point scale from “0 = no pain” to “5 = worst pain possible”. The VRS is established as a valid, reliable and change-sensitive measure of subjective pain (31).

The 8-item EUROHIS assesses quality of life (32). Responses to the 8 items (5-point scale, range 8–40) form a sum-score, with higher scores denoting higher quality of life.

Data analysis

The data were coded and analyzed using SPSS17.0. Descriptive statistics were used to examine the demographic variables, characteristics of the living situation in Switzerland and the mental health variables. Kolmogorov-Smirnov tests were used to analyse whether the interval data were normally distributed. Paired sample t-tests (normally distributed continuous data), Wilcoxon tests for paired samples (ordinal

data), McNemar-Bowker tests (nominal data), and McNemar's test (binominal data) were conducted to identify differences between the two samples.

Results

The situation in exile

Although the samples were matched on sociodemographic characteristics, they differed significantly on most variables concerning life in exile (see Table 2). While the FAS had no valid visa by definition, the claims of more than three quarters of the AS-group were still undecided after nearly 4 years in Switzerland. The groups also differed significantly in their duration of stay in Switzerland, with the FAS having been in the country longer than the AS – by necessity: asylum applications take years to process. While AS were more likely to have family members in Switzerland, the FAS indicated more social contacts with Swiss people. Regarding variables that are often seen as indicators of “integration”, such as working, command of German and following the news of the host country as well as the home country, no group differences emerged. Relative to FAS, pending/temporarily accepted asylum seekers were significantly more satisfied with their living conditions in Switzerland and indicated better quality of life. Nevertheless, the groups did not differ regarding homesickness, with about two thirds of each sample indicating that they felt homesick very often.

Number of traumatic experiences

Both samples - the FAS sample as well as the total AS sample - were severely traumatised. Therefore we controlled the trauma load by using it as a matching variable. As a result of this procedure, both groups had experienced comparable numbers of traumatic event types. These included high-impact traumatic events such as imprisonment (FAS: 60.0%; AS: 40.0%), torture (FAS: 30.0%, AS: 47.5%) and the killing of family members (FAS: 32.5%, AS: 40.0%).

Mental health

The proportion of this non-clinical population with mental problems was high. Both groups indicated comparably high PTSD symptomatology. Based on the symptom severity rating categories suggested by the authors of the PDS (33), the whole sample showed moderate symptom severity; separate analysis of the PTSD cases only revealed “moderate to severe” symptom severity (FAS: \underline{M} = 25.60, \underline{SD} = 10.81; AS: \underline{M} =26.51, \underline{SD} =9.13). Accordingly less than one third of each sample did not meet criteria for full-blown or sub-clinical PTSD respectively. Similarly, both samples reported high anxiety and depression severity scores with more than two thirds being clinically significant in both conditions as well as “moderate” pain intensity during the last month. The samples did not differ regarding PTSD, depression, anxiety or pain intensity. Descriptive statistics and group differences for traumatic events and mental health variables are reported in Table 3.

Based on the PDS and HSCL-25 scores, only 12.5% (\underline{N} =5) of the FAS and 17.5% (\underline{N} =7) of the AS did not meet the criteria for any of the diagnoses assessed (full-blown PTSD, anxiety, depression). In contrast, 37.5% (\underline{N} =15) of the FAS and 53%

($N=21$) of the AS suffered from all three conditions, and 47.5% ($N=19$) of the FAS and 22.5% ($N=9$) of the AS from two conditions. The groups did not differ regarding their overall prevalence of mental illness ($Z=-.15$, $p=.882$).

Discussion

Asylum has become a major issue of political debate in the western world. It is known that many asylum seekers suffer severe mental health problems (4), and that substantial numbers of FAS decide to stay illegally in the “host” country (e.g. 3). To our knowledge, this is the first study to compare the mental health of FAS with that of pending/temporarily accepted asylum seekers. Only one study to date has examined the immediate effects of rejection on asylum seekers (10). Reasons for the dearth of data may be that AS are per se an understudied population and that FAS, particularly, are very difficult to recruit.

One main finding of our study is that both samples showed severe mental health problems. Particularly PTSD rates approaching 50% in both samples are alarming. These figures are consistent with previous findings in AS- (5) and FAS-samples (10). They are significantly higher than in western populations, where epidemiological studies have found PTSD rates ranging from 0% in Switzerland (34) to 1–2.2% in Germany (35) and 8% in the United States (36). From a psychopathological perspective with a particular focus on traumatic events and PTSD symptomatology, it seems that people applying for asylum in Switzerland are severely traumatised by premigratory factors such as surviving war and torture and suffer from severe mental health problems. Consequently they would desperately need mental health care.

However, in contrast to pending/temporarily accepted asylum seekers, who theoretically do have access to mental health care – although specialist centres are rare and overcrowded – FAS do have limited or no access to non-emergency health care, including mental health consultations.

Besides the adversities that many asylum seekers have faced in their home countries, high levels of postmigration stress caused by factors such as living in illegality or uncertainty about asylum decisions are hypothesised to negatively impact the mental health of AS and FAS (10). Our results show, that even though no group differences emerged regarding variables indicating integration, FAS were less satisfied with their actual living conditions and also reported lower quality of life as compared to AS. The fact that these major - albeit not surprising - findings are not reflected in differing rates of psychopathology might be explained in ceiling effects regarding psychopathology in both samples or in the fact that both samples do experience high levels of actual stress - be it pending asylum decisions or be it the fact of living in illegality.

As in other host countries, in Switzerland applicants whose claims for asylum are rejected, but who have severe illness like PTSD that cannot be treated in the home country, qualify for temporary “humanitarian” visas. The alarmingly high rate of PTSD cases in the FAS-sample shows that the authorities are failing to make use of this possibility – although it is evident that many of those rejected will not have access to PTSD treatment in their home countries. Alarmingly, a recent study found that even after psychological training, official judicial interviewers were unable to identify

PTSD cases during asylum interviews (6). From a psychological perspective, it is obvious that many of the FAS would qualify for a temporary humanitarian visa.

The relatively small sample size as well as the use of self-reports (as opposed to clinician ratings) are a limitation of the study as both factors have been found to overestimate mental disorder prevalence estimates (37,38). The use of larger samples as well as inclusion of structured diagnostic interviews additionally to standardised questionnaires would be helpful for future studies. As the study design was cross-sectional, we cannot draw conclusions on longitudinal patterns or make causal inferences. Future studies should employ longitudinal data and include a comprehensive psychological assessment. While we were able to recruit a random sample from all AS living in the canton of Zurich, the FAS-sample were recruited from protesters fighting for better asylum policies and provisions for hardship cases. It is conceivable that they may have felt a wave of hope, solidarity and social support from the Swiss population during this protest. As the participants in our study may be the more active and courageous of those FAS living in illegality, it is also possible that our data underestimate the PTSD rate in FAS. Comparing FAS with successful asylum claimants may help to specify the relation between insecure or secure visas and mental health. In this study, we used an ad-hoc list of postmigration living problems - although this list was derived with regard to previous research (25,26), further studies indispensably should include a more detailed measure of post-migration stress.

Our results have implications for both policy makers and clinicians. The rates of severe mental problems in the groups of FAS and AS are alarming. Specifically, the

high rates of PTSD and high symptom severity suggest that these individuals have survived severe trauma; moreover, the data show that PTSD is a common condition in asylum seekers, whether recognised by the state as refugees or not. Given these findings it seems crucial to establish effective means of identifying and providing adequate medical treatment for traumatised asylum seekers early in the asylum process. As argued before, the denial of medical support to FAS is unethical and affects the most vulnerable people in western host countries (15,21,22).

Furthermore, given the vulnerability of asylum seekers, western host societies must continue to work to improve asylum decisions. Firstly, it seems doubtful that decision makers to date have a sufficient understanding of the effects of PTSD to inform their decisions about these vulnerable individuals. Psychological knowledge could help them to better understand the often complex presentation of claimants with mental health needs, and thus ensure that these claimants are offered the necessary protection in the form of asylum or at least temporary visas (11,14,39). Secondly, to reduce postmigration stressors and to foster the healing of this vulnerable group, the usually long and unsettling asylum processes should be accelerated substantially and should be followed by immediate and intensive means of integration into the host country.

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Conflicts of interest

None declared.

Key points

- Failed asylum seekers showed as much severely affected mental health as pending and temporarily accepted asylum seekers.
- Long and unsettling asylum processes seem problematic, as does the withdrawal of health and social welfare benefits after rejection of asylum claims.
- The high rates of psychopathology amongst the rejected asylum seekers indicate that refugee and humanitarian decision-making procedures may be failing to identify those most in need of protection.

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Table 1: Demographic characteristics of failed (FAS) and pending/temporarily accepted (AS) asylum seekers.

Demographic Characteristics		Samples		Group Differences ^a	
		FAS (<u>n</u> =40)	AS (<u>n</u> =40)	<u>t</u> (<u>df</u>)/ χ^2 (<u>df</u>)	<u>p</u>
Sex ^b	<u>N</u> (%) Male	38 (95.0)	38 (95.0)		1.000
Age ^b	Mean in years	32.10 (7.11)	32.40 (7.86)	<u>t</u> = .49(39)	.627
	Range	22 – 51	18 – 51		
Region of origin	<u>N</u> (%) Africa	18 (46.2)	11 (27.5)	$\chi^2 = 9.33(7)$.230

West Asia (incl. Turkey)	16 (41.0)	16 (40.0)
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East Asia (incl. Russia)	5 (12.8)	5 (12.5)
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Married	4 (10.0)	15 (37.5)
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Education ^b	<u>M (SD)</u> in years	9.78 (4.69)	9.70 (4.18)	$t = .11(39)$.914
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Religion	<u>N</u> (%) (main categories)	3.22(3)	.360
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Christian 19 (47.5) 9 (25.7)

Ethnic/religious persecution 20 (60.6) 9 (22.5)

Notes.

^aThe following tests were used: paired t-tests (normally distributed continuous data); McNemar-Bowker test (nominal data); McNemar's test (binominal data).

^bAs these variables were matched, group differences were calculated solely for control reasons.

Table 2: Characteristics of the situation in Switzerland (CH) for failed (FAS) and pending/temporarily accepted (AS) asylum seekers.

Situation in Switzerland		Samples		Group Differences ^a	
		FAS (<u>n</u> =40)	AS (<u>n</u> =40)	t(df)/ χ^2 (df)/ Z	p
Years since entry	<u>M</u> (<u>SD</u>)	5.78 (4.59)	3.93 (3.50)	t = 2.87	.007
Type of visa ^b	<u>N</u> (%)			$\chi^2 = 40.00(3)$.000
	Pending cases	0 (-)	31 (77.5)		
	Temporary visa	0 (-)	9 (22.5)		
	Failed/no visa	40 (100)			
Family members present	<u>N</u> (%)				.002
	No	37 (92.5)	24 (60.0)		
	Yes	3 (7.5)	16 (40.0)		
Social contact beyond family	<u>N</u> (%)			Z = -2.27	.023
	Never	4 (10.0)	11 (27.5)		
	Sometimes	17 (42.5)	19 (47.5)		
	Often	19 (47.5)	10 (25.0)		
Social contact to Swiss	<u>N</u> (%)			Z = -.58	.564
	Never	14 (35.9)	12 (31.6)		
	Sometimes	19 (48.7)	18 (47.4)		
	Often	6 (15.4)	8 (21.1)		
Working	<u>N</u> (%)				.687
	No	38 (57.6)	33 (89.2)		
	Yes	2 (14.3)	4 (10.8)		
Command of German	<u>N</u> (%)			Z = -1.36	.174
	None	8 (20.5)	16 (40.0)		
	Little	15 (38.5)	11 (27.5)		
	Sufficient	14 (35.9)	9 (22.5)		
	Fluent	2 (5.1)	4 (10.0)		
Follow the news	<u>N</u> (%)			$\chi^2 = 4.27(3)$.233
	No	16 (40.0)	11 (28.2)		
	Home country	9 (22.5)	5 (12.5)		
	Home country and CH	15 (37.5)	23 (59.0)		

To be continued

		Samples		Group Differences ^a	
		FAS	AS	$t(df)/$ $\chi^2(df)/ Z$	p
Situation in Switzerland		($n=40$)	($n=40$)		
Satisfaction with life in CH	N (%)			$Z = -.36$.000
	Very good	4 (10.3)	13 (32.5)		
	OK	9 (23.1)	16 (40.0)		
	Very bad	26 (66.7)	11 (27.5)		
Homesickness	N (%)			$Z = -.08$.938
	Never	6 (15.0)	4 (10.3)		
	Seldom	0 (0.0)	2 (5.0)		
	Sometimes	16 (40.0)	16 (41.0)		
	Often	18 (45.0)	17 (42.5)		
Quality of Life (EUROHIS)	$M(SD)$	19.23(4.79)	24.17 (6.17)	$t = -4.69(39)$.000

Notes. EUROHIS: short form of the WHOQOL-Bref quality of life assessment.

^aThe following tests were used: paired t-tests (normally distributed continuous data); Wilcoxon matched-pairs signed rank test (ordinal data); McNemar-Bowker test (nominal data); McNemar's test (binominal data).

^bAs this variable was matched, group differences were calculated solely for control reasons.

Table 3: Traumatic event types experienced and psychiatric outcome measures for failed (FAS) and pending/temporarily accepted (AS) asylum seekers.

Variables		Samples		Group Differences ^a	
		FAS (<u>n</u> =40)	AS (n=40)	<u>t</u> (<u>df</u>) / χ^2 (<u>df</u>) / <u>Z</u>	<u>p</u>
Number of traumatic event types experienced ^b	<u>M</u> (<u>SD</u>)	6.68 (4.49)	6.68 (3.45)	<u>t</u> = .00(39)	1.000
PTSD (PDS)					
Severity (sum score)	<u>M</u> (<u>SD</u>)	16.68 (12.88)	19.99 (12.68)	<u>t</u> = 1.09(37)	.284
Diagnosis	<u>N</u> (%)			<u>Z</u> = -.70	.487
Full-blown PTSD		18 (45.0)	20 (50.0)		
Sub-clinical PTSD ^c		9 (22.5)	11 (27.5)		
No PTSD		13 (32.5)	9 (22.5)		
Anxiety (HSCL-25)					
Severity (mean)	<u>M</u> (<u>SD</u>)	2.30 (.73)	2.25 (.80)	<u>t</u> = .34(39)	.738
Clinically significant	<u>N</u> (%)				.424
Yes		31 (77.5)	27 (67.5)		
No		9 (22.5)	13 (67.5)		
Depression (HSCL-25)					
Severity (mean)	<u>M</u> (<u>SD</u>)	2.41 (.60)	2.37(.71)	<u>t</u> = .23(38)	.819
Clinically significant	<u>N</u> (%)				.754
Yes		35 (87.5)	32 (82.1)		
No		5 (12.5)	7 (17.9)		
Pain intensity (VRS)	<u>M</u> (<u>SD</u>)	2.35 (1.83)	2.40 (1.88)	<u>t</u> = .11(39)	.911

Notes. PDS: Posttraumatic Diagnostic Scale. HSCL: Hopkins Symptom Checklist-25. VRS: Verbal Rating Scale.

^aThe following tests were used: paired t-tests (normally distributed continuous data); Wilcoxon matched-pairs signed rank test (ordinal data); McNemar's test (binominal data).

^bAs this variable was matched, variable group differences were calculated solely for control reasons.

^cDefined as meeting criteria for only 2 out of 3 PTSD symptom clusters according to DSM-IV.