The Journey of a Lifetime:

Conceptualising Mental Health in Community-Based Asylum-Seekers Negotiating the Refugee Determination Process

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ABSTRACT

There is a paucity of research on the mental health of asylum-seekers, particularly in comparison with refugee and migrant populations. Yet asylum-seekers occupy a vulnerable place in our community. After applying for a protection visa upon arrival in the host country, asylum-seekers frequently endure uncertainty for a protracted period as they traverse the Refugee Determination Process (RDP). The RDP in Australia and other Western countries can take years. Furthermore, asylum-seekers face psychosocial difficulties including numerous barriers to employment and access to health services, which can precipitate or perpetuate mental health problems. Despite this, little research has been undertaken with asylum-seekers negotiating the RDP, particularly studies employing a prospective design.

The usual psychiatric classifications do not necessarily capture the extent and severity of distress experienced by asylum-seekers. 'Demoralisation syndrome' (Kissane, Clarke, & Street, 2001) is a construct which features hopelessness, meaninglessness, and existential distress. However, these symptoms may be a normal response to adversity. It is not known if demoralisation in asylum-seekers is distinct from major depression (MDE) and other psychiatric disorders. Demoralisation has long been considered "emotional and somatic distress" rather than a discrete clinical disorder. It is believed to be a consequence of unremitting, unavoidable stress in a range of adverse situations and is understood to result from an imbalance between personal coping and environmental stress. While demoralisation has been researched in migrant and refugee populations, this has not been extended to asylum-seekers.

The current study is a prospective, mixed design with both exploratory and predictive aims. 131 adult asylum-seekers (56 at follow-up) living in the Melbourne community were recruited; one quarter were refugees, having been granted permanent protection, while the remainder were asylum-seekers. Questionnaires measured depression and anxiety (HSCL-25), psychological trauma (HTQ-R), demoralisation (PERI-D) and post-migration stress (PMLDC). Self-report measures were validated with the MINI structured interview at follow-up. It was predicted that rates of all mental health indices would increase both as a function of time and number of asylum application rejections in the RDP. The relationship between demoralisation and other clinical measures (MDE and PTSD) was also explored.

High rates of psychiatric morbidity were found in both asylum-seekers and refugees, although the prevalence of MDE and PTSD was significantly greater in asylum-

seekers. 'Demoralisation syndrome' did not adequately describe the symptom profile, which was more indicative of a pan-distress syndrome. Relationships between time in the RDP and mental health symptoms did not globally emerge, although a diagnosis of PTSD in asylum-seekers was predicted by four or more RDP rejections. Several post-migration stressors were associated with PTSD symptoms, and the type of stressors distinguished between the asylum-seeker and refugee cohorts. The findings have implications for Government policy regarding the prevention and management of mental health disorders in those seeking asylum in Australia.

STUDENT DECLARATION

I, Debbie Hocking, declare that the Doctor of Psychology (Clinical Psychology) thesis entitled *The Journey of a Lifetime: Conceptualising Mental Health in Community-Based Asylum-Seekers Negotiating the Refugee Determination Process* is no more than 40,000 words in length, exclusive of tables, figures, appendices, references and footnotes. This thesis contains no material that has been submitted previously, in whole or in part, for the award of any other academic degree or diploma. Except where otherwise indicated, this thesis is my own work.

Debbie Hocking
March 2012

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Finally, I would also like to acknowledge the inspiring legacy of the socially conscious researchers who have gone before me.

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… Come, my friends,

'Tis not too late to seek a newer world.

… for my purpose holds to sail beyond the sunset, and the baths

Of all the western stars, until I die.

…Tho' much is taken, much abides; and tho'

We are not now that strength which in old days

Moved earth and heaven; that which we are, we are –

One equal temper of heroic hearts,

Made weak by time and fate, but strong in will

To strive, to seek, to find, and not to yield.

Ulysses

– ALFRED LORD TENNYSON

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AAT	Administrative Appeals Tribunal
AMIL	Absence-of-Meaning-In-Life
AS	Asylum-seeker
ASAS	Asylum Seeker Assistance Scheme
ASIO	Australian Security Intelligence Organisation
ASRC	Asylum Seeker Resource Centre
BV	Bridging Visa (A, E, C)
DCPR	Diagnostic Criteria for Psychosomatic Research
DIAC	Department of Immigration And Citizenship
DS	Demoralisation Syndrome
DSM-IV(-TR)	Diagnostic and Statistical Manual - Fourth Edition (-Text Revision)
HSCL-25	Hopkins Symptom Checklist - 25
HTQ-R	Harvard Trauma Questionnaire - Revised Version
ICD(-10)	International Classification of Diseases (-10)
IMA	Irregular Maritime Arrival
MDD	Major Depressive Disorder
MDE	Major Depressive Episode
MINI	Mini International Neuropsychiatric Interview
NGO	Non-Government Organisation
PERI-D	Psychiatric Epidemiology Research Interview - Demoralisation Scale
PMLDC	Post Migration Living Difficulties Checklist
PTDS	Post Traumatic Demoralisation Syndrome
PR	Permanent Residency/Refugee
PTS	Post Traumatic Stress
PTSD	Post Traumatic Stress Disorder
PV	Protection Visa
RDP	Refugee Determination Process
TPV	Temporary Protection Visa
UNHCR	The Office of the United Nations High Commissioner for Refugees

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CHAPTER 1: Literature Review

1.1 Asylum-seekers

1.1.1 Forced migration in a global context

One of the greatest humanitarian achievements of the 20th century has been to acknowledge that the refugee problem is a matter of concern for the international community and must be addressed in the context of international cooperation (UNHCR, 1951). This notion first emerged after World War I under the League of Nations, which was called upon to deal with successive waves of refugees. It was further developed and strengthened after World War II through continuing action undertaken by the United Nations to address numerous refugee situations throughout the world (Office of the United Nations High Commissioner for Refugees, 1951).

Grounded in Article 14 of the Universal Declaration of human rights 1948, which recognises the right of persons to seek asylum from persecution in other countries, the United Nations Convention for the Status of Refugees (hereafter referred to as 'the Refugee Convention') was adopted in 1951 and became the cornerstone of international refugee protection (UNHCR, 2010b). The Office of the United Nations High Commissioner for Refugees (UNHCR) is the body responsible for protecting refugees and overseeing countries' adherence to the Refugee Convention. The UNHCR was established by the United Nations General Assembly at the end of 1950 following the end of World War II which generated the largest number of displaced persons that had been seen in modern history (Hargreaves, 2001), estimated at 1.5 million refugees (McMaster, 2001). Hence, the Refugee Convention was first adopted when refugees were predominantly of European origin. Sixty years on, some 43.7 million people globally have been forcibly displaced due to natural and man-made disasters. Of these, an estimated 15.2 million are refugees (UNHCR, 2010a) with many millions of others, internally displaced (UNHCR, 2010a). At the end of 2009, the UNHCR estimated that there were 983,000 asylum-seekers around the world (Department of Immigration & Citizenship, 2010b).

From the perspective of international law, the Refugee Convention accords refugee status to a person who has lost the protection of their state of origin or country. It is essentially the loss or failure of state protection, which makes international protection necessary for refugees (UNHCR, 1951).

At the universal level, the most comprehensive legally binding international instrument defining standards for the treatment of refugees is the 1951 Refugee Convention (UNHCR, 1951). The Convention is a rights-based status instrument and is underpinned by fundamental principles including non-discrimination, non-penalisation and *non-refoulement*, that is, *not* allowing the repatriation of individuals to homelands where their safety may be threatened (UNHCR, 2010b).

The Convention further stipulates that refugees should not be penalised for illegally entering a country that is a Convention signatory, thereby allowing an exception for those seeking asylum to br 2010b), work (Article 17, UNHCR, 2010b), social security including health care (Article 24, UNHCR, 2010b) and freedom of movement, including the right to be granted travel documents (Articles 26-28, UNHCR, 2010b).

Being both a status and rights-based instrument, the 1951 Refugee Convention is employed by the UNHCR and the various international country signatories to the Refugee Convention, to determine whether an asylum claimant will be accepted as a bona fide refugee. The Convention's definition of 'refugee' puts particular emphasis on the presence of a fear of persecution based on reasonable, objective or substantiated grounds (UNHCR, 1951) and the need to protect the individual from such persecution. Article 1 of the 1951 Convention Relating to the Status of Refugees defines a refugee 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/her nationality and is unable, or owing to such fear, is unwilling to avail himself/herself of the protection of that country*
>
> (UNHCR, 2010b, p. 14)

Today there are 147 countries that are signatories to the 1951 Refugee Convention, the 1967 Protocol or both (UNHCR, 2011). Australia is one of the signatories to the 1951 Refugee Convention and 1967 Protocol[i] and therefore has undertaken to assess asylum claims according to these instruments in order to determine whether it has protection obligations toward a refugee claimant. As a signatory, Australia is obliged to process asylum claims made by individuals once they reach our shores according to international law, to offer support and ensure that the person is not sent back unwillingly to a country of origin where there is a reasonable or substantiated threat.

i Originally, the scope of application of the Convention was limited to events occurring in Europe or elsewhere before 1 January 1951. However, this limitation was removed on 4 October 1967 to allow for refugee situations which were not related to pre-1951 events.

Australia has both offshore and onshore components to its refugee Humanitarian Programme. The offshore component accepts those whom the UNHCR has determined to be refugees (e.g., those living in refugee camps throughout the world). The onshore component offers protection to those who lodge an application after arriving in Australia, whether by boat or plane. The merit of the individual's application for the onshore process is determined by Australian immigration officials according to Australian legislation, current information on conditions in the applicant's country of origin, and the criteria set out by the Refugee Convention (DIAC, 2011d).

1.1.2 Asylum-seekers vs. Refugees: the socio-legal milieu of the West

The terms 'asylum-seeker' and 'refugee' are frequently used interchangeably. Not every asylum-seeker will be recognised as a refugee but every refugee was initially an asylum-seeker (IGC, 2009). Both are often mistakenly referred to as 'economic migrants' (Silove, Austin, & Steel, 2007; Steel & Silove, 2000). However, migrants and asylum-seekers/ refugees can be differentiated in terms of 'push and pull' factors. Forced migrants flee to avoid aversive aspects of their home environment, whereas voluntary migrants are attracted by positive aspects of the host environment (Ryan, 2007). Hence, the former seek safety rather than a life of greater prosperity. In fact, refugees arriving in Western countries are commonly well-educated (Gorst-Unsworth & Goldenberg, 1998; Loutan, Bollini, Pampallona, Bierens De Haan, & Gariazzo, 1999; Schweitzer, Melville, Steel, & Lacherez, 2006; Silove, Steel, McGorry, & Drobny, 1999; Sinnerbrink, Silove, Field, Steel, & Manicavasagar, 1997), with many having been professionally employed (Dupont, Kaplan, Verbraeck, Braam, & van de Wijngaart, 2005; Schweitzer et al., 2006; Sinnerbrink et al., 1997) and having enjoyed a high standard of living in their home countries (Begley et al., 1999; Dupont et al., 2005). While migrants can plan their exit and have the option of returning to their homeland, refugees are usually forced to flee with little warning and often cannot return.

Hence, both asylum-seekers and refugees are 'forced migrants' and, by definition, differ only in their legal status. The insecure legal status of the asylum-seeker impacts upon every aspect of their lived experience. In a study comparing the psychosocial experiences of asylum-seekers and refugees, Gerritsen et al. (2006) found that the former reported significantly more post-migration stress and significantly less social support. Almost half of the asylum-seekers did not feel at home in the host country compared with only a quarter of the refugees and twice as many asylum-seekers as refugees reported having poor general health (Gerritsen et al., 2006).

The disparity is particularly apparent between asylum-seekers and settled refugees in the context of Western host countries whereby the latter are afforded benefits that are not (equally) afforded to the former. Silove (2002) states, "Forced displacement is a phenomenon that is as old as history itself. Almost as universal, has been the secondary abuse of refugees [including asylum-seekers]" (p.290). It is impossible to consider asylum-seekers without an understanding of the socio-political context by which they are defined. Throughout the Western world asylum-seekers are subject to ever-tightening social and legal constraints aimed at reducing the numbers of individuals seeking asylum on their shores. Since the mid-nineties, industrialised countries have vied with each other to develop the most restrictive asylum policies possible (Ingleby & Watters, 2005). Consequently, daunting challenges are faced by asylum-seekers arriving in many Western countries including Australia (Silove, Steel, & Watters, 2000), New Zealand (Pernice & Brook, 1994), South Africa (Bandeira, Higson-Smith, Banjes, & Polatin, 2010), within Europe (IGC, 2009; Loutan et al., 1999) and the USA (Piwowarczyk, 2007).

Steel et al. (2009) have noted that 'policies of deterrence' involve not only the curtailing of freedoms associated with civil and political rights, but have also extended to violations of second-generation rights: to health, economic freedom, a reasonable standard of living and to a positive future. Such policies include denying asylum-seekers access to employment and education, limiting access to welfare and health care, and restricting options for accommodation, freedom of movement and family reunion (Ingleby & Watters, 2005; Robjant, Hassan, & Catona, 2009; Ryan, Dooley, & Benson, 2008; Silove et al., 1999; Silove, Steel, Susljik, et al., 2007; Silove et al., 2000; Sinnerbrink et al., 1997; Sinnerbrink, Silove, Manicavasagar, Steel, & Field, 1996). These factors have serious implications for the social and financial welfare of asylum-seekers. Consequently, becoming an asylum-seeker results in a significant loss of autonomy and control over one's own life (Kramer & Bala, 2004; Watters, 2001). The UNHCR noted that even those residing in the community (as opposed to detention centres) in Western countries "are liable to find that their access to basic needs such as shelter, food and medical care is severely restricted" (UNHCR, 1997, p. 198). Unlike (offshore) refugees accepted for resettlement, asylum-seekers face the additional stress of being regarded as illegal immigrants while living in limbo under the ever-present threat of forcible repatriation (Silove, McIntosh, & Becker, 1993). Because of the contemporary, global preoccupation with 'border protection' and the narrow, legalistic interpretation of the Refugee Convention being applied by Western nations in greater numbers (Silove et al., 2000; Steel, Frommer, & Silove, 2004),

asylum-seekers are increasingly becoming "debatable problematised objects" (Hage, 1998, cited in Mansouri & Cauchi, 2007).

Globally, however, the severity of these social policies varies. For example, in Denmark, UK, France, Belgium and Ireland asylum-seekers are not permitted to work, while access to the labour market (with varying restrictions) is available to asylum-seekers in Norway, Spain, Netherlands, Sweden, and USA (IGC, 2009). Similarly, the Netherlands provide asylum-seekers with equal access to health services as nationals (IGC, 2009), while the UK has "tightened up" access to free treatment for asylum-seekers on the National Health Scheme (Ashcroft, 2005). In Australia, those on a Bridging Visa E are automatically denied rebated health care through Medicare.

In some European countries asylum-seekers have the option of living in the community or in 'reception centres' (e.g., Sweden and Netherlands), while in others, group-home accommodation is compulsory. Restriction of movement within the community for those living in reception centres also varies from country to country (Ingleby & Watters, 2005). In Australia, while asylum-seekers who arrive by plane with a valid visa are free to live in the community, since 1992, those who arrived without a visa or identifying documentation have been mandatorily detained in on- or offshore detention facilities, or in 'community detention'. This is despite the practice being specifically condemned in Article 31 of the Refugee Convention (Goodwin-Gill, 2001).

The Australian Human Rights Commission regards permission to work as a human rights issue (Australian Human Rights Commission, 2009) and empirical evidence points to deleterious effects on mental health for asylum-seekers denied the right to work (Begley et al., 1999; Dupont et al., 2005; Gorst-Unsworth & Goldenberg, 1998; Laban, Gernaat, Komproe, van der Tweel, & De Jong, 2005; Lavik, Hauff, Skrondal, & Solberg, 1996; Ryan, Benson, & Dooley, 2008). In Australia, asylum-seekers may face difficulties obtaining work permits, and the length of time before work rights are granted can vary considerably (Cox & Van Amelsvoort, 1994). This can be due to a number of factors, not least of all the stipulations of the particular visa conditions to which an individual is subject. For those who do find employment, it is often temporary, casual and unskilled (Marson, 2003, cited in Mansouri & Cauchi, 2007).

In summary, concerns have arisen about the inadequacy of health care and social support for asylum-seekers throughout the West (Asylum Seeker Resource

Centre, 2010; Hargreaves, 2001), with suggestions that they are being systematically disadvantaged (Mansouri & Cauchi, 2007; McNevin, 2005; Rees, 2003).

1.1.3 The mental health game

Epidemiological studies are virtually impossible to undertake due to the lack of accessible registers of asylum-seekers (Silove, Steel, McGorry, & Mohan, 1998; Sinnerbrink et al., 1997). Notwithstanding sampling limitations, high rates of psychopathology have been found amongst refugees worldwide compared with non-refugee controls (Porter & Haslam, 2005). Furthermore, there is evidence to suggest that asylum-seekers are more vulnerable to mental health problems than settled refugees (Macleod & Reeve, 2005; Silove et al., 1998; Steel, Chey, et al., 2009). For example, a Dutch study of 178 refugees and 232 asylum-seekers found that asylum-seekers were at least three times more likely than refugees to experience symptoms of PTSD or depression/anxiety. Even after adjusting for other variables, asylum-seekers were found to have greater prevalence of poor general health and psychiatric conditions (Gerritsen et al., 2006). Furthermore, a meta-analysis of populations exposed to mass conflict and displacement by Steel et al. (2009) found residency status to be a significant predictor of diagnosed depression – secondary only to number of traumatic events and reported torture. Those with an insecure residency status (i.e., displaced internally or externally to the source country, or living in a refugee camp) were 1.3 times more likely to be diagnosed with depression than those with a secure residency status (i.e., not displaced or resettled in a high-income country).

Most studies of forced migration have focused on those whose refugee status was determined prior to arriving in their host country (Ryan, Benson, et al., 2008; Silove et al., 1998). Thus, there is a relative paucity of research on the mental health of asylum-seekers (Ryan, Benson, et al., 2008; Silove et al., 1993; Silove et al., 1998; Sinnerbrink et al., 1997). Despite this, asylum-seekers attending community service centres have reported levels of trauma exposure and persecution similar to those reported by refugees authorised to resettle in Western countries (Sinnerbrink et al., 1997). While it is known that adult refugees and asylum-seekers living in Western countries experience a high rate of mental health problems, particularly posttraumatic stress disorder (PTSD), depression and anxiety (Fazel, Wheeler, & Danesh, 2005), the majority of research involving forced migrants has focused on either refugees or asylum-seekers, without contrasting their different health experiences (Toar, O'Brien, & Fahey, 2009). Furthermore, the psychological sequelae of the socio-legal constraints placed upon asylum-seekers have been the focus of only a relatively small number of studies which have compared the two groups.

An Irish study (Toar et al., 2009) found that asylum-seekers were six times more likely than refugees to report symptoms of PTSD or depression/anxiety. It was concluded that the two groups differed in ways that may affect mental health status and the utilisation of health care services (e.g., asylum-seekers' precarious living arrangements and their inability to work). Similarly, an Australian study (Silove et al., 1998) found that post-migration stress was associated with asylum-seekers' insecure residency status and was higher than that of refugees, even though the two groups did not differ on measures of past trauma or psychiatric symptoms. Furthermore, a prospective study examining the impact of legal status on two groups going through the refugee determination process in Ireland found that the asylum-seeker group (insecure legal status) reported greater distress than the refugee group (secure legal status) at both time intervals (Ryan, Benson, et al., 2008).

Although challenges face social researchers investigating both the health profile of asylum-seekers and the social policies and inequalities that may shape such profiles (Correa-Velez & Gifford, 2007), it is apparent that the convergence of high-prevalence mental health disorders and lack of access to appropriate health care potentiates further harm to an already vulnerable, "invisible underclass" (Correa-Velez & Gifford, 2007, p.278). Consequently, there has been a strong reaction within factions of the health profession to the increasingly stringent restrictions placed on asylum-seekers. Some argue that Western governments are abnegating their responsibilities toward asylum-seekers by limiting access to health care, while others argue that employing policies of deterrence risks violating key principles of the 1951 Convention by which such governments are bound (ASRC, 2010; Hargreaves, 2001; McNevin, 2005; Sales, 2002; Sweet, 2007). Thus, there are growing concerns that asylum-seekers faced with policies that restrict access to health and welfare in the countries where they seek refuge may increase already high levels of stress (Correa-Velez & Gifford, 2007; Rees, 2003).

Ashcroft (2005) claims that the treatment of asylum-seekers is an issue of medical ethics stating, "When denial of medical treatment… to people with genuine medical need is being used as a lever to move people out of the country, ethicists and healthcare professionals should speak out" (Ashcroft, 2005, p. 125). Furthermore, Hargreaves (2001) believes it is essential to use health as a platform to promote positive media and political attention, and to collect data on which to base effective targeted programmes for asylum-seekers. The latter is particularly important given that not all mental health services established for refugees have provision for asylum-seekers (McNevin, 2005; Silove, Sinnerbrink, Field, Manicavasagar, &

Steel, 1997), who have particular needs including managing the stress inherent in the refugee determination process, being separated from family and welfare disadvantage (Laban et al., 2005).

The irony has been noted that, "at a time when many Western countries are promoting public health strategies aimed at preventing mental ill-health, other policies may be pursued that are demonstratively destructive to the psychological well-being of certain vulnerable minorities such as traumatized asylum-seekers" (Steel & Silove, 2000, p.435). To underscore this, Australia is considered to be a world leader in the development and implementation of policies deterring asylum-seekers (Mansouri & Cauchi, 2007). However, researchers and mental health professionals are in a prime position to address the issue of mental suffering in asylum-seekers, and many have – by advocating not only for equity of health care and welfare provision but through efforts to influence the governmental immigration and social policies that perpetuate inequity and its potential harm (Correa-Velez, Gifford, & Bice, 2005; Hallas, Hansen, Staehr, Munk-Andersen, & Jorgensen, 2007; Hargreaves, 2001; McNevin, 2005; Silove, 2002; Silove, Austin, et al., 2007; Silove et al., 1993; Silove et al., 2000). Indeed, it has been suggested that the most efficacious intervention for asylum-seekers and refugees may rely more on government policy than professional input (Gorst-Unsworth & Goldenberg, 1998).

1.2 Refugee Determination Process (RDP)

1.2.1 The Australian refugee determination process

The process of applying for refugee status in Australia is complex, lengthy and often poorly understood by asylum-seekers (Sultan & O'Sullivan, 2001). Furthermore, although the Refugee Convention does not privilege the merits of asylum-seekers who arrive with valid documents over those who do not, Australia is unique in that it has a two-tiered system by which protection applications are processed.

Individuals who arrive in Australia with a valid visa and subsequently lodge an application for a protection visa (PV) have their asylum claim processed onshore within Australia's legal framework, which is governed by the Migration Act 1958 and Migration Regulations 1994 (IGC, 2009). Unauthorised arrivals (i.e., those without a valid visa or documentation) are subject to a different framework – now called the Protection Obligations Determination process (DIAC, 2011d) – which includes mandatory detention. Refugee processing arrangements for the latter group have allegedly undergone recent improvement, however. Such changes include the

provision of publicly funded independent legal advice and assistance, more robust procedural guidance for asylum decision-makers, external scrutiny of the process by the Commonwealth Ombudsman (IGC, 2009) and – in response to the High Court's decision of 11 November 2010 – access to the judicial review process (DIAC, 2011d).

Onshore claimant applications are initially assessed by the Federal Government's Department of Immigration and Citizenship (DIAC). An interview at this stage of the process is not mandatory but has become increasingly common, where further information is sought (IGC, 2009). If an individual's protection claim is refused at the Primary (DIAC) Stage, claimants are entitled to appeal the decision, which comprise escalating levels of judicial process, starting from the Refugee Review Tribunal (RRT) – or the Administrative Appeals Tribunal (AAT), depending on the basis for the initial refusal – and proceeding through to the High Court of Australia. Since the 12th December 2005 legislation was implemented, requiring DIAC and the RRT to process PV applications within 90 days. Conversely, the appeals process can be protracted (IGC, 2009).

In considering an appeal, the RRT may affirm the original primary refusal or remit the case back to DIAC for reconsideration. The grounds for remittal vary and can be for reasons such as acquisition of new information to substantiate the claim or changed circumstances in the country of origin (DIAC, 2011b). The RRT reviews the merits of cases for which DIAC has refused to grant a PV, which it does by examining the claim against the Refugee Convention and giving the applicant the opportunity of a personal hearing. Applications for review at the RRT must be lodged within 28 days of the primary decision (rejection) notification; in approximately 75 percent of cases, the DIAC decision is upheld (DIAC, 2011d).

The Federal Magistrates Court or Federal Court hears applications for judicial review of an RRT decision if there has been an error of law. Errors of law include whether the correct procedures were followed in the decision-making process, whether the person was given a fair hearing, whether the decision-maker correctly interpreted and applied the relevant law and whether the decision-maker was unbiased (IGC, 2009). Applicants may pursue judicial review to the High Court – either having exhausted Federal Court avenues, or by taking the case directly to the High Court's jurisdiction (IGC, 2009). All of the aforementioned bodies work independently when reviewing DIAC PV decisions (IGC, 2009).

Finally, under section 417 of the Migration Act 1958, the Minister (for Immigration) has the power to substitute a decision more favourable than that of

the review tribunal if it is considered to be in the public interest to do so (DIAC, 2011c). This allows the granting of a permanent visa to certain individuals who have been found by a review tribunal and/or court appeals processes to not satisfy the Refugee Convention criteria for a protection visa. These powers are commonly called 'Ministerial intervention' and visas of this nature are issued on humanitarian grounds (IGC, 2009). The claimant's circumstances must align with the guidelines of being 'unique and exceptional' (DIAC, 2010e) and, if rejected, further requests for ministerial intervention cannot be considered unless there has been a significant change in circumstances to subsequently meet these guidelines (DIAC, 2011c). The Minister may grant a visa for a range of reasons but very few protection visas are granted through this process (DIAC, 2011d). Thus, it has been argued that the current system lacks a process for assessing those who have strong humanitarian claims, but who fail to meet the Convention definition of a refugee (Boilerhouse Community Engagement Centre, 2004).

Before a PV is finalised and granted, where an applicant is found to be a person to whom Australia has protection obligations, s/he must undergo health, character and security checks. The latter includes being cleared by the Australian Federal Police of criminal conduct in Australia and overseas (if the claimant lived in a third country for a period of 12 months or more), and by Australian Security Intelligence Organisation (ASIO), to ensure they do not pose a risk to national security (IGC, 2009).

In 2010-11, the quota for settlement places for the Humanitarian Program (including offshore-determined refugees) was 13,750. Of this quota 7,750 were allocated to 'other humanitarian' places, which are shared between the offshore Special Humanitarian Program and onshore protection applicants (DIAC, 2010b).

In 2009-10 the top 10 countries granted protection visas included Afghanistan (ranked #1), Sri Lanka (#2), Iraq (#3), Zimbabwe (#6) and Pakistan (#7). These five countries alone comprised 71% of the total number of onshore protection visas granted at the primary stage for that year (DIAC, 2010a). In 2010-2011, these same countries were ranked #10, #6, #7, #4 and #3, respectively, in relation to onshore visa success, for those arriving by plane (DIAC, 2011b). Those from Sri Lanka, Afghanistan and Iraq were ranked in the top three to be granted refugee status in the Protection Obligations Determination process, for 'irregular maritime [IMA; boat] arrivals', that same year (DIAC, 2011b).

In 2010-11, 25% of onshore protection claims were successful at the Primary Stage (DIAC, 2011b). Those granted protection visas through the appeals process

increased the total final success rate from that of the primary stage by less than 20%, to 44% (DIAC, 2011b). This highlights the diminishing odds of success individuals face as they progress through the appeals process. Furthermore, in 2010-11, the Minister intervened to grant a permanent visa in only 15% of cases (DIAC, 2011c).

In the 2010-2011 year 11,491 protection visas were lodged onshore (DIAC, 2011a). Fifty-six percent of onshore protection visas were granted to those who had arrived by boat. Those arriving by plane had a 33% success rate in attaining a protection visa compared with 53% of boat arrivals, with an overall percentage of 42% of onshore applicants obtaining a protection visa (DIAC, 2011a). While there was a change from the previous year, of the top 10 countries for visas granted, Pakistan (#3), Zimbabwe (#4), Sri Lanka (#6), Iraq (#7) and Afghanistan (#10) collectively comprised one third (32%) of the total protection visas granted for plane arrivals (DIAC, 2011a). Almost half (49%) of all successful maritime claimants were from Afghanistan, Iraq and Sri Lanka (DIAC, 2011a).

A perceived lack of credibility is arguably the most common reason for rejecting refugee claims at all stages of the RDP, and has obvious implications for those most disturbed by psychiatric conditions, especially PTSD (Aron, 1992; Mueller, Schmidt, Staeheli, & Maier, 2010; Piwowarczyk, 2007). The investigators of a British study found that asylum-seekers with PTSD at the time of their immigration interviews were more likely to have their claims rejected the longer their application took (Herlihy, Scragg, & Turner, 2002). Because traumatic memories can result in a fragmented intrapersonal narrative (Herman, 1992), asylum-seekers may give inconsistent accounts of their refugee experiences at immigration and RRT hearings which may undermine the credibility of their case (Coffey, 2003; Silove et al., 2000; Steel, Frommer, et al., 2004). Despite the UNHCR's exhortation that signatory nations be cognisant that variations in personal accounts over time may be due to psychological trauma (UNHCR, 2005), there is no requirement for decision-makers to seek expert psychological evidence in cases where complex trauma histories are indicated (Steel, Frommer, et al., 2004). Thus, a perceived lack of credibility on the part of asylum-seekers continues to be an inherent problem in the refugee status decision-making process, both in Australia and internationally (Aron, 1992; Rousseau, Crepeau, Foxen, & Houle, 2002).

1.2.2 Bridging visas and welfare provision in Australia

Asylum claimants living in the community are usually issued a Bridging visa (BV), which allows them to remain lawfully in Australia for the duration of the refugee determination process. The BV is issued with certain conditions and is valid until the final claim is determined. A further BV may be granted if a person pursues judicial review or seeks ministerial intervention (IGC, 2009).

Claimants who arrive lawfully on a valid visa are granted a BVA when their original visa expires (Centre for Population and Urban Research, 2006). This entitles them to work rights, Medicare and – under some circumstances – welfare support (i.e., Asylum-seeker Assistance Scheme – ASAS) (DIAC, 2010d). Generally, individuals granted a BVA remain on this until their claim is either accepted (at which time they are granted a PV) or they are refused at the RRT and opt to mount further appeals through either the judicial review process or Ministerial intervention. In the latter instance the individual is then issued a BVE (DIAC, 2010c). Once an appeal is lost at the RRT, if the asylum-seeker was in receipt of ASAS support, this ceases (ASRC, 2010).

Bridging Visa Es are the second largest group of bridging visas allocated and are granted to individuals in a range of circumstances, enabling them to remain in the community rather than be subject to immigration detention (Centre for Population and Urban Research, 2006). While refugee advocates believe that a person is not a 'failed' asylum-seeker so long as avenues of appeal are being pursued (McNevin, 2005), it is the Government's view that most asylum-seekers on BVEs have had a "fair go" from the Australian taxpayer and should leave the country (Millbank, 2007, p. 1). Hence, BVEs generally do not entitle individuals to work and study rights, Medicare, or any form of government funded income support (Millbank, 2006). Because these visas are an alternative to detention, individuals on BVEs are on 'departure grounds' and are required to comply with strict reporting procedures (DIAC, 2010c). Therefore, asylum-seekers reporting to DIAC on a monthly basis do not know from one month to the next if their visa will be renewed, or if they will be detained pending deportation.

Unlike many European countries, Australia does not have reception centres to accommodate asylum-seekers. Therefore housing is a significant problem, with a large proportion being rendered homeless due to restricted access to longer-term accommodation (Boilerhouse Community Engagement Centre, 2004). It is therefore incumbent on the asylum-seeker to secure accommodation through family, friends,

faith communities or Non-government Organisations (NGOs). NGOs provide a range of services to asylum-seekers, including advocacy, legal advice, health services, case-management, social/recreational activities, housing, material aid, English classes and food.

While accurate data concerning the number and location of community-based asylum-seekers in Australia is not available (McNevin, 2005; Purcell, 2004; Sinnerbrink et al., 1997), in 2005 it was estimated there were between 8,000-10,000 asylum-seekers living in the Australian community, 750-900 of whom were estimated to be living in Victoria (McNevin, 2005). This appears to be an underestimation, but is consistent with the ASRC's report of providing assistance to approxomiately1,000 asylum-seekers annually (ASRC, 2010).

A call to action released by the Uniting Church of Australia reported that, since 1997, there have been thousands of asylum-seekers living in the community on BVEs without work rights and, "as a result of the restrictions on their visa, many are living in devastating poverty and insecurity" (Uniting Church of Australia, 2007). Consequently, BVE holders are dependent upon charity organisations in the face of spiralling difficulties with homelessness, cumulative debt, family breakdown and the exacerbation of existing health problems (McNevin, 2005).

In 2009, the Rudd Government made policy changes to allow BVE holders to apply for work rights if they could demonstrate a 'compelling need to work'. However, these changes were not retroactive. Therefore, asylum-seekers who did not have work rights prior to 1 July 2009 remain ineligible (DIAC, 2009). Consequently, a number of asylum-seekers who have been in the refugee determination process for many years continue to be at a socioeconomic and socio-legal disadvantage. For asylum-seekers who remain on a BVE without work rights, engaging in an appeals process – as is their right under law – is rendered virtually impossible. The hardship they experience hampers their capacity to participate in the legal process and undermines the integrity of the determination procedure (McNevin, 2005).

1.2.3 Asylum-seekers in the community vs. detention

Disproportionate attention has been focused upon asylum-seekers in Australian detention centres, largely overlooking the greater majority who remain in the community while their claims are processed (Boilerhouse Community Engagement Centre, 2004; Silove et al., 2006). This is not to minimise the plight of those detained. The traumatising effects of prolonged immigration detention have been well documented (Mansouri & Cauchi, 2007) and, compared with asylum-seekers

living in the community, detained asylum-seekers exhibit significantly higher levels of depression, anxiety and PTSD symptoms (Ichikawa, Nakahara, & Waidai, 2006; Robjant, Robbins, & Senior, 2009; Steel & Silove, 2001; Thompson, McGorry, Silove, & Steel, 1998). B.A. Bracken and Gorst-Unsworth (1991) documented the cases of 10 detained asylum-seekers, which they described as having a "high level of psychological disturbance in all cases… All reported depressed mood, appetite loss and multiple somatic complaints" (p. 657). Other pervasive symptoms included intense fear and anxiety, sleep disturbance and nightmares, irritability and frustration as well as profound hopelessness, concerns about their mental health, suicidal ideation and suicide attempts. Furthermore, some asylum-seekers have reported that detention was more traumatic than the torture already endured (Mansouri & Cauchi, 2007).

A substantial body of research suggests that time in immigration detention (Coffey, Kaplan, Sampson, & Tucci, 2010; Green & Eagar, 2010; Ichikawa et al., 2006; Momartin et al., 2006; Robjant, Hassan, et al., 2009; Silove, Austin, et al., 2007; Silove & Steel, 1998; Steel, Momartin, et al., 2004; Sultan & O'Sullivan, 2001) and even in reception centres (Hallas et al., 2007; Laban, Gernaat, Komproe, Schreuders, & De Jong, 2004) is deleterious to asylum-seekers' mental health, with a dose-response effect for PTSD, depression and anxiety (Hallas et al., 2007; Keller et al., 2003; Laban et al., 2004; Steel et al., 2006; Sultan & O'Sullivan, 2001). One study found that individuals in detention for more than 24 months had rates of new mental illness 3.6 times higher than those who were released within three months (Green & Eagar, 2010). Furthermore, there is evidence to suggest that the psychological sequelae of detention persists for prolonged periods post-release (Coffey et al., 2010; Steel et al., 2006).

A UK study (Robjant, Robbins, et al., 2009) found an interaction between length of detention and prior exposure to interpersonal trauma on depression scores, suggesting that asylum-seekers who are subject to detention may have experienced greater levels of pre-migration trauma than those not detained. Similarly, Steel and Silove (2001) found that detained asylum-seekers endorsed more than two-and-a-half times the trauma (experienced) categories than community-based asylum-seekers. Furthermore, because the variance was not entirely accounted for by level of past trauma exposure, the findings indicated that detention conditions independently contributed to the mental ill-health of detainees. Research also suggests that asylum-seekers who have experienced torture are detained in immigration detention in greater numbers than those living in the community (Steel, Frommer, et al., 2004; Steel & Silove, 2000).

Few studies have compared the prevalence of mental health problems in detention with community-based asylum-seekers. An Australian study (Thompson et al., 1998) which surveyed a group of 25 detained (or recently released) Tamil asylum-seekers found that these individuals were more symptomatic than Tamil asylum-seekers living in the community – on six indices of mental health. The former cohort scored three-fold higher on suicidality, two times higher on depression and anxiety, and approximately one-and-a-half times higher on PTSD scores – even when pre-migration trauma was accounted for. As with Silove and Steel (2001), a Japanese study (2006) comparing formerly detained with non-detained asylum-seekers found that post-migration detention was independently related to worsened mental health. As was the case in the Thompson et al. (1998) study, while there were no significant differences in pre-migration trauma exposure, the former-detainees returned higher symptom scores on PTSD and anxiety (Ichikawa et al., 2006).

By way of elucidating the adverse psychological impact of detention in a broader sense, an Australian study (Steel, Silove, Bird, McGorry, & Mohan, 1999) examined the pathways to psychological trauma, including the influence of pre-migration trauma events. Factors associated with (pre-migration) detention and abuse contributed the only unique direct effect for PTS symptoms, thus suggesting that those subject to pre-migration human rights abuses of this nature would be sensitized to future similar traumatic experiences, such as post-migration detention. Adding weight to this argument, a review of 10 studies (Robjant, Hassan, et al., 2009) examined the mental health impact of immigration detention in the UK, USA and Australia. The authors observed a recurrent theme of the detention environment potentiating an adverse effect on mental health, in addition to reactivating and exacerbating pre-existing trauma.

An observer-participant study by Sultan and Sullivan (2001) reported survey findings of 33 asylum-seekers detained in Villawood Detention Centre for more than nine months. In addition to "alarmingly high" rates of mental health conditions, they observed that psychological distress and psychiatric disability increased through successive stages, triggered by negative decisions of asylum claims. It was observed that in the first ('non-symptomatic') stage before the primary refugee determination decision was made, feelings about being detained were mitigated by "unwavering hope" that the claim would be successful. The 'Primary depressive stage' was precipitated by a negative decision at the Primary Stage of the determination process, at which time a detainee's presentation was observed to be consistent with a major depressive disorder, with level of severity likely mediated by pre-migration

trauma and personal predisposition to depression. Pre-existing PTS reactions may also be reactivated in this stage. The 'Secondary depressive stage' typically followed the rejection by the RRT, which generally occurred between 6-18 months after first being detained. Typically, detainees in this stage displayed worsening depressive symptoms, marked by increased vegetative symptoms, agitation, disengagement from others and feelings of impending doom. The 'Tertiary depressive stage' was characterized by significant and chronic impairment in concentration and becoming dominated by paranoia, sometimes leading to psychic symptoms and/or self-harming behaviours.

Notwithstanding the vastly different environmental contexts, it could be argued that a parallel can be drawn between detained asylum-seekers and community-based asylum-seekers in the judicial appeals process, in that the time frame for both can be indeterminate. Several studies have shown that long waiting periods before receiving a decision on one's asylum claim have a negative impact on mental health status in particular (Hallas et al., 2007; Laban et al., 2004; Silove et al., 1997). For example, Gerritsen et. al., (2006) found that those with an insecure legal status scored higher on PTSD symptoms than those with a secure legal status, with post-migration stress and low social support being associated with both PTSD and depression/anxiety symptoms. Laban (2004) found that a long asylum procedure was the most important risk factor for psychopathology after gender. Hence, concerns have been raised for not only the indeterminate length of time in which people are held in detention while their application is processed, but for the fact that "community-based asylum-seekers can also be subject to lengthy delays in processing of their claims despite the existence of time limits for decision-making at both the DIAC and RRT stages" (ASRC, 2011, p. 7).

Yet it is not clear whether community-based asylum-seekers follow a similar trajectory of declining mental health the longer they are in the refugee determination process and there have only been four longitudinal studies of community-based asylum-seekers to empirically test this supposition (Davis, 2006; Ryan, Benson, et al., 2008; Silove, Steel, Susljik, et al., 2007; Steel et al., 2011). These studies found that all mental health indices did not increase, but continued to be high over time for asylum-seekers who remained in the determination process, especially when compared to those who had been granted permanent protection at follow-up. However, there is no shortage of anecdotal evidence to suggest that the refugee determination process has a deleterious effect on mental health which increases over time. For example, one Australian academic (McNevin, 2005), when

reflecting on the suggestion that Australia detains and re-traumatizes asylum-seekers who ultimately become Australian residents, stated, "The same pattern [as those detained] is clearly evident amongst asylum-seekers living in the community on BVE where the lack of entitlements is directly contributing to mental and physical health deterioration" (p.44).

A Canadian study (Davis, 2006) prospectively examined PTSD symptoms of claimants pre- and post-RDP interview. While all met criteria for PTSD at baseline, at follow-up, the attainment of refugee status was associated with a decreased rate of PTSD diagnosis and symptom count. All unsuccessful claimants reported recurrent intrusive distressing recollections and dreams and intense distress upon exposure to trauma triggers. The most frequently reported PTSD symptoms included avoidance and sleep impairment (both 40%). The authors concluded that the acceptance of an application for refugee status likely had a significant impact on the course of PTSD and generalised distress (Davis, 2006).

Uncertainty is often thought to be central to the suffering induced by the refugee determination process and legal status insecurity. This is evidenced by the outcome of a Swedish study (Roth, Ekblad, & Agren, 2006) of mass evacuees from Kosovo which found that individuals who had lodged an application for asylum had a significantly higher rate of PTSD than those who had voluntarily returned to Kosovo. This finding was "the opposite of what was expected when the Swedish authorities granted temporary residence to these Kosovars" (p. 157). The authors commented that Swedish authorities gave contradictory messages to the Kosovars regarding the duration of their temporary stay. Hence, the results reflected "an important finding related to psychosocial context, such as post-migration stress factors… [and that] one significant post-migration stress factor … was insecurity about their future domicile" (Roth et al., 2006, p.157). Qualitative studies have echoed the findings of quantitative research, with insecurity and uncertainty experienced by asylum-seekers emerging as dominant and pervasive themes (Dupont et al., 2005; Silove et al., 2002).

In the four aforementioned prospective studies with community-based asylum-seekers where no significant increase in trauma symptoms were found over time (Davis, 2006; Ryan, Benson, et al., 2008; Silove, Steel, Susljik, et al., 2007; Steel et al., 2011), ceiling effects were offered as a possible explanation (Ryan, Benson, et al., 2008; Steel et al., 2011). While distress was not found to increase over time, all four prospective studies reported a decrease in psychological distress for individuals who attained permanent residency at follow-up (Davis, 2006; Ryan, Benson, et al., 2008;

Silove, Steel, Susljik, et al., 2007; Steel et al., 2011). However, that symptomatology remained high for those who retained asylum status up to two years from baseline suggests that "the refugee decision exerts a substantial impact on the trajectory of symptoms of PTSD, depression and anxiety in a trauma-affected asylum population" (Silove, Steel, Susljik, et al., 2007, p. 328).

1.2.4 Impact of the RDP on mental health

As already noted, it is well established that the asylum-seeking process and the material conditions of settlement can exacerbate the psychological trauma from which the individual is seeking refuge. The crucial issue remains, however, as to whether the RDP in itself is a significant cause (Mansouri & Cauchi, 2007).

There is growing evidence that asylum procedures increase the mental health difficulties of traumatised individuals seeking asylum (Robjant, Hassan, et al., 2009). In Western countries it is usually a matter of years before asylum-seekers are informed as to whether they will receive refugee status (Bandeira et al., 2010; Drožđek, Noor, Lutt, & Foy, 2003; Kramer & Bala, 2004; Laban et al., 2004; Mansouri & Cauchi, 2007; Renner & Salem, 2009; Sourander, 2003; Summerfield, 2001; Toar et al., 2009). Although empirical data has been lacking (Boilerhouse Community Engagement Centre, 2004; Laban et al., 2004), clinical impressions of those working with asylum-seekers suggest an association between long asylum procedures and psychological distress (Silove & Steel, 1998; Sourander, 2003). Some have gone as far as describing the refugee determination process itself as "inherently traumatic" (Mansouri & Cauchi, 2007), even "toxic" (Ryan, 2007). Ryan (2007) states, "Entering the asylum process is by its very nature demeaning, disempowering, dehumanising and highly stressful" (p.28). He further opines that the asylum process systematically destroys the individual's sense of personal control, which is necessary for psychological well-being (Ryan, 2007).

In a cross-sectional study of community-based Iraqi asylum-seekers, Laban et al. (2004) found that the duration of the asylum process was a greater risk factor for psychiatric problems than that of adverse events experienced in Iraq. Individuals who had been in the Dutch refugee determination process more than two years were twice as likely to have one or more psychiatric disorders than those who had been in the process less than six months. Laban et al. (2005) argued that this was due to cumulative post-migration stress factors, particularly worries about the refugee determination process, lack of work and family-related issues (i.e., missing and worrying about family). Similar findings have been reported by others (e.g., Lavik et al., 1996; Silove et al., 1997; Steel et al., 1999).

In a prospective study that found high levels of distress in a sample of community-based asylum-seekers in Ireland, Ryan (2008) proposed that elevated distress levels could be explained in terms of "social causation" (p.42), whereby forced migrants live in social environments which expose them for prolonged periods, to multiple stressors and where access to resources is limited. He concluded that "the combination of a highly stressful environment with poor access to resources places forced migrants at risk for experiencing severe distress" (Ryan, Benson, et al., 2008, p.44).

It has been noted by Jespen (1987, cited in Iversen & Morken, 2004), that for many asylum-seekers, the waiting associated with the decision on their asylum application is the worst part, especially when they do not know when a decision will be reached and what the outcome will be. Ryan (2007) states, "The longer we are exposed to a noxious stressor, the greater is the chance that it will cause harm. After a person has lodged an asylum application the experience of legal status insecurity can last for years" (p.30). Coupled with this waiting is the inability to care for oneself and being dependent on charity or welfare (Iversen & Morken, 2004), assuming this is available.

While asylum-seekers frequently face alternating periods of suffering and calm, an individual's distress becomes increasingly intolerable at times of re-interviewing and rejection of refugee claims (Procter, 2005), perhaps suggesting a cyclical or dialectical, rather than linear trajectory of distress. This may account for mixed research findings in respect to length of time in the refugee determination process and psychological distress (i.e., depression/anxiety). For example, some researchers have found an association between psychological distress and length of time in the RDP (Hosking, Murphy & McGuire, 1997 cited in Silove & Steel, 1998) or length of time in Australia (Steel & Silove, 2000), while others have found no such relationship (Silove et al., 1997; Silove, Steel, Susljik, et al., 2007). Silove et al. (1997) found PTSD to be associated with several post-migration stressors, including delays in processing refugee applications.

A Canadian survey (Matas, 1992, cited in Silove et al., 1993) of 200 asylum-seekers awaiting refugee status determination reported that 58% stated their symptoms of anxiety or depression had worsened since they arrived in Canada, with rates of suicidal ideation being associated with the length of time the individuals had resided in Canada – that is, a measure of the delay in processing applications. Levels of anxiety and depression have also been found to increase with length of time in the UK (Ager, Malcolm, Sadollah, & O'May, 2002). In contrast, a Danish study (Schwarz-Nielsen, 2009) of 53 rejected Iraqis living in an asylum centre – despite high

prevalence of self-reported anxiety, depression and PTSD – found no relationship between severity of psychopathology and time in the asylum centre. This was in spite of lengths of stay being 5-10+ years for 79 percent of the sample. The length of stay was predicted to be a strong contributing factor for psychological symptoms and it was postulated that a distress threshold may have been reached, rendering further deterioration undetectable (Schwarz-Nielsen, 2009).

A prospective study (Silove, Steel, Susljik, et al., 2007) examining the impact of the refugee decision on the trajectory of traumatic stress symptoms found that asylum-seekers who were granted permanent residency at follow-up showed a substantial decrease in symptoms of PTSD, anxiety and depression an average of 3.8 months post-decision. However, whilst those who had been rejected at follow-up were high on all three mental health indices, their scores did not increase. Similar results were found in a prospective study (Nickerson, Steel, Bryant, Brooks, & Silove, 2011) of 97 Mandaeans, all of whom had attained permanent residency at follow-up. Thus, the authors found that when the prolonged uncertainty associated with temporary protection was removed, participants' psychological functioning improved.

Silove, Steel and colleagues have investigated the impact of the refugee determination process on the mental health of asylum-seekers for over a decade. They state, "The important question for mental health professionals is whether the rigors associated with the asylum process adds to or compounds the stress caused by past traumas in those with bona fide refugee claims" (Silove et al., 2000, p.605). Consequently, researchers (e.g., Schweitzer et al., 2006; Steel et al., 1999) have tested re-traumatisation models in which post-migration, policy-related experiences such as insecure residency, poverty, unemployment and restricted access to health care were hypothesised to exacerbate mental health consequences of pre-migration trauma (Steel, Bateman Steel, et al., 2009).

In a comparative study of community-based Tamil asylum-seekers (62), refugees (30) and immigrants (104), Steel and his colleagues (Silove et al., 1998) examined the level of pre-migration trauma, post-migration living difficulties and symptoms of psychological distress. They found that those asylum-seekers exposed to the highest levels of trauma in their home countries showed greater vulnerability to the effects of post-migration stress. Asylum-seekers with high levels of pre-migration trauma exposure showed greater posttraumatic stress reactions than other asylum-seekers when faced with unemployment, not having work rights and fears of deportation (Silove & Steel, 1998). Their model of the additional impact of post-migration stress on the psychological well-being of trauma survivors is illustrated in Figure 1 (Silove & Steel, 1998).

Using this model, Silove et al. (2007) examined the impact of the RDP decision by comparing the trajectory of symptoms among asylum-seekers whose claims were accepted or rejected. Their data showed the refugee decision-making process to exert a significant impact on the trajectory of PTSD, depression and anxiety symptoms. Two primary contributing factors to psychological distress are the processing of claims and access to services (1993). The former relates to both chronic and acute aspects of the refugee determination process – that is, individuals remaining in a state of prolonged uncertainty in the community while being vulnerable to periodic exacerbation of psychological symptoms (e.g., PTSD) due to the requirements of the system (e.g., DIAC reporting; RRT or court hearings). The latter refers to asylum-seekers who hold particular visas (e.g., BVE) which restrict access to health care and other essential services.

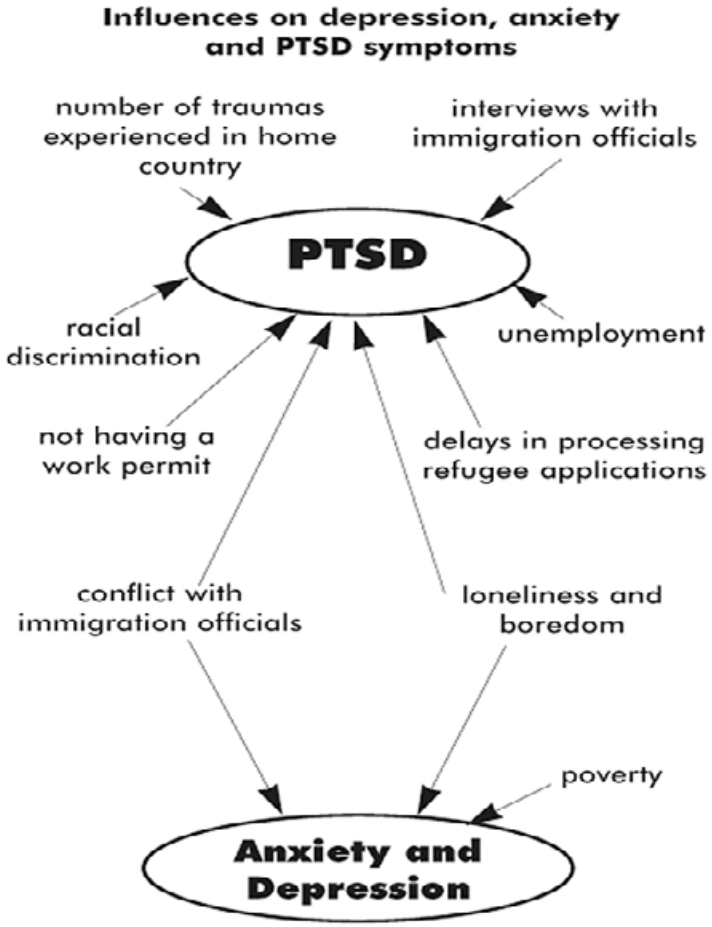

Figure 1

Influences on Depression, Anxiety and PTSD Symptoms. Reprinted from The Mental Health and Well-Being of On-Shore Asylum Seekers in Australia (p. 12), by D.M. Silove & Z.P. Steel, 1998, Sydney, NSW. Copyright 1998 by Psychiatry Research and Teaching Unit, University of New South Wales. Reprinted with permission.

1.3 Psychological Trauma

1.3.1 Prevalence and profile of trauma in forced migrant populations

Refugees and asylum-seekers living in Western countries experience high rates of mental health problems, especially PTSD, depression and anxiety (Toar et al., 2009). Epidemiological surveys of asylum-seekers have found mental disorders to be second only to musculoskeletal and respiratory disease, with PTSD and Major Depressive Disorder (MDD) being most frequently diagnosed (Bischoff, Schneider, Denhaerynck, & Battegay, 2009). Such morbidity is most striking when measured against citizens of the host countries in which they reside: an Irish study found that asylum-seekers were five times more likely to be diagnosed with a psychiatric illness in community health settings than Irish citizens, particularly anxiety (McMahon, MacFarlane, Avalos, Cantillon, & Murphy, 2007). Similar findings emerged in a Norwegian study of psychiatric hospital admissions of asylum-seekers compared with both immigrants and Norwegian citizens, most notably for acute stress disorders and adjustment disorders (Iversen & Morken, 2003).

However, PTSD is the most common mental health condition diagnosed among refugees and asylum-seekers (Carta, Bernal, Hardoy, & Haro-Abad, 2005), with refugees resettled in Western countries being likely to have PTSD at a rate ten times that of the general population in those countries (Fazel et al., 2005). Furthermore asylum-seekers in particular may even have disproportionately higher rates of PTSD than their non-asylum-seeking compatriots. For example, in a study of Sri Lankan Tamils, PTSD in asylum-seekers was three- to four-fold that of immigrants (Silove et al., 1998). While elevated PTSD rates would be expected among psychiatric patients, PTSD has been found to be as high as 86% in non-clinical samples of forced migrants (Carlson & Rosser-Hogan, 1991).

A robust dose-response association has emerged between cumulative exposure to trauma and psychiatric morbidity (Steel et al., 1999; Steel, Silove, Phan, & Bauman, 2002). Therefore, ascertaining which experiences are most likely to precipitate and perpetuate PTSD is critical to the development of psychosocial interventions (Momartin, Silove, Manicavasagar, & Steel, 2003). In an Australian study of 126 Bosnian refugees investigating psychosocial disability secondary to PTSD, Momartin et al (2003) found that traumatic events comprised four distinct categories: Human Rights Violations, Threat to Life, Traumatic Loss (of family) and Dispossession and Eviction. Furthermore, subgroups differed according to levels of exposure (Momartin, Silove, Manicavasagar, & Steel, 2002). However, only Threat to Life

predicted PTSD status, while both Threat to Life and Traumatic Loss contributed to symptom severity and disability associated with PTSD (Momartin et al., 2003).

Iversen and Morken (2004) found that asylum-seekers were more likely to be diagnosed with PTSD than refugees (43% vs. 11%) which they proposed was likely due to the uncertainty of living in Norwegian asylum-seeker centres and the risk of deportation. Other studies have also found greater prevalence of PTSD and other psychiatric disorders in asylum-seekers compared to refugees (Gerritsen et al., 2006; Momartin et al., 2006; Steel, Chey, et al., 2009; Toar et al., 2009). Therefore, post-migration stress which distinguish between refugees and asylum-seekers – who have comparable levels of pre-migration trauma (Mollica, Wyshak, & Lavelle, 1987; Silove, 2002) – is an obvious compounding factor to pre-existing trauma. Moreover, extrapolating upon Momartin et al.'s (2003) findings, the ongoing threat to life by way of deportation if an asylum-seeker's application is rejected highlights the fundamental distinction between asylum-seekers and refugees, and is therefore likely to be reflected in the relative prevalence of PTSD for each group. Steel et al. (2009) assert that "PTSD increasingly is conceptualised not simply as a condition triggered by [past] life-threatening potential traumatic events, but one that is shaped by conditions of ongoing threat or insecurity" (p.347); a position which aligns with numerous other investigators (e.g., Hallas et al., 2007; Laban et al., 2004; Lie, 2002; Mansouri & Cauchi, 2007; Masmas et al., 2008; Porter & Haslam, 2005; Van Velsen, Gorst-Unsworth, & Turner, 1996). Furthermore, Hallas et al. (2007) argued that "psychopathology among refugees and asylum-seekers is not an inevitable consequence of acute wartime stress but rather reflects the economic, social and cultural conditions from which they have escaped and into which they are placed" (p.292).

While there is little research into the prevalence of PTSD in asylum-seekers, in samples of refugees in Western countries, the prevalence of PTSD differs widely, from 3% to 86% (Fazel et al., 2005; Laban et al., 2004; Ryan, Kelly, & Kelly, 2009). Therefore, even conservative rates of PTSD in forced migrant populations are predominantly multifold higher than the 12-month prevalence of 6.4% in the general Australian population (Slade, Johnston, Oakley Browne, Andrews, & Whiteford, 2009). Most international 12-month prevalence rates for the general population cluster around 0.5–1.0% (Hinton & Lewis Fernández, 2010).

Methodological differences between studies are often cited as contributing to the vast variability in epidemiological estimates of PTSD in forced migrant populations. Sample size exerts an important influence on prevalence, with this

alone accounting for close to 10% of the variance in PTSD scores in studies of populations exposed to mass conflict and displacement (Steel, Chey, et al., 2009). In a review of 20 studies of adult refugees across seven Western countries, Fazel et al. (2005) found a prevalence in the larger studies (i.e., $N \geq 200$) of only 10% for PTSD. Steel and colleagues (2009) found important interaction effects for sample size with, in particular, the type of measure used. For example, studies of $N>500$ employing diagnostic interview averaged a PTSD prevalence of 13% compared to an average of 33% for studies utilising self-report measures (Steel, Chey, et al., 2009). However, even when employing diagnostic interviews, the threshold for a diagnosis of PTSD has been found to be lower using the DSM-IV criteria (Friedman & Jaranson, 1994), with ICD-10 diagnosing more than twice as many cases in epidemiological samples (Peters, Slade, & Andrews, 1999).

In the aforementioned meta-analysis, Steel et al. reviewed 161 papers comprising 81,866 forced migrant adults from 40 countries over a 19-year period, finding inter-survey variability in rates of PTSD from 0%-99% (Steel, Chey, et al., 2009). Methodological factors accounted for 13% of the variability, with non-random sampling, small sample sizes and self-report questionnaires all being associated with higher rates of mental disorder. The primary predictors for PTSD are considered to be experiences of torture (Hondius, van Willigen, Kleijn, & van der Ploeg, 2000; Masmas et al., 2008; Roth et al., 2006; Silove, 2000) and the number of traumatic events experienced (Schauer, Neuner, & Elbert, 2011). This was supported by Steel et al.'s meta-analysis, which found that these two variables had the strongest association with PTSD once methodological factors were controlled, together accounting for 23.6% of the variance in PTSD (Steel, Chey, et al., 2009). For example, studies with a high proportion of torture survivors (≥ 40%) had a higher rate of PTSD diagnosis than studies in which those reporting torture was < 40%, regardless of sample size and sampling method. This was also the case for the ratio of exposure to traumatic events (Steel, Chey, et al., 2009). Those who reported torture were twice as likely, and those who had greater cumulative exposure to traumatic events were 1.5 times more likely, to have a diagnosis of PTSD. The only other factors associated with PTSD after controlling for methodology were level of political terror (derived by the Political Terror Scale, see Gibney & Dalton, 1996) and the amount of time that had passed since war/conflict (Steel, Chey, et al., 2009). The authors concluded that their meta-analytic findings of between 13% and 25% for PTSD was "broadly comparable with the World Health Organization's estimate of 20% for the median prevalence of mental disorder that may be expected in societies exposed to humanitarian emergencies" (Steel, Chey, et al., 2009, p. 548).

1.3.2 Pre- and post-migration factors

For asylum-seekers who suffer from clinical disorders such as PTSD, the challenge is to understand the connection between the traumatic experiences from the country of origin and the post-migration difficulties inherent in the asylum-seeker experience (McFarlane, 2004).

Two consistent risk factors have emerged in the literature regarding the determinants of mental disorder in forced migrants: past trauma and post-migration stress (Silove & Ekblad, 2002). Steel and Silove (2000) state, "Increasingly, it is recognized that the characteristics of the peri-and post-traumatic environments are important in determining the persistence and severity of ongoing PTSD symptoms" (p.423). Indeed, post-migration trauma has been found to contribute almost as much to PTS symptomatology as pre-migration trauma (Steel et al., 1999). Although findings of another study challenged the supposition that post-migration factors mediate or eclipse pre-migration traumas, the authors believed their findings indicated that post-migration stressors may diminish with prolonged resettlement whereas the effects of pre-migration trauma can persist (Steel et al., 2002). Furthermore, the subjects were refugees, not asylum-seekers.

For asylum-seekers, their insecure legal status impedes the recovery process, ensuring that their journey through trauma is ongoing (Mansouri & Cauchi, 2007; Silove & Steel, 2006). Steel (2003) considers this "future oriented PTSD" to be a "core adaptive survival response" to a state of uncertainty, which is almost impossible to treat while the situation of impermanence remains (cited in Mansouri & Cauchi, 2007, p. 142).

Any trauma experienced in the homeland risks being compounded by the stress of migration and adjustment (Aron, 1992; Rees, 2003), with one UK study reporting that asylum-seekers had claimed post-migration concerns were of greater severity than pre-migration issues (Crowley, 2005). In a different context, recent trauma for Cambodian refugees living in a refugee camp was found to be a more potent influence on current trauma symptoms than trauma experienced during the Pol Pot regime (Mollica, McInnes, Poole, & Tor, 1998). Moreover, an Australian sample of asylum-seekers with PTSD reported greater stress in relation to post-migratory factors, particularly pertaining to pursuing refugee status (Silove et al., 1997). Thus, not having refugee status has been found to be a significant risk factor for PTSD (Hondius et al., 2000), prompting the assertion that, for asylum-seekers, "the term 'post' in 'posttraumatic stress disorder' should perhaps be deleted" (Hondius et al., 2000, p. 633).

Other post-migration stressors associated with asylum-seekers diagnosed with PTSD include being denied a work permit, worrying about family left behind, fear of repatriation, loneliness and boredom (Hondius et al., 2000; Mann & Fazil, 2006; Steel & Silove, 2000). For example, Steel and Silove (2000) found that individuals with the highest levels of trauma exposure displayed "an additional sensitization effect to fears associated with forced repatriation and stressors due to … not having work rights" (p.435).

As aforementioned, it has been postulated that particular post-traumatic stressors, such as the threat of repatriation, may interact with experiences of past trauma to increase the severity of PTSD symptoms (Steel & Silove, 2000). Specific concerns have been raised by Aron (1992), who warned that the complexities of the legal process involved in seeking asylum have the potential to re-traumatise persons fleeing persecution. Hence, failure to rapidly determine refugee status and the associated on-going economic hardship may prolong or intensify traumatisation from pre-migration experiences (Ehrenreich, 2003).

Lazarus and Folkman (1984) proposed a theory in relation to psychological stress and coping which incorporates several situational factors that may impact on an individual's ability to cope with stressful situations. Of these, three factors pertinent to asylum-seekers are 'duration', 'event uncertainty' and 'temporal uncertainty'. Temporal uncertainty refers to not knowing when an event is going to happen. The authors argue that event uncertainty "…can have an immobilising effect on anticipatory coping processes and cause mental confusion" (Lazarus & Folkman, 1984, p.115), with greater uncertainty being associated with poorer adjustment. For asylum-seekers, the duration of their wait can be lengthy and the timing of receiving an outcome to their application, uncertain – particularly for those undergoing the appeals process. Asylum also brings with it the constant threat of an event – a negative decision and possible deportation – that may or may not take place (Ryan, 2007). Regarding this, the authors state, "The coping strategies for anticipating an event's occurrence are often incompatible with strategies needed to anticipate the event's non-occurrence" (Lazarus & Folkman, 1984, p.91). In other words, asylum-seekers are placed in a psychological double bind whereby they need to concurrently prepare for the antithetical outcomes of being deported and of making a new life in the host country.

More recently, an asylum-seeker-specific model based on adaptational theory was proposed by Silove and Steel (2006). The ADAPT model postulates that the 'eco-social' conditions that prevail in the posttraumatic environment may be central

to perpetuating or resolving symptoms of PTSD (Silove, Steel, Susljik, et al., 2007). The theory is based on the premise that the PTSD reaction derives from a psycho-physiological reaction that evolved to promote the survival of the species. Hence, persistence of the PTSD reaction may be influenced by whether conditions of safety or threat emerge in the posttraumatic environment. The model predicts that asylum-seekers accepted as refugees should show immediate reductions in PTSD symptoms, with the converse being the case for those whose refugee claims are rejected (Silove, Steel, Susljik, et al., 2007).

Research testing the ADAPT model has provided empirical support for the contention that post-migration stress compounds past traumas by prolonging mental disorders among asylum-seekers, and that secure residency status for asylum-seekers may be important to recovery from trauma-related psychiatric symptoms (Silove, Steel, Susljik, et al., 2007). These findings are consistent with previous research, suggesting that uncertainties and fears associated with temporary visa status (Nickerson et al., 2011; Steel et al., 2006), protracted asylum processes (Hondius et al., 2000; Laban et al., 2004) and rejected visa applications (Silove, Steel, Susljik, et al., 2007) are linked to increased rates of PTSD and other mental health conditions.

1.3.3 Trauma nosology and co-morbidity

Until relatively recently, 'trauma' did not feature in refugee health nomenclature (Summerfield, 1999). However, there has been a growing awareness that physical, cognitive and spiritual effects may follow a traumatic event, with these dimensions varying in salience according to culture (Hinton & Lewis Fernández, 2010; Kinzie & Jaranson, 2001). The heterogeneity and mutability of symptoms in response to trauma in a trans-cultural setting has posed nosological and clinical challenges, prompting deliberation about the need for taxonomies which integrate Western and indigenous symptom profiles to improve case identification (Friedman & Jaranson, 1994; Steel, Silove, et al., 2009). Proposed taxonomies include cultural bereavement (Eisenbruch, 1992), complicated grief (Momartin, Silove, Manicavasagar, & Steel, 2004b), somatoform disorders (Silove & Steel, 2006) and Post Traumatic Demoralisation Syndrome (Parson, 1990).

While research can extract dimensions of trauma, these tend not to capture the full range of subjective experiences and reactions to complex traumatic events (Momartin et al., 2002). Despite this, few studies have examined criteria beyond those included in DSM-IV-TR. Some have argued that the PTSD model

may be useful in conceptualizing the traumatic experiences of refugees so long as cultural phenomenology is incorporated in the formulation (Renner, Salem, & Ottomeyer, 2006; Silove, Steel, & Bauman, 2007). Frequently cultural context is not appropriately considered, however, and the trans-cultural validity of PTSD has been criticised on the grounds of 'category error' (A. Kleinman, 1991) – the assumption that an illness or symptom in Western society has semantic equivalents in other societies. For example, a study of Vietnamese refugees (Silove, Steel, & Bauman, 2007) found no specific dimensions that corresponded directly to PTSD, thus highlighting the risk of category error when dominant cultural assumptions are not critically examined. This is most pertinent when investigating forced migrant populations. Watters (2001) states, "While categories and sub-categories continue to be refined in relation to general populations, refugees tend to be encapsulated within the ubiquitous designations of PTSD or trauma-related problems" (p.1716). Thus, commentators have observed the value of combining qualitative and quantitative methods when researching trauma suffered by these populations (Momartin et al., 2002). This approach facilitates the generation of items specific to trauma-related cultural syndromes to increase the cultural validity of PTSD checklists (Hinton & Lewis Fernández, 2010; Mollica et al., 1992)

Diagnostic criticism has led some investigators to consider 'disorders of extreme stress not otherwise specified' (DESNOS) to be a more appropriate construct than PTSD, to characterise trauma-related disorders in certain cultural groups due to its broader range of symptoms (De Jong, Komproe, Spinazzola, van der Kolk, & van Ommeren, 2005). The content validity of DESNOS has been found to be superior to PTSD in trans-cultural populations due to criteria incorporating somatic symptoms, trauma-related anger, and dissociation (Hinton & Lewis Fernández, 2010). In particular, cultural data indicate that there may be a higher rate of somatic symptoms associated with PTSD in certain cultures (Renner et al., 2006; Silove, Steel, & Bauman, 2007), possibly due to the attribution of trauma symptoms to 'cultural syndromes' resulting from traumatic events (Hinton & Lewis Fernández, 2010), and a mind-body approach to well-being which perplexes Western health models embedded in Cartesianism (Dana, 2007; Watters, 2001). Thus, cultural syndromes and PTSD may have a synergistic relationship, with the role of cultural syndromes patterning symptoms and linking PTSD with particular co-morbid symptoms (Hinton & Lewis Fernández, 2010).

Co-morbidity of PTSD and other disorders such as generalised anxiety disorder and depression is the rule rather than the exception (Creamer, Burgess, & McFarlane, 2001), with research suggesting co-morbid depression and PTSD in

forced migrant populations to be as high as 80% (Mollica et al., 1992). Indeed, co-morbidity has been so pronounced in certain refugee populations that some have called for it to be recognized as a posttraumatic affective disorder (Momartin, Silove, Manicavasagar, & Steel, 2004a). Others have proposed a category of 'Chronic and Multiple Stress Syndrome' for forced migrants who present with atypical depressive symptomatology mixed with anxious, somatoform and dissociative symptoms (Carta et al., 2005). The question of co-morbidity is one of clinical importance for forced migrants, as there is evidence to suggest that co-morbid depression and PTSD symptoms are associated with substantially increased risk for functional impairment in this population (Mollica et al., 1999; Momartin et al., 2004a). As yet however, the mechanisms linking the aetiology and course of co-occurring PTSD and depression remain unclear (Schindel-Allona, Aderkaa, Shahara, Stein, & Gilboa-Schechtmana, 2010).

The prevalence of co-morbidity suggests the possibility that the trauma of being an asylum-seeker may cause a particular pattern of distress – for example, 'mental death' (Ebert & Dyck, 2004), 'complex PTSD' or 'Ulysses syndrome' (Carta et al., 2005) – due to post-migration circumstances. When an individual remains in an environment of ongoing threat, the clinical task of differentiating pathological from 'normal' responses poses a significant challenge (Mann & Fazil, 2006; McFarlane, 2004; Summerfield, 1999). For example, PTSD has been found to be associated with delays in processing refugee applications and difficulty in dealing with immigration officials (Silove et al., 1997). Compounding this difficulty, PTSD checklists can be poor at distinguishing between the physiology of normal and pathological distress (Summerfield, 2001). Furthermore, Davis (2006), in respect to a study by the Harvard Program in Refugee Trauma, noted that variables associated with the migration process and with bereavement may have explained the apparent chronicity of PTSD in that population. This diagnostic quandary therefore raises particular nosological concerns as to whether PTSD constitutes a specific disorder of traumatic stress across cultural groups, or is so heterogeneous as to function merely as a barometer of nonspecific, reactive distress (Hinton & Lewis Fernández, 2010; McFarlane, 2004).

Certain PTSD clusters and items appear to be less valid in trans-cultural and refugee populations based on frequency of item endorsement and dose-effect associations to trauma. While re-experiencing (Criteria B) and hyperarousal (Criteria D) show relative consistency as valid predictors of PTSD (Hinton & Lewis Fernández, 2010), in several studies avoidance/numbing (Criteria C) has demonstrated a poorer

performance (Friedman & Jaranson, 1994; Hinton & Lewis Fernández, 2010; Mollica et al., 1992; Mollica et al., 1998). While Criteria C may be under-endorsed in refugee samples (Gorst-Unsworth & Goldenberg, 1998; Hondius et al., 2000; Renner et al., 2006), there is some evidence to suggest that endorsed Criteria C symptoms may predict the severity or level of impairment of the other clusters (Hinton & Lewis Fernández, 2010). It is possible that the under-representation of avoidance/numbing symptoms may be an artefact of ethnocultural and religious factors influencing the expression of these symptoms in refugee populations (Friedman & Jaranson, 1994). Regardless, these profile patterns have resulted in calls for the sociocultural meaning of PTSD subcategories to be clarified (Mollica et al., 1998). For example, unlike Western populations, symptoms of recurrent nightmares and avoiding potential triggers have been found to be poor predictors of PTSD (Hinton & Lewis Fernández, 2010; Mollica et al., 1992), possibly due to culture-specific interpretations of these symptoms or due to contextual factors such as being in situations of ongoing, pervasive trauma (Hinton & Lewis Fernández, 2010).

1.3.4 Cross-cultural validity of PTSD?

As previously touched upon, there is considerable debate about PTSD being a Western 'culture-bound' diagnostic category, with evidence of cross-cultural variability indicating a need for revision and further research (Friedman & Jaranson, 1994; Hinton & Lewis Fernández, 2010; Thakker & Ward, 1998). In particular, PTSD has been challenged by some regarding its validity as a diagnostic category for refugees (P. J. Bracken, Giller, & Summerfield, 1995; Summerfield, 1999; Watters, 2001). Commentators have raised concerns about the medicalisation of existential fear, suffering and the social and political dilemmas central to producing refugees – particularly when conceptualised within a simplistic or reductionistic explanatory model imposed by the West on non-Western populations (P. J. Bracken et al., 1995; Hinton & Lewis Fernández, 2010; McFarlane, 2004; Silove, 1999; Summerfield, 1999; Thakker & Ward, 1998; Watters, 2001). Whilst a culture-bound trauma syndrome has yet to be identified (Mollica et al., 1992) , it has also been suggested that a trans-culturally valid posttraumatic syndrome may not exist (Renner, Salem, & Ottomeyer, 2007).

Some have argued that consideration be given to symptom complexes other than PTSD that are more strongly associated with impairment and culture-bound syndromes, as it is not clear that PTSD is the most appropriate construct for traumatized refugees with symptoms currently defined as PTSD (Dana, 2007; Hollifield et al., 2002; Silove, 2005). Hollifield et al. (2002) state, "Culture and

language complicate diagnosis, and polytrauma is pathogenic for disorders that are different compared with those found in non-refugee populations" (p.618). For example, individuals from refugee backgrounds may be more inclined to draw explicit links between psycho-physiological symptoms and social circumstances (Watters, 2001).

Hence, a major criticism of the formulation of PTSD is that it has been universally accepted with little examination of its cross-cultural validity and clinical utility (P. J. Bracken et al., 1995; Hinton & Lewis Fernández, 2010; McFarlane, 2004; Mollica et al., 1992; Thakker & Ward, 1998; Watters, 2001). For this reason, Bracken, Giller & Summerfield (1995) caution against the global application of the construct, stating "…the fact that symptoms and signs can be reliably identified in different settings is no guarantee that they mean the same thing in those settings" (p.1074). Although physiological markers may be universal, the cognitive and emotional domains of trauma may vary across cultures, including the subjective meaning of potentially traumatic events (P. J. Bracken et al., 1995). While P. J. Bracken et al. (1995) do not advocate that the diagnosis of PTSD in non-Western populations be abandoned outright, they register concern about the potential misuse of diagnosing "in isolation from the social, political and cultural context" (p.1077). By focusing on the individual and their symptoms, there is a tendency to conceptualise the effects of trauma in purely individual and medical terms (P. J. Bracken et al., 1995; Steel, Bateman Steel, et al., 2009; Summerfield, 1999; Watters, 2001).

The individual-centric orientation of PTSD has implications for the treatment and putative course for non-Western patients. For example, it is not uncommon for non-Western individuals to present with symptoms consistent with a diagnosis of PTSD who would rather attend to the somatic, social and/or practical problems secondary to their traumatic experience (P. J. Bracken et al., 1995; Summerfield, 1999; Watters, 2001). Summerfield, who worked with rural South American community populations subject to war and displacement, observed that individuals who commonly experienced PTSD symptoms were "undoubtedly fearful, grieving and weary, but not psychological casualties in any sense meaningful to them; they were active and effective in maintaining their social worlds as best they could in the face of poverty and continuing threat…" (Summerfield, 1999, p. 1454). Thus, contrary to the bio-medical model, the mending or strengthening of social relationships may be the most efficacious intervention for such individuals (Bracken et al., 1995; Silove, 1999). This is illustrated by Summerfield's observation that "War-affected populations are largely directing their attention not inwards, to their mental

processes, but outwards, to their devastated social world" (Summerfield, 1999, p. 1454). Hence, P. J. Bracken et al. (1995) conclude, "…if we ignore these problems, we are at risk of introducing inappropriate treatment models and strategies in our attempt to help the rehabilitation of individuals and communities who are the victims of violence and trauma" (p.1087).

Not only do refugees rarely view their problems in terms of mental illness (Mann & Fazil, 2006), but a diagnosis of PTSD may not fully encapsulate the experiences and responses of asylum-seekers and refugees (Schweitzer, Buckley, & Rossi, 2002). Hence, there is a need to better understand the role of the various aspects of the refugee experience and the range of disorders observed in such populations regarding multiple adversities and the high co-morbidity in association with PTSD (McFarlane, 2004; Silove, 1999).

Therefore, PTSD may be a hybrid of biological and phenomenological markers. Arousal and re-experiencing symptoms may be more driven by the biology of trauma, whilst avoidance and numbing may primarily represent coping mechanisms resulting from culture-specific ways of managing distress (Hinton & Lewis Fernández, 2010; Renner et al., 2007). It has been suggested that the prominence of particular PTSD symptoms may be influenced by the persistence of stressors and ontological insecurity. That is,

> *In settings of multiple traumatisation, multiple stressors and great insecurity, it may be that arousal, hypervigilance, panic, anger, and arousal-caused somatic symptoms may be more common based on the premise that ongoing threat may activate arousal-related biological and psychological systems.*
>
> (Hinton & Lewis Fernández, 2010, p. 11)

Given this, the aforementioned ADAPT model (1.3.2) may have particular utility in explaining elevated PTSD levels in asylum-seekers.

Notwithstanding the controversy, even critics of the applicability of PTSD to non-Western populations acknowledge that a minority of individuals will develop a "clear-cut" mental disorder such as PTSD following traumatic events (Silove & Steel, 2006; Silove, Steel, & Bauman, 2007; Summerfield, 1999). This is supported by a growing body of evidence that PTSD manifests across culturally diverse samples (Friedman & Jaranson, 1994; Hinton & Lewis Fernández, 2010; Mollica et al., 1999; Silove, Steel, & Bauman, 2007), with an equivalent DSM-IV PTSD factor structure of symptoms emerging across cultural settings (Hinton & Lewis Fernández, 2010).

Instead, concerns relate to the risk of over- or under-estimation of diagnosis

(Renner et al., 2006) and the individual-centric, simplistic and reductionistic interventions that often ensue (Mann & Fazil, 2006; Summerfield, 1999). The greatest concern regards undermining individual and collective resilience by re-labelling survivors as victims (Silove & Steel, 2006; Steel, Bateman Steel, et al., 2009; Watters, 2001) "who are passive receptacles of negative psychological effects" (Summerfield, 1999, p. 1453).

1.4 Demoralisation

1.4.1 Definitions of demoralisation

The term 'demoralisation' first emerged in the psychiatric literature in the 1970s, following clinical observations of patients entering psychotherapy by American psychiatrist, Jerome Frank. To Frank, "The state of demoralisation… is one of hopelessness, helpless and isolation in which the person is preoccupied with merely trying to survive" (Frank & Frank, 1991, p. 35). Typically such patients would believe they had failed to meet their own or others' expectations or feel unable to cope with some pressing problem, feeling powerless to change either their situation or their response to it (Frank & Frank, 1991). He observed low self-esteem and despair in patients referred for depression, which he believed was not depression (Connor & Walton, 2011). He viewed symptoms of anxiety and depression as direct expressions of demoralisation, reflecting a persistent failure to cope with stress. More than four decades on, distinguishing between depression and demoralisation remains central in the literature (Connor & Walton, 2011).

Demoralisation is experienced as existential despair, helplessness, hopelessness, and loss of meaning and purpose in life (Clarke & Kissane, 2002), and is believed to be a major public health problem which cuts across most diagnostic categories (Frank, 1973). It is likely to be experienced in association with a variety of problems including stressful life events, psychiatric disorders and conditions of social marginality, as experienced by minority groups (Dohrenwend, Dohrenwend, et al., 1980). Demoralisation has been commonly observed in the medically and psychiatrically ill (Clarke & Kissane, 2002; Fava, Fabbri, Sirri, & Wise, 2007). However, it has also been reported to affect approximately 25% of the general population at any given time (Link & Dohrenwend, 1980; Poulin, Lemoine, Poirier, & Lambert, 2005) and migrant populations have been found to have elevated rates of demoralisation (Flaherty, Kohn, Golbin, Gaviria, & Birz, 1986).

Demoralisation – or the characteristics thereof – can been perceived to be synonymous with other psychological rubrics such as minor depression (Howland

et al., 2008; Rapaport et al., 2002), sub-clinical depression (Pincus, Wakefiled, & McQueen, 1999), subsyndromal depression (Judd, Rapaport, Paulus, & Brown, 1994), reactive depression (Klein, 1974; Maj, 2007), adjustment disorder (Angelino & Treisman, 2001), learned helplessness (Seligman, 1975), existential distress (Kissane, 2001), 'Social Breakdown Syndrome' (Gruenberg, 1967) and the 'Giving-up, Given up' complex (Engel, 1967). However, it is most commonly referred to as 'nonspecific (psychological) distress' (Dohrenwend, Shrout, Egri, & Mendelsohn, 1980) and lies on a spectrum of vulnerability (Cheuk, Chan, & Ungvari, 2009; Kissane, 2004) whereby even the most resilient person may become demoralised under extreme circumstances (Jacobsen, Maytal, & Stern, 2007). For this reason, the concept of demoralisation has been criticized by some (Parker, 2004; Slavney, 1999) for pathologising what may be considered a normal response in certain circumstances – much like grief – whilst others (Clarke & Kissane, 2002; de Figueiredo, 2000) take the position that it is always maladaptive. Therefore, demoralisation may be considered a boundary phenomenon: occurring at the boundary between the person and the environment and between the 'normal' and 'abnormal' (de Figueiredo, 2007).

Over the past 30 years, a growing body of research has attempted to define demoralisation as a distinct clinical construct. However, there is still disagreement about its exact nature (Cheuk et al., 2009). Hence, demoralisation is a diffuse construct, both theoretically and empirically (e.g., Blazer et al., 1989), despite numerous attempts to define and operationalise it. The key theorists and researchers in the area of demoralisation are American psychiatrists Frank (Frank, 1973, 1974), de Figueiredo (de Figueiredo, 1983b, 1993; de Figueiredo & Frank, 1982) and Slavney (1998), psychiatric epidemiologist Dohrenwend (Dohrenwend, Levav, & Shrout, 1986) and Australian psychiatrists Clarke and Kissane (Clarke & Kissane, 2002; Kissane et al., 2001).

The epidemiological surveys of Dohrenwend and colleagues (Dohrenwend & Crandel, 1970; Dohrenwend, Dohrenwend, et al., 1980; Dohrenwend et al., 1986; Dohrenwend, Shrout, et al., 1980; Link & Dohrenwend, 1980; Shrout, Dohrenwend, & Levav, 1986) provide strong empirical support for the importance of demoralisation (Frank & Frank, 1991), although their work has been criticised on methodological (Murphy, 1986), empirical (Blazer et al., 1989) and criterion grounds (de Figueiredo, 1993). Notwithstanding these critiques, Dohrenwend et al.'s research employing the Psychiatric Epidemiology Research Interview (PERI) identified eight scales that appeared to measure a single dimension, which collectively corresponded closely

to the construct of demoralisation described by Frank (1973). These scales were labelled as: poor self-esteem, sadness, dread, anxiety, perceived physical health, somatic complaints, helplessness-hopelessness and confused thinking (Dohrenwend et al., 1986).

Despite its clinical and prognostic relevance, demoralisation has not been adequately recognised by traditional psychiatric classifications (Fava et al., 2007). Furthermore, the greatest difficulty for researchers and clinicians is distinguishing it from depression. The main controversy centres on whether feelings of demoralisation a) constitute a syndrome of despair, distress, and hopelessness separate from depression; b) reflect clinical depression; or c) represent a normal response to difficult circumstances (Briggs & Macleod, 2010). From the viewpoint of clinical utility, the crucial issue is whether demoralisation can reliably be differentiated from depression (O'Keeffe & Ranjith, 2007). Symptoms said to characterise demoralisation include feelings of hopelessness and helplessness, confusion, loss of meaning, isolation, subjective incompetence, distress and apprehension – most of which are shared with depressive disorders (O'Keeffe & Ranjith, 2007).

Evidently agreement has yet to be reached regarding a unified definition and it has been argued that, because it is equivalent to nonspecific psychological distress, demoralisation does not represent a specific psychopathological entity (Blazer et al., 1989). However, the problem of demoralisation and its relationship to psychopathology is still considered to be of theoretical and practical importance (Gutkovich et al., 1999) because it appears to influence the course, and worsen the prognosis, of other disorders (Marchesi & Maggini, 2007). Snaith (1987) states, "The definition of the ubiquitous states that masquerade under the term 'depression' is of central importance and no real progress will be made in research and the development of clear guidelines to effective intervention until this is done" (p. 393). Hence, the validity and usefulness of demoralisation as a construct will ultimately be determined by whether or not it guides effective intervention (Clarke & Kissane, 2002).

1.4.2 Nosological considerations and differential diagnoses

A number of criterion-based differences between depression and demoralisation have been offered over the decades. Demoralisation is essentially a crisis of meaning with hopelessness and helplessness as its key criteria (Kissane & Kelly, 2000). Conversely, major depression is characterized by neuro-vegetative

symptoms, depressed mood and/or anhedonia. However there is considerable blurring of criteria, confounding the issue of differential diagnosis. For example, whilst anhedonia and depressed mood are the cardinal features (criterion A) of a major depressive episode (American Psychiatric Association, 2000), the place of anhedonia in major depression remains ambiguous, being an important core symptom, but not necessary to the diagnosis (McKenzie, Clarke, Forbes, & Sim, 2010). Furthermore other depressive disorders, such as minor depression, also frequently have depressed mood as a feature (Rapaport et al., 2002).

Schildkraut and Klein (1975, cited in Shader, 2005) were among the first to note the importance of separating depression from demoralisation, with the key distinction being that depressed persons lose their capacity to feel pleasure (i.e. anhedonia) whilst demoralised persons lose their sense of self-efficacy (i.e. mastery). Klein (1974) used the term "endogenomorphic depression" to describe the syndrome for which both anticipatory and consummatory pleasure are affected in those with depression. Conversely, in demoralisation, only anticipatory pleasure is affected. In Klein's model, endogenomorphic depression is synonymous with demoralisation and research has lent support to Klein's theory that, in the demoralised person, anhedonia is absent and mood reactivity is preserved (Clarke, Mackinnon, Smith, McKenzie, & Herrman, 2000; Griffith & Gaby, 2005; Gutkovich et al., 1999; Kissane et al., 2001). Furthermore, the demoralised patient can experience hope and feel enjoyment as adversity is overcome (Jacobsen et al., 2007), which has been particularly noted in a medical context when illness remits (Slavney, 1998). Therefore the term 'demoralisation' is a useful construct to describe a dysphoric mood that can change in response to external circumstances (Jacobsen et al., 2007). Demoralisation is more transient than major depression, for which the source of distress is located within the individual rather than in his or her environment (Mangelli et al., 2005). In this way, major depression is less responsive to the external environment and is maintained by biogenic rather than psychosocial factors (Snaith, 1987).

Snaith (1987) also considered anhedonia to be the central symptom by which to reliably diagnose hypo-melancholic depression, believing it to be "… the nearest guide to the biogenic depressive disorder" (p.393). He argued that, if anhedonia is persistent and not adequately accounted for by the person's circumstances, it should respond to antidepressant medication, thereby distinguishing it from other diffuse depressive states, including demoralisation (Snaith, 1987). de Figueiredo (1993) also noted that demoralised patients lacked the physiological markers characteristic

of melancholic depression – most notably those involving sleep, appetite and motivation. Conversely, Slavney (1998) observed that sleep and appetite were often disturbed in demoralised patients. Furthermore, in an inpatient medical population, Clarke et al. (2003) found that a diagnosis of MDE was not particularly associated with anhedonic depression. Notwithstanding the lack of concordance regarding symptom patterns, demoralisation differs from depression in that it generally fails to show robust improvement when antidepressant medications are prescribed (Griffith & Gaby, 2005). Instead, the treatment of choice for demoralisation is psychotherapy (Frank, 1974). Consequently, failure to recognise demoralisation in patients may result in misdiagnosis or misuse of pharmacotherapy (de Figueiredo, 1983b).

Motivation is believed to be another distinguishing feature between the two diagnoses (de Figueiredo, 1993; Kissane, 2000). In depression, avolition arises from amotivation even when a person knows the direction of the action, whilst in demoralisation, a sense of incompetency and future uncertainty inhibits action even in the presence of significant motivation (de Figueiredo, 1993).

Thus, there appears to be agreement about demoralisation being a state of self-perceived incapacity to deal effectively with stressful situations (Klein, 1974), although terminology differs. de Figueiredo (1982) coined the term 'subjective incompetence' – or 'copelessness' (Murphy, 1986) – which he considers to be the clinical hallmark of demoralisation. This is purported to encapsulate a feeling of being trapped by an inability to plan and initiate action toward one's goals (de Figueiredo, 2007). According to de Figueiredo (1983a), however, a diagnosis of demoralisation requires the presence of both distress and subjective incompetence.

Whilst demoralisation is thought to have a negatively-oriented and pessimistic cognitive dimension (Kissane et al., 2001; McKenzie et al., 2010), the content of such cognitions do not necessarily contain the themes of guilt or self-reproach characteristic of major depression. For example, even when physical symptoms are severe, the demoralised patient almost never believes s/he deserves to suffer (Slavney, 1998). However, Clarke and Kissane assert that the cognitive state of the demoralised includes negative self-labelling which lowers self-esteem (Kissane et al., 2001).

Suicidality is a contentious issue in the debate. It has been claimed that the distinction between depression and demoralisation can be supported by evidence that suicidal ideation is differentially associated with hopelessness and depression (Clarke & Kissane, 2002), with hopelessness being more highly correlated with

suicide than depression (Beck, Kovacs, & Weissman, 1975; Jacobsen et al., 2006) and even being a predictor of suicidality independent of depression (Chochinov, Wilson, Enns, & Lander, 1998; Wetzel, Margulies, Davis, & Karam, 1980). Slavney (1999) also linked suicidal tendencies to demoralisation.

In an Australian study of hospitalised medically ill patients (Clarke et al., 2000), five dimensions of psychiatric symptoms emerged, including anhedonia and demoralisation. Analyses revealed that suicidal ideation loaded on the demoralisation dimension rather than the anhedonia dimension (Clarke et al., 2000). Furthermore, the demoralisation dimension was noted to be similar to both the concept of demoralisation described by Frank (1974) and the "giving up-given up complex" (Engel, 1967). Those categorised as demoralised had the greatest levels of distress whilst those in the anhedonic depression group were highest on social dysfunction (Clarke et al., 2003), raising the possibility of a plausible distinction between depression and demoralisation for Criterion C of MDD.

Thus, taxonomical boundaries remain blurred between the two conditions, with a high prevalence of co-morbidity (Angelino & Treisman, 2001; Kissane, 2004; Mangelli et al., 2005). Therefore, in spite of improved reliability, the diagnostic systems of DSM and ICD inadequately capture the nature and range of dysphoric states (Clarke & Kissane, 2002). In an attempt to address "conceptual flaws and clinical inadequacies" in the diagnostic criteria of DSM and ICD, Fava et al. (1995) developed the Diagnostic Criteria for Psychosomatic Research (DCPR) to operationalise some of the psychosocial factors thought to be relevant to subclinical syndromes frequently encountered in the medical setting.

Most theorists agree that, unlike major (melancholic) depression, the aetiology of demoralisation is not endogenous, but comprises both intrapsychic and environmental factors. Kissane et al. (2001) concur with de Figueiredo (1982) in regarding subjective incompetence as the key individual factor in demoralisation, whereas Frank (1991) attributes intrapersonal factors to putative genetic makeup or early-life stressors. Social isolation or weak social and familial support is unanimously believed to be a requisite for the development of demoralisation.

1.4.3 Demoralisation syndrome

Clarke and Kissane (2002) argue that demoralisation is not simply nonspecific distress, but "a clearly defined syndrome of existential distress occurring in patients suffering from mental and physical illness" (p. 734). Furthermore, they assert that it exists as its own entity, with face, descriptive, predictive, construct, and

divergent validity in the context of palliative care, thereby terming this phenomena 'demoralisation syndrome' (2001). Clark and Kissane believe that demoralisation syndrome has hopelessness as its core construct and propose it as a diagnostic category, arguing that it should be given a place in psychiatric taxonomies (Clarke & Kissane, 2002). The diagnostic criteria for demoralisation syndrome are set out in Table 1.1.

Table 1.1

Diagnostic Criteria for Demoralisation Syndrome

A.	Affective symptoms of existential distress, including hopelessness or loss of meaning and purpose in life
B.	Cognitive attitudes of pessimism, helplessness, sense of being trapped, personal failure, or lacking a worthwhile future
C.	Conative absence of drive or motivation to cope differently
D.	Associated features of social alienation or isolation and lack of support
E.	Allowing for fluctuation in emotional intensity, these phenomena persist across more than two weeks
F.	A major depressive or other psychiatric disorder is not present as the primary condition

(Adapted from Kissane et al., 2001, p.15)

Demoralisation syndrome is seen as a change in morale spanning a spectrum, from disheartenment (slight loss of confidence) through despondency (diminished hope and increased distress) to despair and demoralisation (having given up) (Kissane, 2004). However, the course is not necessarily linear and a person may move towards more severe demoralisation and back again (Clarke & Kissane, 2002).

Once a diagnosis of demoralisation syndrome is ascertained, the degree of morbidity is dependent upon treatment, with a more serious outcome likely if the condition is not monitored (Kissane et al., 2001). Should this occur, the individual may become suicidal due to feeling trapped and helpless with no alternatives and no hope (Kissane et al., 2001). Major depression may or may not accompany this trajectory (Kissane et al., 2001).

1.4.4 Demoralisation: Dimensional or categorical?

Despite the contention that the two are distinct, it has been argued that diagnosing both major depression and demoralisation is inappropriate given the assumption that they are hierarchically related and share a significant number of symptoms (Fava et al., 2007). Slavney (1998) disagrees, believing that the two are differentiated on clinical grounds and that a diagnosis of both may be warranted. His position has some justification on the basis that the two conditions can be differentiated by treatment approach (Kissane, 2000; Slavney, 1999). In fact, most investigators consider demoralisation to be distinct from depression (de Figueiredo, 1983b, 1993; de Figueiredo & Frank, 1982; Dohrenwend, Shrout, et al., 1980; Fava et al., 2007; Gutkovich et al., 1999; Jacobsen et al., 2006; Kissane et al., 2001; Slavney, 1998).

However, there is insufficient evidence to claim demoralisation as a separate psychiatric disorder (Cheuk et al., 2009). Like others who have posited dimensional models for depressive disorders (Backenstrass et al., 2006; Rapaport et al., 2002), Rickelman (2002) conceptualises demoralisation as existing at the milder end of a continuum of depressogenic disorders. She posits that demoralisation is less severe and pervasive than depression and is primarily driven by the cognitive domain. Rickelman describes a similar cognitive profile to that of Kissane (2001), whereby the demoralised person's thinking is rigid, helpless, uncertain and pessimistic (Rickelman, 2002). In the continuum model, cognitive factors interact with social isolation to contribute to a person's vulnerability to demoralisation (2002). Therefore, while the mild end of the spectrum is an understandable response to adversity, the severe form is pathological because it is maladaptive, a source of distress, and has the potential to increase in intensity or severity if there is progression to major depression (Marchesi & Maggini, 2007; Rickelman, 2002).

Klein (1974) asserted that the categorical and dimensional viewpoints are not mutually exclusive, with depressive states being categorically distinct on some traits whilst sharing other symptoms with different disorders. Even proponents for the categorical model acknowledge symptom overlap and concede that demoralisation is a significant risk factor for the development of major depressive disorder (Gutkovich et al., 1999; Kissane, 2001; Marchesi & Maggini, 2007). Furthermore, a recent study (McKenzie et al., 2010) found that all of the key symptoms of demoralisation and anhedonia, when analysed individually, were significantly associated with a diagnosis of DSM–IV major depressive disorder. Epidemiological and clinical studies have also demonstrated the fluidity of depressive symptoms and disorders

(Rapaport et al., 2002). Therefore, like minor depression, demoralisation may be positioned 'midway' between MDD and euthymia (Howland et al., 2008).

Overwhelmingly, research examining differences in demoralisation and depression have been undertaken with inpatient and outpatient medical populations (Clarke et al., 2000; Grassi et al., 2007; Kissane et al., 2001; Mangelli et al., 2005; McKenzie et al., 2010; O'Keeffe & Ranjith, 2007; Wellen, 2010). Consequently, differences in the clinical profile and features of the two conditions may not be uniform across other populations, particularly non-medical and non-Western populations (Briggs & Macleod, 2006; Thakker & Ward, 1998). For example, in a prospective study with migrant and refugee outpatients, diagnostic differentiation was not possible because the more depressed participants were also more demoralised (Briggs & Macleod, 2010). Interestingly, however, whilst (pharmacotherapy) treatment for mood disorder brought about no significant change in scores for depressive symptoms or demoralisation, scores on both hopefulness and anhedonia measures improved. This suggests that a continuum model may be of greater diagnostic and clinical utility than a categorical model in this population. The tendency for non-Western populations to somatise psychological distress (Flaherty et al., 1986; Gutkovich et al., 1999) may result in false positives in the direction of major depression, for which neurophysiological symptoms are weighted more heavily (e.g. appetite, sleep). Another possibility is that, given that untreated demoralisation may evolve into MDD (Marchesi & Maggini, 2007), the reverse may also be the case whereby MDD symptoms may remit in some patients if demoralisation is reduced.

1.4.5 Aetiology, risk factors and protective factors

Dohrenwend asserted that, if researchers could isolate favourable conditions to allay demoralisation, policy makers may be able to institute changes that could relieve some of the suffering associated with psychiatric impairment, even in the absence of definitive aetiology (Dohrenwend, Dohrenwend, et al., 1980). Since then, a number of protective and risk factors have emerged. Commonly identified risk factors for demoralisation include female gender (Dohrenwend, Dohrenwend, et al., 1980; Flaherty et al., 1986; Gilboa, Levav, Gilboa, & Ruiz, 1990; Marchesi & Maggini, 2007), older age (Flaherty et al., 1986; Gutkovich et al., 1999) and low socioeconomic status (Burnam, Timbers, & Hough, 1984; Flaherty, Kohn, Levav, & Birz, 1988; Tweed, Shern, & Ciarlo, 1988).

Given that many patients with potentially demoralising disorders do not become demoralised, or become demoralised only after a lengthy period, Slavney

(1999) concluded that factors other than illness must play a role. He believed that the most important of these factors were the patient's personality and their relationships. Further to this, de Figueiredo (de Figueiredo & Frank, 1982) believed demoralised persons to be distributed along a continuum, with those experiencing multiple negative life events and poor social bonds being more demoralised. de Figueiredo further contended that the prevalence of demoralisation is inversely related to sociocultural integration (1983a) and that distress and subjective incompetence are less likely to occur together in the presence of adequate social bonds (de Figueiredo & Frank, 1982). Frank & Frank (1991) concur that personality resilience, and material and social supports serve to buffer an individual from demoralisation.

The social support theory is supported by the literature, which points to low level social support as the most potent contributor to demoralisation. Several studies found a significant correlation between demoralisation and poor social support (Cockram, 2004; Flaherty et al., 1986; Kissane et al., 2001; Levav, Kohn, & Billig, 2008). In fact, Marchesi and Maggini (2007) found support to be so central to demoralisation, that feelings of low self-esteem, sadness, helplessness, hopelessness and anxiety all increased when family supports were poor. Conversely, strong social bonds protect against demoralisation. Research has found that persons better integrated in their social groups report less distress than those less integrated, even when the former have more stressful life events (de Figueiredo, 1993). More specifically, Gorst-Unsworth and Goldenberg (1998) found that depression in Iraqi refugees was better predicted by poor social support in exile than pre-arrival trauma factors, including torture.

Poor social support is associated with a number of demographic factors such as unemployment, poverty, and social exclusion. Epidemiological surveys have demonstrated that the more socially disadvantaged the group, the higher the rate of demoralisation (Dohrenwend, Dohrenwend, et al., 1980). Thus, welfare recipients and the unemployed and are among the most psychologically vulnerable individuals in our society and have been found to score higher on hopelessness, worthlessness and psychological distress than their employed peers (Butterworth, Fairweather, Anstey, & Windsor, 2006; Loxton, Mooney, & Young, 2006). Conversely, the benefits of structured activity are well recognised. Gilboa et al. (1990) state, "Surely no other measure of a member's personal characteristic is more emphasized than his or her identification with work, probably because it represents the degree of one's commitment to the collective effort (p. 60)". This is particularly pertinent in forced migrants, for whom "involvement in some kind of meaningful activity is important

in order to cope with the stress of the exile situation" (Lavik et al., 1996, p. 727). Numerous studies have lent support to the association between unemployment and psychological distress in forced migrants (Bandeira et al., 2010; Begley et al., 1999; Lavik et al., 1996; Lie, 2002; Ryan, Benson, et al., 2008; Silove et al., 1997), with one finding unemployment to be the only significant psychosocial factor associated with demoralisation (Briggs & Macleod, 2010).

Religion has been found to inoculate against both demoralisation and trauma (Kaplan et al., 2008; S. B. Kleinman, 1990; Levav, et al., 2008), perhaps because it provides a vehicle for connectivity with others who share a common belief system. An Israeli study (Levav et al., 2008) found demoralisation scores to be significantly lower among religious groups than secular and traditional groups. Furthermore, religion has been shown to be a down-regulator of stress and provides a framework that enables a person to find an explanation for their particular life journey (Levav et al., 2008).

1.4.6 PTSD or Post Traumatic Demoralisation Syndrome (PTDS)?

With the taxonomical debate between demoralisation and depression still very much alive, demoralisation has also been proffered as a differential diagnosis to PTSD. Parson (1990), reflecting on his work with Vietnam veterans, claims, "individuals who experience psychological symptoms of inner tension states, distress, hopelessness, depressive feelings and foreboding apprehensiveness as they relive aspects of a trauma, may be experiencing post traumatic demoralisation, as opposed to a clearly delineated diagnosis of PTSD" (p.17). He argued that the symptoms and complaints of certain individuals often do not 'add up' to a full traumatic disorder, or may be classified as 'partial PTSD'. Both PTSD and PTDS share symptomatology, including nightmares, detachment and irritability, but Parson argues that demoralisation is even more salient among the traumatised. He posits that trauma-related demoralisation emerges from three sources: a) a traumatic and psychologically overwhelming event; b) a psychologically "non-holding" post-trauma environment; and c) social-historical changes (Parson, 1990). The latter encapsulates the dynamism of the sociocultural zeitgeist. For example, Vietnam veterans suffered mass public rejection due to a dramatic societal shift from largely pro- to pervasively anti-Vietnam war sentimentality. For asylum-seekers, social-historical changes have shifted markedly from the 1970s and1980s, when there was bipartisan government support for inclusive and humanitarian refugee policies, to the bipartisan preoccupation with border protection and policies of deterrence from the 1990s to the present.

The symptomatic profile of PTDS refers to "a mental, interpersonal and social dysfunctional state in which the individual suffers a variety of specific and nonspecific psychological and physical symptoms, accompanied by a devastated sense of self, isolation, affectlessness, sadness, grief, apathy, hopelessness and helplessness" (Parson, 1990, pp. 18-19). Whilst acknowledging that PTDS incorporates distress and subjective incompetence, Parson extends this to include absence-of-meaning-in-life (AMIL), which he considers to be the central feature of PTDS (Parson, 1990). Contrary to most contributors to the demoralisation discourse, Parson includes anhedonia as a dimension of PTDS. This may be a reflection of his target population (Vietnam veterans) and/or the differential aetiology and symptomatology between PTSD and MDD. Although focused on Vietnam veterans, parallels can be drawn with asylum-seekers when he states "[the war] had become a personal burden because it wasn't shared by the entire country" (Parson, 1990, p. 31). It could be argued that the politicisation of the asylum-seeker plight has divided the Australian populace, resulting in hostility from within some community factions. This has potentially serious implications given the deleterious impact of discrimination and social isolation/exclusion on the mental health of asylum-seekers (Begley et al., 1999; Laban et al., 2005; Ryan, Benson, et al., 2008; Silove et al., 1997).

1.4.7 Demoralisation and forced migrants

The most obvious distinction between the (particularly) palliative care populations and asylum-seekers is that the former desire death whilst the latter generally want to live. Therefore, the presence of suicidal ideation may be a key difference between depression and demoralisation in forced migrants (Briggs & Macleod, 2006). However, the psychological picture is a complex one. Although refugees uncommonly attempt suicide, they may experience 'worthlessness' and 'hopelessness' (Briggs & Macleod, 2006). An Australian study of detained asylum-seekers (Coffey et al., 2010) found hopelessness and demoralisation to be dominant themes for the majority, with all citing a decline in morale following visa refusals. Furthermore, all registered a sense of social isolation and cited examples in which their capacity for initiative and goal-directed activity was impaired – thereby lending support to de Figueiredo's motivation criterion. Others have documented the deleterious impact on psychological health, and loss of control and mastery over one's life (Steel et al., 2011; Van Dijk, Bala, Öry, & Kramer, 2001). However, as with other populations, strong social bonds are protective against psychological ill-health in asylum-seekers (Schweitzer et al., 2006).

'Demoralisation syndrome' has been thought to have relevance to asylum-seekers (Briggs & Macleod, 2006). However, whilst Clarke, Kissane and others

commonly refer to individuals diagnosed with a terminal illness, psychosocial stressors placed on an individual may equally threaten their identity, future outlook and stretch them beyond their ability to cope. Thus, the perspective of demoralisation as a normal response to adversity attributed to psychosocial rather than biogenic causation is a compelling one in the context of asylum-seekers. Psychiatrist David Kissen (1963, cited in Fava, 2007) privileged the exploration and understanding of psychosocial variables over psychological factors that give rise to illness. This approach may have particular relevance for asylum-seekers, as many individuals from forced migrant backgrounds who present to services may not view themselves as suffering from sickness, but instead from a range of social, political and economic circumstances (Watters, 2001). Further to this, there has been a call for greater emphasis to be placed on demoralisation suffered by asylum-seekers, particularly the practical difficulties they face (The Royal College of Psychiatrists, 2002). This approach aligns with Frank's (1974) view, that "diagnoses … include determining the modifiability of the environmental stresses contributing to the person's demoralisation" (p. 272).

Fava (2005) cited the utility of a psychosomatic approach as crucial to managing individuals with unexplained somatic symptoms and to identify psychological distress that cannot be diagnosed by psychiatric categories. Thus, demoralisation has strong face validity for asylum-seekers given that a) demoralisation has been described as a psychosomatic syndrome (Fava et al., 2007) and b) the propensity for individuals from non-Western cultures to express psychological symptoms somatically (Cheung, 1993; Gutkovich et al., 1999; Hinton & Lewis Fernández, 2010). Further to this, Briggs and McLeod (2006) found a significant association between 'somatic complaints' and demoralisation, but not between demoralisation and low mood. The latter adds weight to the premise that demoralised individuals have preserved reactivity and/or euthymic mood. Consistent with previous research, Briggs and McLeod (2006) also found that demoralisation did not predict a positive response to antidepressant medication.

CHAPTER 2: Rationale and Aims of Present Study

2.1 Rationale of Present Study

Most research carried out in forced migrant populations has focussed on trauma in the pre-arrival context as the key factor in mental health problems, rather than taking into account the circumstances in host countries (Gerritsen et al., 2006; Watters, 2001). Additionally, most studies have focused on persons whose refugee status was already recognized when they arrived in their host countries (Ryan, Benson, et al., 2008).

Due to inherent difficulties in accessing asylum-seeker populations, studies have overwhelmingly been cross-sectional in design. Consequently, previous research has recommended that future studies with asylum-seekers be prospective in design (Porter & Haslam, 2001; Silove et al., 1997), as "only longitudinal studies… will be able to disentangle the complex possible pathways linking post-migration stressors to ongoing PTSD symptoms" (Silove et al., 1997, p.356). Of those studies that have examined mental health in asylum-seekers, few have explored the psychosocial impact of community-based asylum-seekers traversing the refugee determination process (RDP). Of those that have, only four have been prospective designs (Davis, 2006; Ryan, Benson, et al., 2008; Silove et al., 2006; Silove, Steel, Susljik, et al., 2007; Steel et al., 2011) and only one of these (Silove et al., 2006) employed established structured interviews (i.e., SCID) to address the limitation of determining the prevalence of mental health indices using self-report measures.

Two of the four prospective studies were Australian (Silove et al., 2006; Silove, Steel, Susljik, et al., 2007; Steel et al., 2011), both of which were conducted under the former Howard Government. Therefore, these studies preceded the change of Federal Government which heralded a number of subsequent changes – at least in the medium term – to immigration policy concerning asylum-seekers. One of the aforementioned studies (Steel et al., 2011) compared refugees with holders of Temporary Protection Visas, which have since been repealed. The other study (Silove et al., 2006; Silove, Steel, Susljik, et al., 2007) examined the trajectory of trauma-related psychiatric symptoms among asylum-seekers over the course of the RDP, and followed up subjects an average of 3.8 months after their Primary refugee decision.

The current study extends the research undertaken by Silove and colleagues (Silove, Steel, Susljik, et al., 2007) by recruiting a larger sample and prospectively investigating mental health symptomatology beyond the Primary Stage of the RDP.

Recent Australian Government policy changes have seen the release of increasing number of asylum-seekers from detention centres. In their report, Green and Eagar (2010) recommended the future 'profile-analysis' of those awaiting immigration decisions while living in the community, stating that this would help separate the health impact of detention from that resulting from the uncertainty of an unknown future.

In addition to extending previous research, this study also aims to fill a gap in the literature pertaining to demoralisation. Whilst demoralisation – and 'demoralisation syndrome' – has been examined in the context of medical disease (Jacobsen et al., 2007; Kissane et al., 2001; Mangelli et al., 2005), it has recently been explored in refugee and migrant populations (Briggs & Macleod, 2006; Briggs & Macleod, 2010) but not with asylum-seekers. The applicability of demoralisation syndrome to both refugee and asylum-seeker populations requires further research to be undertaken with culturally appropriate tests to assist in this endeavour (Briggs & Macleod, 2006). Furthermore, it has been recommended that future studies be conducted in a cross-cultural context to take into account the socio-cultural determinants of demoralisation (Cheuk et al., 2009).

The data gleaned from the present study will be used to determine the prevalence of 'demoralisation syndrome' as well as other psychiatric disorders in an asylum-seeker population. It is hoped that it will then be possible to determine the relationship between demoralisation and other psychiatric disorders. If so, this will confer a better nosological understanding of psychological distress and, ultimately, contribute to the development of more appropriate and efficacious mental health interventions for asylum-seekers negotiating the refugee determination process.

2.2 Aims and Hypotheses

The present study has both exploratory and predictive aims. To determine whether a composite of the aforementioned factors is able to capture what has been labelled 'demoralisation syndrome' in the asylum-seeker population, the following research questions have been formulated:

1. a) What is the prevalence of demoralisation (as measured by the PERI-D) in a community-based asylum-seeker population?

   b) How does this rate compare with other groups as defined by the literature, for example, refugees, migrants and the general population.

2. What are the social and demographic factors associated with demoralisation in a community-based asylum-seeker population?

3. What are the clinical characteristics that predict whether there will be a demoralisation syndrome?

Specific hypotheses informed by previous research were also formulated to determine the extent and severity of mental health symptoms in asylum-seekers as a function of the Australian Federal Government's Refugee Determination Process. Therefore it is further hypothesised that demoralisation, depression, anxiety, trauma symptomatology and post-migration stress will be found to be a function of:

4. Time in the refugee determination process. It is expected that the longer individuals are in the RDP, the greater the symptoms of PTSD, depression, anxiety, demoralisation and post-migration stress.
5. Number of rejections in the Refugee determination process. It is expected that higher rates of rejections throughout the RDP will be associated with greater symptoms of PTSD, depression, anxiety, demoralisation and post-migration stress.
6. It is further hypothesised that there will be a significant positive correlation between PTSD symptomatology and level of post-migration stress.

CHAPTER 3: Method

3.1 Participants

Participants were 131 adult asylum-seekers (AS), (*n*=98) and refugees (PR), (*n*=33) aged 18 and over, whose application for asylum was being, or had been, processed whilst they were living in the community. All participants were recruited through the Asylum Seeker Resource Centre (ASRC) in West Melbourne. To meet inclusion criteria for the study, participants must have lodged their application for asylum. Almost all (*n*=128) of the participants had arrived from one of five countries: Sri Lanka (*n*=49), Pakistan (*n*=36), Zimbabwe (*n*=21), Iraq (*n*=12) and Afghanistan (*n*=10). The remainder were from Iran and Lebanon and most participants (*n*=118) were proficient in English.

3.2 Measures

Four questionnaires were administered to ascertain levels of depression, anxiety (HSCL-25), post-traumatic stress (HTQ-R) and demoralisation (PERI-D). The HSCL-25 and HTQ in particular have demonstrated efficacy in the identification of mental illness and psychological distress in culturally diverse populations and both are accepted internationally as the gold standard in the assessment of traumatized populations (Mollica, Wyshak, de Marneffe, Khuon, & Lavelle, 1987). Hence, these are the most widely used instruments in populations of forced migrants who have experienced pre- and post-migration trauma (Steel, Chey, et al., 2009). The HSCL-25 and HTQ were initially developed to assist clinicians to assess the mental health of patients in specialist refugee mental health services and in primary care settings and both instruments have been used for several purposes including: screening, individual clinical assessments, and epidemiological and risk factor research (Mollica, Wyshak, de Marneffe, et al., 1987). The instruments can be used to a) characterize the population seeking treatment and b) quantify symptom profiles and functioning.

3.2.1 Demographics questionnaire

A questionnaire was developed specifically to collect background information for the present study and was completed at interview. Demographic data for Phase I included age of the participant, date of arrival in Australia, country of origin, cultural/ethnic identity, religion, marital status, number of children, and the geographical location of partners/children. Other items asked about level of

education, pre-and post-migration occupational status, current source of income and accommodation status. There were a number of questions pertaining to legal status including the visa currently held, when the asylum application was lodged and at what stage of the RDP the participant was, including any rejections of their claim. Participants were also asked about whether they had resided in a refugee camp or had been subject to immigration detention in Australia. Finally, they were asked about medical or psychiatric conditions and prescribed medication. Demographic data for Phase II sought to identify any changes in the aforementioned demographic areas since the first interview. Participants were also asked about the progress of their legal case, whether they had consulted a counsellor or psychiatrist, and were asked to cite positive and negative life changes that had transpired.

3.2.2 Hopkins Symptom Checklist-25 (HSCL-25)

The HSCL-25 is a self-report symptom rating scale which has undergone several major revisions and numerous minor alterations (Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974). The scale has been used as a screening instrument to elicit information on symptoms of anxiety and depression in medical patients, psychiatric patients, and non-clinical populations (Derogatis et al., 1974).

The HSCL-25 (Mollica, Wyshak, de Marneffe, et al., 1987) was devised for Indochinese respondents as a shortened version of the American form of the Hopkins Symptom Checklist (Renner et al., 2007). It is a 25-item revision of the HSCL-58, which retained 10 items from the anxiety cluster, 13 items from the depression cluster and two from the somatisation cluster. The HSCL-25 is divided into two parts: anxiety symptoms (Part I, 10 items, questions 1-10) and depression symptoms (Part II, 15 items, questions 11-25), with the Total Scale measuring 'nonspecific emotional distress'. The depression and somatisation items comprise the Depression subscale. All items are coded 1 *(not at all)*, 2 *(a little)*, 3 *(quite a bit)* and 4 *(extremely)* indicating the degree of distress within the previous seven days.

The HSCL-25 has been validated in the general US population, has been translated into several languages (Mollica, McDonald, Massagli, & Silove, 2004) and used in many refugee studies (Hollifield et al., 2002). It was one of only two instruments which met all five criteria in a critical review (Hollifield et al., 2002) of the validity and reliability of psychometric tools to measure mental health status in refugees. The HSCL-25 has demonstrated high test-retest reliability (1 week; r=0.82 for each scale; r=0.89 for total scale) (Hollifield et al., 2002) and excellent internal reliability in a number of non-Western populations (Renner et al., 2006).

Empirical studies have determined that the 15 depression items are consistent with the DSM-IV diagnosis of major depression (Mollica et al., 2004). A cut-off of ≥

1.75 for 'clinically significant distress' is recommended, unless instrument cut-off is standardized against a psychiatric diagnosis using standardized interviews (Mollica, Wyshak, de Marneffe, et al., 1987).

3.2.3 Harvard Trauma Questionnaire – Revised Version (HTQ-R)

The Harvard Trauma Questionnaire - Revised (HTQ-R) (Mollica et al., 2004) is the gold standard instrument in the assessment of traumatised populations, having been subjected to numerous studies evaluating its psychometric properties. It is a cross-cultural instrument designed for the assessment of trauma and torture related to mass violence and its sequelae. Its purpose is two-fold: to obtain information about actual trauma events, including torture experienced, and to assess DSM-IV symptoms associated with PTSD (Mollica et al., 2004).

The HTQ comprised five parts: I) trauma events II) personal description III) brain Injury IV) post-traumatic symptoms, and V) scoring of the instrument. The Revised version has improved its measurement accuracy without changing the basic structure of the HTQ (Mollica et al., 2004) and also includes a 28-item Torture History checklist.

Only parts I, II, IV and the Torture History Checklist were used in the present study. Part I lists 38 refugee-related traumatic life events with a Yes/No response format for each event. Part II comprises two open-ended questions asking respondents for a subjective description of the most traumatic event(s) experienced to date, and in their current living situation. Part IV includes 40 trauma symptoms. The scale for each of these items includes four categories of response, coded 1 *(not at all)*, 2 *(a little)*, 3 *(quite a bit)*, and 4 *(extremely)* indicating the degree of distress within the previous seven days.

The first 16 items of Part IV relate to trauma history and were derived from the DSM-IV criteria for posttraumatic stress disorder (PTSD). The 1-16 item PTSD scale has demonstrated high inter-rater reliability (k = 0.98) and high internal consistency – ranging from r=0.87 to r=0.96 – in South East Asian (Mollica et al., 1992, cited in Hollifield et al., 2002), Afghan and West African populations (Renner et al., 2006). High Full-scale (Part IV, 30 items) test-retest reliability (1 week) for the HTQ has also been reported (0.92). (Mollica et al., 2002).

The last 24 items of the Part IV scale comprise 'refugee-specific' items relate to functioning and social disability in response to persecution, violence and displacement. These items represent the traumatized person's self-perception of psychosocial functioning and may reflect their primary concern with functioning

in contrast to more limited concern with PTSD symptoms. This 'refugee trauma' subscale includes six underlying domains of social functioning (skills/talents; physical impairments; intellectual functioning; emotional functioning; social relationships; spiritual/existential concerns) and may be more highly correlated with trauma-related distress than the symptoms of PTSD (Mollica et al., 2004). However, as yet, the revised scale has not been compared with other measures of social functioning, work, and disability. Therefore it is unclear whether these functional items reflect an objective measure of disability or whether they are proxy symptoms of distress primarily reflecting subjective feelings (Mollica et al., 2004).

A PTSD score of ≥ 2.5 is generally considered "checklist positive" for PTSD in an Indochinese population. For other populations the Harvard Program in Refugee Trauma recommends a cut-off of ≥ 2.00 or use of a DSM-IV algorithm to indicate PTSD (Items 1-16), until a cut-off value is standardized against a diagnostic gold standard (Mollica et al., 2004).

3.2.4 Psychiatric Epidemiology Research Interview–Demoralisation Scale (PERI-D)

The PERI-D (Dohrenwend, Shrout, et al., 1980) demoralisation scale comprises 27 items which measure nonspecific distress using a fixed-alternate response format. Based on an epidemiological study of urban residents in the United States using the Psychiatric Epidemiology Research Interview, the demoralisation scale emerged through factor analysis, comprising eight subscales: poor self-esteem, sadness, dread, anxiety, perceived physical health, unspecific psycho-physiological complaints, helplessness-hopelessness, and confused thinking. Taken together, these subscales closely correspond to the construct of demoralisation described by Frank (1973) (Dohrenwend et al., 1986). The absence of scales such as guilt, insomnia, and suicidal ideation suggest discriminant validity regarding major affective disorder according to DSM-III criteria (Dohrenwend, Shrout, et al., 1980). Reliability and validity tests of the PERI-D in the USA and Israel have shown satisfactory results (Dohrenwend et al., 1986). In a sample of 253 clinical and non-clinical Israeli citizens, the overall sensitivity was 77%, and the specificity was 84% (Shrout et al., 1986) with cut-off scores reported as 1.27 for males and 1.55 for females (Levav et al., 2008).

The PERI-D has been employed in a conflict-affected population (Levav et al., 2008), clinical and community populations (Shrout et al., 1986), a non-clinical kibbutz population (Gilboa et al., 1990) and with Jewish and Middle Eastern immigrants (Dohrenwend et al., 1986; Ritsner, Rabinowitz, & Slyuzberg, 1995).

In an international study with a diverse population across five sites, the internal consistency was 0.90 (Dohrenwend et al., 1986).

3.2.5 Post-migration Living Difficulties Checklist (PMLDC)

The Post-migration Living Difficulties checklist (Silove et al., 1998) is a 23-item checklist developed by Australian researchers to assess current life stressors of asylum-seekers, and is an important instrument to measure life experiences other than war (Hollifield et al., 2002). The PMLDC was developed from an *ad hoc* checklist of a range of typical problems reported by asylum-seekers (Silove et al., 1997) whereby respondents were asked to indicate whether any of the items on the checklist had been a problem over the previous 12 months. Items refer directly to asylum-seeking processes such as immigration matters, as well as secondary problems, such as difficulties finding work or gaining access to health care. Each item is rated on a 5-point scale from 'no problem' to 'very serious problem', with a composite score determined.

Principal component analyses yielded five factors accounting for 69.8% of the variance of the 23 items: refugee determination process; health, welfare, and asylum problems; family concerns; general adaptation stressors; and social and cultural isolation. The PMLDC was evaluated in a mixed asylum-seeker, refugee and immigrant population (Silove et al., 1998), with asylum-seekers scoring higher than immigrants on all five factors and higher than refugees on factors 1, 2 and 3, demonstrating good discriminant validity. However, no other validity or reliability data are published (Hollifield et al., 2002). This checklist has been used (e.g., Schweitzer et al., 2006; Silove et al., 1998; Steel et al., 2006) or adapted for use (e.g. Laban et al., 2005; Ryan, Benson, et al., 2008) in refugee populations in Australian and internationally.

3.2.6 Mini-International Neuropsychiatric Interview 6.0 (MINI)

The Mini-International Neuropsychiatric Interview 6.0 (MINI) (Sheehan et al., 1998) is a brief, structured diagnostic interview developed in the United States and Europe for assessing the presence of DSM-IV and ICD-10 psychiatric disorders. It has an administration time of approximately 15 minutes, has good reliability, and convergent validity with the CIDI and SCID have been reported (Lecrubier et al., 1997).

Whilst the MINI has been translated and validated in many languages, in the MINI (Lecrubier et al., 1997), 6 of the 11 items of the MDD module and 5 of the 11 items of PTSD module were rated as having 'many comprehension problems' or

being 'completely inadequate' for Arabic-speakers (among others) (Durieux-Paillard, Whitaker-Clinch, Bovier, & Eytan, 2006). Therefore, the present study employed the MINI 6.0 whilst incorporating modified versions of the MDD and PTSD modules which have been adapted for asylum-seekers (Durieux-Paillard et al., 2006) and have demonstrated moderate sensitivity and high specificity despite cultural difference and use of interpreters (Eytan, Durieux-Paillard, Whitaker-Clinch, Loutan, & Bovier, 2007).

The main revisions to these MINI modules were a) omitting questions in the MDD module which distinguished between current and recurrent MDE and b) having the subject think of a significant event within the 2-weeks (MDE) or 4-weeks (PTSD) to use as a reference point. The latter is to accommodate temporal difficulties for asylum-seekers (e.g., lack of structure of everyday life) and different concepts of time (Durieux-Paillard et al., 2006), particularly for those from Middle Eastern and African cultures. Overall revisions to question re-wording were dictated by the 'life context' of the asylum-seeker population rather than according to cultural specificities (Durieux-Paillard et al., 2006).

Both the revised PTSD module and the original MINI 6.0 PTSD module screen for point (as opposed to lifetime) prevalence. In contrast to the MINI 6.0 MDD module, the revised module only screens for MDE (Major Depressive Episode, current) – that is, point prevalence.

3.3 Procedure

3.3.1 Ethics approval

Research approval was sought from the ASRC and was granted by the CEO without revision. The Victoria University Ethics Committee granted approval for Phase I and Phase II of the research separately after minor revisions.

In the initial phone call and at interview, participants were informed of the voluntary nature of the study, of their right to withdraw at any time, the confidentiality of their responses and that participating in the study would not help or hinder their legal case. Written consent was obtained from all participants, with the consent form being translated *in vivo* for those who did not speak English. The Phase I consent form, also asked participants to indicate whether they gave permission to be re-contacted for a follow-up interview.

Participants were provided with a daily travel card to reimburse their travel costs in Phase I and were provided with $40 to compensate for travel costs in Phase II.

3.3.2 Research design

The research design was a two-phased prospective study of a quantitative nature. Phase I employed self-report questionnaires to evaluate whether there was a significant predictive relationship between demoralisation and mental health indices (PTSD, depression and anxiety), and the number of asylum claim rejections and length of time in the refugee determination process. Phase II employed a modified demographics sheet and the same self-report questionnaires used in Phase I, to identify any within-subject variation in symptoms from baseline scores. A structured interview was also added to the second phase. The MINI was incorporated to provide construct validity for the HTQ-R and HSCL-25 self-report measures and establish a valid cut-off score for PTSD and Major Depressive Episode in the sample. Inclusion of the MINI also enabled the presence of other Axis I psychiatric disorders to be screened.

Considering limitations with respect to established methods of clinical diagnoses, it has been recommended that qualitative approaches be employed in order to assess symptoms of trauma in a culture-sensitive way (Ahearn, 2000; Momartin et al., 2002; Renner et al., 2006). Furthermore, little writing on refugee policy in Australia has given expression to those directly affected (Mansouri & Cauchi, 2007). Hence, comprehensive clinical notes were taken to record individuals' responses. These were later collated and coded for an adjunctive qualitative analysis to contextualise and further validate the quantitative data.

Due to database inaccuracies, randomized selection of participants was abandoned in favour of a convenience sample to reflect current asylum-seeker trends based on country of origin. The nationalities represented by the sample comprised 37% of the total ASRC population as of August 2010. 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 greater ASRC population: Sri Lanka (72%), Pakistan (52%), Zimbabwe (72%), Iraq (71%) and Afghanistan (90%). The ASRC population by gender breakdown is approximately 70:30 (male:female), which was not reflected by the study sample, being 84% male. Whilst the proportion of those with permanent visas was slightly over-represented (25% compared with 16%), the distribution by visa type for asylum-seekers was reflective of the ASRC population. That is, BVA was 24% in both, BVE was 28% compared with 32% and student visa was 11% compared with 9%.

3.3.3 Method of recruitment

All interviews took place at the Asylum-seeker Resource Centre (ASRC), a charitable organisation. The ASRC is funded predominantly through philanthropic donation and was established 10 years ago to service the needs of community-based asylum-seekers. As the largest provider of aid, advocacy and health services for asylum-seekers in Australia, the ASRC supports approximately 1,000 asylum-seekers each year and runs numerous programmes including: legal, casework, counselling/ psychiatry, employment, health, material aid and a foodbank. All participants were recruited through the casework programme to attain as heterogeneous a sample as possible in relation to psychosocial circumstances. Caseworkers are the primary contact point for all asylum-seekers regardless of the presenting need.

For Phase I, each caseworker was individually briefed about the project by the researcher. The researcher identified prospective participants from the database who met the inclusion criteria and regularly informed all caseworkers regarding which of their clients to approach about the research. The caseworker then informed their respective clients about the research project and (where applicable) received verbal permission for the researcher to make direct contact. The prospective participant was then contacted by the researcher who explained the study in greater detail, answered any questions and provided them with the Participant Information Sheet (in person, via email or post). A follow-up call was usually made to arrange an interview time if the individual wished to proceed. Appointments frequently needed to be rescheduled either at the request of the participant or due to non-attendance.

For Phase II, participants who consented to being re-contacted for a second interview were contacted directly by the researcher.

Due to the initial unavailability of funds for interpreters, only asylum-seekers conversant in English were recruited for the first 20 months. Even with the assistance of interpreters, recruiting non-English speaking participants proved more difficult.

3.3.4 Data collection

A protocol comprising a demographics sheet and four measures was administered via semi-structured interview. All data were collected between September 2008 and June 2011. The interview time was approximately 75 minutes, with the shortest being 45 minutes and the longest being approximately 4.5 hours in total. Three interviews were conducted over two sittings. In five cases data were collected via protocols being posted due to participants having moved from the

Melbourne metropolitan area, or being unable to attend the ASRC. Three interviews were conducted over two sittings. Interviews using interpreters took at least two hours.

For those not conversant in English, interviews were conducted with an onsite or phone interpreter after funding was secured in March 2010. Persian (Farsi/Dari) and Arabic versions of the HTQ and HSCL-25 measures were not obtained until September 2010. Therefore these measures were translated *in vivo* prior to this time. The other two questionnaires and the MINI were also translated *in vivo*, as were all protocols for participants whose first language was Urdu (n=1), Punjabi (n=1) (both Pakistani participants) or Sinhalese (n=1) (Sri Lankan participant). No other language translations for the measures were available and it is not known whether the Persian and Arabic versions of the HTQ and HSCL-25 were developed using translation and masked-back translation methods (B. A. Bracken & Barona, 1991).

All participants were debriefed at the conclusion of the interview and a follow-up phone call was offered (and made) in several cases. On occasion, the interview inadvertently served as an entry point to other services due to the identification of needs which were hitherto unknown to the participant's caseworker. In such cases, with the participant's consent, the researcher contacted the caseworker to alert them of concerns and/or provided a referral to the counselling/ psychiatry programme.

3.4 Data Analysis

3.4.1 Power analysis

A priori power analyses were conducted using the on-line program G-power (Erdfelder, Faul, & Buchner, 1996). Power at a level of .80 and a medium effect size was selected. For a 2-tailed independent samples t-test analysis (Point biserial model), the sample size required was 82. For a one-way analysis of variance (ANOVA) (fixed effects, omnibus), the sample size required for two groups was calculated at 90, and for three groups, at 111. For a repeated measures, mixed within-between groups ANOVA for 3 groups with 6 measures, the sample size required was 18. For a test of linear multiple regression: (Fixed model, R^2 deviation from zero) with six predictor variables, the number of participants required was calculated at 98. For a 2-tailed Chi-square test (Variance: Difference from constant, one sample case) with power at a level of .80 and a ratio variance of 1.5, the number of participants required was calculated at 93.

3.4.2 Establishing cut-off scores

The MINI was applied in the Phase II interviews to validate self-report measures and thereby establish a cut-off score for the caseness of major depressive episode (MDE) and PTSD. For each of the 56 subjects reinterviewed at Time 2, a table was produced with HSCL-25 (depression) and HTQ-R (PTSD) scores along with whether the participant met criteria for MDE or PTSD as assessed by the MINI. Cut-off scores for the HSCL-25 and the HTQ-R were then determined based upon optimal rates of specificity and sensitivity. A cut-off score of ≥ 2.29 for depression as measured by the HSCL -25 yielded 100% specificity and 87% sensitivity (2 false negatives, *N*=55). A cut-off score of ≥ 2.50 for PTSD as measured by the HTQ-R resulted in 96% specificity (1 false negative, *N*=54) and 88% sensitivity (2 false negatives, *N*=54).

These cut-off scores were then applied to the Phase I data to establish caseness for MDE and PTSD at Time 1.

3.4.3 Statistical analysis

Quantitative analyses were undertaken using SPSS Statistics for Windows (Version 19.0). The first step in the preliminary analysis was to generate descriptive statistics for all variables for the total sample and the two sub-samples (AS and PR). The next step involved assessing the reliability of the measures used in the present study by checking their internal consistencies. Pearson product-moment correlations were conducted to assess the strength and direction of the association between the specified variables, and independent t-tests and one-way independent ANOVAs were conducted to ascertain differences in the dependent variable (scale measures) between groups. Spearman's rho correlations were conducted to assess the strength and association of categorical variables and for non-parametric continuous data. Chi-square tests were performed for tests of independence. Mann-Whitney *U*, Wilcoxon Signed Rank and Kruskal-Wallis tests were performed in place of independent samples t-tests, paired samples t-test and one-way between-groups ANOVAs, respectively, where normality assumptions were violated. A Kolmogorov-Smirnov test of normality was performed to determine the distribution of the continuous dependent variables.

Correlational analyses were conducted to test hypotheses 4, 5 and 6. For the initial three exploratory research questions, odds ratios, correlational analyses and multiple linear regression equations were performed, with further *post hoc* analyses conducted according to the findings of the *a priori* analyses.

For the Phase II analyses, a mixed between-within subject design ANOVA (3 levels) was used to test difference between and within cohorts at two time points.

Qualitative data analysis using NVivo 9 enabled the thematic analysis of participant narratives scribed by the researcher during the interview process. The narratives were included in the analysis to glean further insight into the nuances and complexities of the lives of asylum-seekers negotiating the refugee determination process. The qualitative data was coded using a 'directive content analysis' approach; findings using this approach can offer supporting and non-supporting evidence for a theory (Hsieh & Shannon, 2005).

Directive content analysis rests on *a priori* themes being identified and applied to the coding process in order to elaborate an understanding of the research area. In this study, the aim of qualitative enquiry was to explore the dependent variables under investigation to elucidate a greater breadth of understanding for hypotheses 4 and 5. Therefore, participants' subjective experiences of symptoms as they related to the psychiatric disorders under examination (i.e., PTSD, depression, anxiety and demoralisation) and post-migration stressors, were coded according to themes previously identified in the literature. These were: issues related to the RDP process (e.g., uncertainty and worry); psychosocial issues (e.g., work, health/welfare provision); health and well-being (e.g., mental/physical health; hope and grief); and protective factors (e.g., social support and religion).

CHAPTER 4: Results

4.1 Data Screening and Preliminary Analysis

Prior to conducting the main analyses, descriptive statistics were computed for each dependent variable to check for accuracy and to ensure that all data was within the specified ranges. Missing values were inspected by examining frequency tables, histograms and box plots, and appeared to be missing at random. Missing values comprising less than 25% of the overall scale were replaced by the serial mean for that scale. Cases with missing values were retained wherever possible and were managed by implementing analysis-by-analysis exclusion for each statistical procedure.

Due to the dependent variables (DVs) being scales for neurotic disorders (i.e., HTQ-R, HSCL-25 and PERI-D), cases which met criteria for a psychotic disorder, as assessed by the MINI structured interview, were eliminated from analyses examining these DVs. Three cases were identified and all were asylum-seekers.

A Kolmogorov-Smirnov test of normality was performed to determine the distribution of the continuous dependent variables. All DVs were normally distributed with the exception of anxiety (p=.004) and depression (p=.03), with anxiety also being positively skewed. This was the case for the total sample and for sub-groupings by residency status (i.e., AS and PR groups). For Phase II data, only the post-migration stress and demoralisation scales were normally distributed, however all scales met the normality assumption for change in score over time (T2-T1). The data for the anxiety (T1, T2), depression (T1, T2), PTSD (T2) and refugee trauma (T2) scales were not transformed due to the difficulties associated with interpretation of transformed data (Tabachnick & Fidell, 2007). Therefore, non-parametric tests were used for statistical analyses which examined these variables. Non-parametric tests employed for depression and anxiety measures were Kruskal-Wallis and Mann-Whitney's *U* tests.

Histograms and Box plots were used to inspect univariate outliers of continuous DVs for all six measures and no outliers were identified for Phase I data. For Phase II data, the following univariate outliers were present: depression (n=1), PTSD (n=1), demoralisation (n=1), anxiety (n=2), and refugee trauma (n=6). The mean difference in the measures over time (T2-T1) revealed one outlier for both refugee trauma and demoralisation, and two for anxiety. As inspection of the variable scores in the individual case summaries of the outliers revealed no errors or patterns

of responses, it appeared that the outliers were from the population in question. All outliers were retained on the basis that the 5% trimmed mean did not differ substantially from the mean for their respective scales (Pallant, 2007), indicating that the influence of the outliers was likely to have been minimal.

The Mahalanobis distance statistic was used to test for multivariate outliers. No outliers were identified, since all values were below the Chi-square cut-off value for all cases (Tabachnick & Fidell, 2007).

All scales and subscales had excellent internal consistency at both time points, ranging from α =.81 to α =.95.

The significance level was applied at the .05 level.

4.2 Demographic Characteristics of the Sample – Phase I

One hundred and thirty one adult asylum-seeker (AS) and refugee (PR) members of the ASRC participated in the study. The sample comprised 110 males (mean age 33.92 years; *SD*=10.26) and 21 females (mean age 39.74 years; *SD*=11.61) with a mean age of 34.85 years (*SD*=10.66). The mean time residing in Australia was 3.51 years (*SD*=4.21) and the mean time spent in the RDP was 27.32 months (*SD*=46.78). Table 4.1 displays the descriptive statistics for all continuous demographic variables.

Table 4.1

Descriptive Statistics for Continuous Demographic Variables

Variable	Refugees		Asylum-seekers		Total Sample	
	n	*M* (*SD*)	*n*	*M* (*SD*)	*N*	*M* (*SD*)
Age	32	35.72 (11.03)	99	34.57 (10.58)	131	34.85 (10.66)
Time in Australia (yrs)	32	2.96 (3.40)	99	3.69 (4.45)	131	3.51 (4.21)
Total time since application (mths)	31	25.38 (38.67)	96	30.22 (49.71)	127	29.04 (47.15)
Time since PR (mths)	32	6.14 (7.38)			32	6.14 (7.38)
Refugee camp (mths)	31	1.16 (6.47)	96	0.49 (3.80)	127	0.65 (4.58)
Time in detention (mths)	31	0.00 (0.00)	98	0.87 (5.25)	129	0.66 (4.59)
Rejections at primary stage	31	0.23 (0.43)	98	0.46 (0.50)	129	0.41 (.50)
Rejections at RRT	31	0.23 (0.56)	98	0.51 (0.75)	129	0.44 (0.72)
Rejections at court	31	0.32 (0.95)	98	0.48 (1.05)	129	0.44 (1.02)
Rejections at Ministerial stage	31	0.32 (1.05)	98	0.36 (0.99)	129	0.35 (1.00)
Number of rejections	31	1.10 (2.66)	99	1.82 (2.63)	130	1.64 (2.65)
Number of applications	31	2.06 (2.56)	99	2.71 (2.59)	130	2.55 (2.59)
Number of traumatic events	31	12.06 (5.09)	93	13.06 (5.45)	124	12.81 (5.36)

Very few participants (*n*=8) reported having been detained in an Australian Immigration Detention Centre. Of those who had, some had been mandatorily detained offshore on arrival, while others had spent time in mainland facilities for other visa-related reasons. The reported periods of detention spanned one month to four years. Only four subjects reported having spent time in a refugee camp pre-arrival – two had spent 3 years and the others, 1 month and 10 months, respectively.

The majority of participants (90%) were proficient in English and had arrived in Australia by plane (96%). Table 4.2 sets out the descriptive statistics for the categorical demographic variables for the total sample and for asylum-seekers and refugees separately.

Five nations comprised 98% of the sample population. The largest was Sri Lanka (37%), followed by Pakistan (28%), Zimbabwe (16%), Iraq (9%) and Afghanistan (8%). The remainder were from Iran and Lebanon. There was a significant difference between the five countries for time in Australia, with Sri Lankans having been in Australia for significantly more years (*M*=5.96, *SD*=5.28) than the other four groups, and Zimbabweans (*M*=2.88, *SD*=2.00) having been in Australia longer than Afghanis (*M*=1.06, *SD*=.95) and Iraqis (*M*=1.10, *SD*=.61).

Almost half of the sample identified as Christian (42%); 38% as Muslim; 13% as Buddhist and the remainder as Hindu (4%) or reported nil religion (4%).

Less than half of all participants were single (40%) and childless (47%). Of those who were married, approximately one third were living in Australia without their partner (35%) or any of their children (37%).

Table 4.2

Descriptive statistics for Categorical Demographic Variables

	Total Sample		Asylum-seekers		Refugees		
Variable	***N***	**Frequency (%)**	***n***	**Frequency (%)**	***n***	**Frequency (%)**	***Significance***
Sex	131		98		33		$\chi^2(1)= 6.68$, $p= .01$
Female		21 (16.0)		11 (11.2)		10 (30.3)	
Male		110 (84.0)		87 (88.8)		23 (69.7)	
Country	131		98		33		$\chi^2(6)= 8.43$, $p= .21$
Sri Lanka		49 (37.4)		39 (39.8)		10 (30.3)	
Pakistan		36 (27.5)		30 (30.6)		6 (18.2)	
Zimbabwe		21 (16.0)		12 (12.2)		9 (27.3)	
Iraq		12 (9.2)		8 (8.2)		4 (12.1)	
Afghanistan		10 (7.6)		6 (6.1)		4 (12.1)	
Iran		2 (1.5)		2 (2.0)			
Lebanon		1 (0.8)		1 (1.0)			
Religion	131		98		33		$\chi^2(5)= 12.70$, $p= .03$*, Cramer's $V=.31$
Christian (Protestant)		32 (24.4)		17 (17.3)		15 (45.5)	
Christian (Roman Catholic)		23 (17.6)		18 (18.4)		5 (15.2)	
Muslim		50 (38.2)		40 (40.8)		10 (30.3)	
Buddhist		17 (13.0)		15 (15.3)		2 (6.0)	
Hindu		5 (3.8)		5 (5.1)			
Nil		4 (3.0)		3 (3.1)		1 (3.0)	
Speaks English	131		98		33		$\chi^2(1)= 1.43$, $p= .23$
Yes		118 (90.1)		86 (87.8)		32 (97.0)	
No		13 (9.9)		12 (12.2)		1 (3.0)	
Mode of Arrival	124		92		32		$\chi^2(1)= 0.68$, $p= .41$
Boat		5 (4.0)		5 (5.4)			
Plane		119 (96.0)		87 (94.6)		32 (100)	
Marital Status	131		98		33		$\chi^2(3)= 3.66$, $p=.30$
Married/ DeFacto		70 (53.4)		53 (54.1)		17 (42.4)	
Single/ Never Married		52 (39.7)		38 (38.8)		14 (51.5)	
Divorced/ Separated		8 (6.1)		7 (7.1)		1 (3.0)	
Widowed		1 (0.8)				1 (3.0)	
Location of Partner[a]	75		57		18		$\chi^2(3)= 6.79$, p=.03*
In Australia		49 (65.3)		33 (57.9)		16 (88.9)	
In homeland		26 (34.7)		24 (42.1)		2 (11.1)	

Table Continues

[a] For those with a partner

Variable	Total Sample N	Total Sample Frequency (%)	Asylum-seekers n	Asylum-seekers Frequency (%)	Refugees N	Refugees Frequency (%)	*Significance*
Location of Children[b]	70		52		18		$\chi^2(3)= 11.89$, $p=.01$**, Cramer's V=.30
All children in Australia		39 (55.7)		25 (48.1)		14 (77.8)	
Some children in Australia		5 (7.1)		2 (3.8)		3 (16.7)	
All children in homeland/ 3rd country		26 (37.1)		25 (48.1)		1 (5.6)	
Level of Education	130		97		33		$\chi^2(5)= 10.07$, $p=.07$
Tertiary		82 (63.1)		59 (60.8)		23 (69.7)	
Completed secondary		35 (26.9)		26 (26.8)		9 (27.3)	
Some secondary		8 (6.2)		8 (8.2)			
Completed primary		2 (1.5)		2 (2.1)			
Some primary		2 (1.5)		2 (2.1)		1 (3.0)	
No formal education		1 (0.8)					
Previous occupation	130		98		32		$\chi^2(6)= 6.50$, $p=.37$
Professional		47 (36.2)		31 (31.6)		16 (48.5)	
Business/ Self-employed		16 (12.3)		14 (14.3)		2 (6.1)	
Administrative		16 (12.3)		13 (13.3)		3 (9.1)	
Skilled/ Trade		18 (13.8)		16 (16.3)		2 (6.1)	
Unskilled		10 (7.7)		8 (8.2)		2 (6.1)	
Student		20 (15.4)		14 (14.3)		6 (18.8)	
Nil work		3 (2.3)		2 (2.0)		1 (3.1)	
Current Occupation	131		98		33		$\chi^2(6)= 26.38$, $p<.0001$***, Cramer's $V=.39$
Professional		1 (0.8)				1 (3.0)	
Business/ Self-employed		1(0.8)				1 (3.0)	
Skilled/ Trade		9 (6.9)		5 (5.1)		4 (12.1)	
Unskilled		44 (33.6)		31 (31.6)		13 (39.4)	
Student		4 (3.1)		3 (3.1)		1 (3.0)	
Nil work		41 (31.3)		28 (28.6)		13 (39.4)	
Nil work rights		31 (23.7)		31 (31.6)			
Medicare	124		91		33		$\chi^2(2)= 26.01$, $p<.0001$***, Cramer's $V=.46$
Has Medicare		74 (59.7)		42 (46.2)		33 (100)	
No Medicare		41 (33.1)		40 (44.0)			
Other health cover[c]		9 (7.3)		9 (9.9)			

Table Continues

[b] For those with children

[c] For example, those on student visas are required to have health insurance as part of their visa requirements.

Variable	Total Sample *N*	Frequency (%)	Asylum-seekers *n*	Frequency (%)	Refugees *n*	Frequency (%)	*Significance*
Income Type	130		97		33		$\chi^2(6)= 54.87$, $p<.0001$***, Cramer's $V=.65$
Work		44 (33.8)		30 (30.9)		14 (42.4)	
Centrelink		17 (13.1)		1 (1.0)		16 (48.5)	
ASAS		33 (25.4)		32 (33.0)		1 (3.0)	
Hotham Mission		3 (2.3)		3 (3.1)			
Family/ friends		16 (12.3)		15 (15.5)		1 (3.0)	
Savings		14 (10.8)		13 (13.4)		1 (3.0)	
Other		3 (2.3)		3 (3.1)			
Accommodation	128		95		33		$\chi^2(3)= 11.08$, $p=.01$*, Cramer's $V=.27$
Private rental		70 (54.7)		45 (47.4)		25 (75.8)	
Church/ charity		16 (12.5)		15 (15.8)		1 (3.0)	
Family/ friends		38 (29.7)		31 (32.6)		7 (21.2)	
Other		4 (3.1)		4 (4.2)			
Health Status	117		88		29		$\chi^2(3)= 5.79$, $p=.12$
Nil diagnosis		63 (53.8)		47 (53.4)		16 (55.2)	
Physical medical diagnosis		27 (23.1)		22 (25.0)		5 (17.2.1)	
Psychiatric diagnosis		18 (15.4)		15 (17.0)		3 (10.3	
Dual diagnosis		9 (7.7)		4 (4.5)		5 (17.2)	
Medication	127		95		32		$\chi^2(7)= 3.21$, $p=.87$
Nil		90 (70.9)		68 (71.6)		22 (68.8)	
Antidepressants		5 (3.9)		4 (4.1)		1 (3.1)	
Antipsychotics		2 (1.6)		2 (2.1)			
Insulin/ diabetes tabs		5 (3.9)		3 (3.2)		2 (6.3)	
Antihypertensives		4 (3.1)		2 (2.1)		2 (6.3)	
Anxiolytics/ sleepers		8 (6.3)		6 (6.3)		2 (6.3)	
Analgesics		6 (4.7)		5 (5.3)		1 (3.1)	
Other		7 (5.5)		5 (5.3)		2 (6.3)	
History of Torture	122		91		31		$\chi^2(1)= 0.54$, $p=.46$
Yes		58 (47.5)		41 (41.8)		17 (54.8)	
No		64 (52.5)		50 (51.0)		14 (45.2)	

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

Most participants were well educated, with 90% having completed secondary school or tertiary studies. Furthermore, one third (36%) had worked in a professional occupation prior to arriving in Australia. In comparison, once in Australia, almost one quarter (24%) were without work rights, one third was unemployed (31%) and another third (34%) worked in unskilled jobs. Of those who were not employed and not eligible for Centrelink payments (i.e., asylum-seekers), 33% cited the Red Cross' Asylum-Seeker Assistance Scheme as their primary income source. The remainder of asylum seekers (36%) were financially supported by family or friends, Hotham Mission or lived off savings.

Almost half (44%) of asylum-seekers were not eligible for Medicare and just over half the total sample (56%) reported nil health diagnosis. Of those who reported a health diagnosis, in 21% of cases this was for a physical health condition (most commonly diabetes and/or hypertension), whilst 16% reported a mental health diagnosis (most commonly depression). In 7% of cases, both physical and mental health conditions had been diagnosed.

Table 4.3 sets out the descriptive statistics for visa status and Figure 4.1 depicts the breakdown pictorially. The sample comprised 75% who had an insecure residency status (i.e., asylum-seekers) and 25% with a secure residency status (i.e., those who were determined to be refugees after arriving in Australia). Almost one third of the total sample were on Bridging Visa E (29%), 24% held Bridging Visa A and 10% were on a student visa.

Table 4.3

Descriptive Statistics for Visa Status

Visa Type	Frequency	Percent
No Visa	2	1.5
BVE	38	29.0
Tourist/Visitor	1	0.8
Business	1	0.8
BVC	8	6.1
BVA	32	24.4
Student	13	9.9
TPV/RoS	3	2.3
PR	33	25.2
Total	**131**	**100.0**

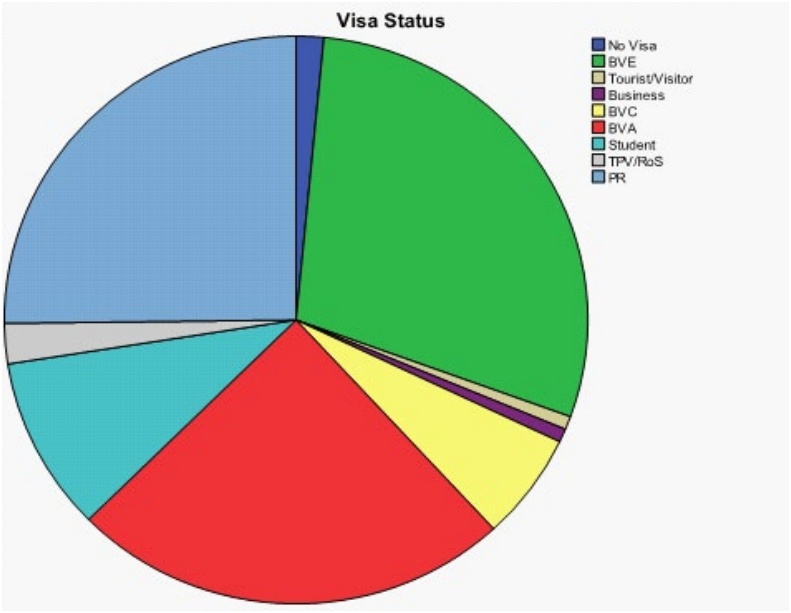

Figure 4.1

Proportion of Sample by Visa Status

4.3. Phase I

4.3.1 Between group differences on clinical scales

Relatively little emerged by way of influence of demographic variables on the clinical measures, (see Table 4.4.1). Those who arrived by boat scored higher on demoralisation than plane arrivals. Sri Lankans scored higher on demoralisation, depression and refugee trauma than Zimbabweans. There was no difference across the measures by visa type – only by residency status, with asylum-seekers scoring significantly higher than refugees on depression, PTSD and post-migration stress. Related to this were a number of other demographic variables, such as whether one had work rights and Medicare. Those without Medicare scored significantly higher on all measures except demoralisation whilst those without work rights reported higher levels of post-migration stress than both those who were working and those with work rights but unemployed. Similarly, those whose income was linked to living off family/ friends and ASAS had higher depression scores than those who were working, or in receipt of Centrelink benefits. Post-migration stress was higher for those reliant on (formal or informal) charity than those who were eligible for Centrelink (i.e., refugees). Significantly elevated anxiety, PTSD (which approached significance) and post-migration stress scores were also reflective of having been tortured, and those who reported a psychiatric diagnosis returned significantly higher scores on all but post-migration stress, than those with a physical condition or nil health diagnosis.

Due to the significant difference between asylum-seekers and refugees in the Visa Type condition, a further analysis of demographic variables across the measures was undertaken for these groups separately.

As illustrated in Table 4.4.2, most of the differences in demographic variables for the total sample population (Table 4.4.1) were influenced by the AS group. Compared with asylum-seekers, the PR all arrived by plane; all had Medicare and were living in private rental (n=25, 76%). The only within-group difference between demographic variables for the PR group was seen in higher scores on anxiety (U=57, p=.01, Z=-2.51) and depression (U=48, p=.004, Z=-2.85) for those with a history of torture. In contrast, a history of torture in the AS group was only associated with elevated post-migration stress scores (and caseness for PTSD). The only other variable for the AS group which differed from Table 4.4.1, was that of Partner in Australia. However, surprisingly, higher anxiety scores were reported by participants whose partner was in Australia. Not having Medicare was associated with higher anxiety, post-migration stress, and PTSD scores. Those without work rights scored higher on post-migration stress than those who were working, and higher depression scores for those without work rights approached significance, $\chi^2(2)=5.86$, p=.054.

As seen in Table 4.5, the AS group returned significantly higher scores on all clinical measures with the exception of demoralisation, which approached significance.

Table 4.5

Differences in Mean Symptom Scores by Residency Status

Variable	Total		Asylum-seekers		Refugees		
	N	***M* (*SD*)**	***n***	***M* (*SD*)**	***n***	***M* (*SD*)**	***Significance***
Anxiety (1-4)	128	*Md*=1.90 (1.00– 3.90)	95	*Md*=2.10 (1.00– 3.90)	33	*Md*=1.60 (1.00– 3.20)	*U*=1080, *p*=.01 *
Depression (1-4)	128	*Md*=2.40 (1.00– 3.93)	95	*Md*=2.67 (1.13– 3.93)	33	*Md*=2.13 (1.00– 3.33)	*U*=1641, *p*<.0001**
PTSD (1-4)	130	2.37 (0.78)	94	2.47 (0.75)	33	2.04 (0.77)	*t*(125)=-2.81, *p*=.01*
Refugee trauma (1-4)	125	2.23 (0.70)	89	2.33 (0.67)	33	1.96 (0.70)	*t*(120)=-2.66, *p*=.01*
Demoralisation (0-4)	130	2.06 (0.87)	95	2.14 (0.86)	32	1.82 (0.89)	*t*(125)=-1.81, *p*=.07
Post-migration stress (1-5)	131	2.67 (0.63)	95	2.83 (0.55)	33	2.20 (0.62)	*t*(125)=-5.42, *p*<.0001**

* Significant at the 0.01 level
** Significant at the 0.001 level

Table 4.4.1

Differences in Symptom Scores by Demographic Variables for Total Sample

Scale	**1. Anxiety**	**2. Depression**	**3. PTSD**	**4. Refugee Trauma**	**5. Demoralisation**	**6. Post-Migration Stress**	
Variable	***Significance***	***Significance***	***Significance***	***Significance***	***Significance***	***Significance***	**Group differences**
Sex	NS	NS	NS	NS	NS	NS	
Age (< 35 years >)	NS	NS	NS	NS	NS	NS	
Country	NS	$\chi^2(4)= 11.73$, $p=.02$*	NS	$F(4,117)= 3.12$, $p=.02$*	$F(4,119)= 3.44$, $p=.01$*	NS	**2**. SL, Pak > Zimbabwe **4.**, **5**., Sri Lanka > Zimbabwe
Mode of arrival (boat, plane)	NS	NS	NS	NS	$t(119)= -3.43$, $p=.001$**	NS	Boat > plane
Visa type (BVA, BVE, Student, PR)	NS	$\chi^2(3)= 14.87$, $p=.002$**	$F(3,108)=3.18$, $p=.03$*	NS	NS	$F(3,109)= 8.70$, $p<.001$**	**2.** BVA, BVE, Student > PR **3.** BVE > PR **6.** BVA, BVE, Student > PR
Time in RDP (< 6 mths > 2 yrs)	NS	NS	NS	NS	NS	NS	
Speaks English	NS	NS	NS	NS	NS	NS	
Marital status	NS	NS	NS	NS	NS	NS	
Religion	NS	NS	NS	NS	NS	NS	
Partner in Aust.	NS	NS	NS	NS	NS	NS	
Children in Aust.	NS	NS	NS	NS	NS	NS	
Medicare	$U= 953$, $p=.003$ ** Z=-2.96	$U= 1031$, $p=.01$ * Z=-2.49	$t(116)= - 3.17$, $p=.002$**	$t(112)= -2.53$, $p=.01$*	NS	$t(117)= -5.70$, $p<.001$***	Nil Medicare > Medicare
Employment (Nil WR, Nil Work, Work)	NS	NS	NS	NS	NS	$F(2,118)= 6.73$, $p=.002$**	Nil WR > Nil Work/ Work

Table Continues

Scale	**1. Anxiety**	**2. Depression**	**3. PTSD**	**4. Refugee Trauma**	**5. Demoralisation**	**6. Post-Migration Stress**	
Variable	***Significance***	***Significance***	***Significance***	***Significance***	***Significance***	***Significance***	**Group differences**
Education	NS	NS	NS	NS	NS	NS	
Income type (Work, ASAS, Centrelink, Hotham Family/ friends, Savings, Other)	NS	$\chi^2(6)=15.91$, $p=.01$*	NS	NS	NS	$F(6,121)= 4.67$, $p<.001$***	**2.** Family/Friends, ASAS/Savings > Centrelink **6.** ASAS, Family/friends, Savings > Centrelink
Tortured	$U=1324$, $p=.02$* Z= -2.34	NS	$t(116)=1.98$, $p=.05$	NS	NS	$t(117)= 2.12$, $p=.04$*	Tortured > not tortured
Medical diagnosis (Nil Dx, Physical Dx, Psych Dx)	$\chi^2(2)=10.34$, $p=.01$**	$\chi^2(2)=7.42$, $p=.03$*	$F(2,102)=3.32$, $p=.04$*	$F(2,102)=3.80$, $p=.03$*	$F(2,102)= 7.93$, $p=.001$**	NS	**1.** Psych Dx > Nil Dx **2.** Psych Dx > Physical Dx **3**. Psych Dx > Physical Dx **4**. Psych Dx > Nil Dx / Physical Dx **5**. Psych Dx > Nil Dx / Physical Dx
Accommodation (Private rental, church/ charity, family/ friends)	NS	NS	NS	NS	NS	NS	

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

Table 4.4.2

Differences in Symptom Scores by Demographic Variables for Asylum-Seekers

Scale	**1. Anxiety**	**2. Depression**	**3. PTSD**	**4. Refugee Trauma**	**5. Demoralisation**	**6. Post-Migration Stress**	
Variable	***Significance***	***Significance***	***Significance***	***Significance***	***Significance***	***Significance***	**Group differences**
Sex	NS	NS	NS	NS	NS	NS	
Age (< 35 years >)	NS	NS	NS	NS	NS	NS	
Country	NS	$\chi^2(4)= 11.07$, $p=.03$*	NS	NS	NS	NS	Iq, Pak, SL > Zim
Mode of arrival (boat, plane)	NS	NS	NS	NS	$t(88)= -3.33$, $p=.001$**	NS	Boat > plane
Visa type (BVA, BVE, Student, PR)	NS	NS	NS	NS	NS	NS	
Time in RDP (< 6 mths > 2 yrs)	NS	NS	NS	NS	NS	NS	
Speaks English	NS	NS	NS	NS	NS	NS	
Marital status	NS	NS	NS	NS	NS	NS	
Religion	NS	NS	NS	NS	NS	NS	
Partner in Aust.	$\chi^2(2)= 6.25$, $p=.04$*	NS	NS	NS	NS	NS	Yes > No
Children in Aust.	NS	NS	NS	NS	NS	NS	
Medicare	$U= 695$, $p=.05$* Z= -1.98	NS	$t(83)= -2.11$, $p=.04$*	NS	NS	$t(84)= -3.90$, $p<.0001$***	Nil Medicare > Medicare
Employment (Nil WR, Nil Work, Work)	NS	NS	NS	NS	NS	$F(2,87)= 3.12$, $p=.049$*	Nil WR > Work
Education	NS	NS	NS	NS	NS	NS	

Table continues

Scale	**1. Anxiety**	**2. Depression**	**3. PTSD**	**4. Refugee Trauma**	**5. Demoralisation**	**6. Post-Migration Stress**	
Variable	***Significance***	***Significance***	***Significance***	***Significance***	***Significance***	***Significance***	**Group differences**
Income type (Work, ASAS, Centrelink, Hotham Family/friends, Savings, Other)	NS	NS	NS	NS	NS	NS	
Tortured	NS	NS	NS	NS	NS	$t(86)=2.50$, $p=.01$*	Yes > No
Medical diagnosis (Nil Dx, Physical Dx, Psych Dx)	NS	NS	NS	NS	NS	NS	
Accommodation (Private rental, church/ charity, family/ friends)	NS	NS	NS	NS	NS	NS	

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

4.3.2 Between group differences: asylum-seekers and refugees

As aforementioned, the primary sub-grouping of interest within the sample was that of residency status – those who were asylum-seekers and those who were refugees at the time of interview.

The mean age was 35.7 years for refugees and 34.6 years for asylum-seekers (see Table 4.1). There were significantly more males than females for both refugees and asylum-seekers, with only 10 females in the refugee group and 11 in the asylum-seeker group (see Table 4.2).

Table 4.7 indicates that there was not a significant difference between the AS and the PR groups in mean age or mean time residing in Australia. Similarly, there was a non-significant difference in time spent in the RDP as a function of residency status. The mean time since being granted permanent residency for refugees was 6 months (*SD*=7.38) (see Table 4.1). Asylum-seekers and refugees did not differ in number of traumatic events reported or history of torture.

More than half (59%) of the total sample had not received a rejection at the time of their first interview. Table 4.6 indicates the number of rejections for refugees and asylum-seekers, respectively.

Two-thirds (75%) of refugees received permanent residency at the Primary Stage (i.e., nil rejections). Conversely, a little over half (54%) of all asylum-seekers were still awaiting a decision at the Primary Stage, while the next largest group (20%) had received four or more rejections. The second largest group of refugees (15%) had also received four or more rejections before being granted permanent residency.

Levene's test of homogeneity of variances found all but two of the continuous demographic variables ('Rejections at Primary Stage' and 'Rejections at RRT') to be normally distributed.

Table 4.6

Total Number of Rejections by Residency Status

	Asylum-seekers (*n*=97)	Refugees (*n*=32)
Number of rejections	**Frequency (%)**	**Frequency (%)**
0 Rejections	52 (53.6)	24 (75.0)
1 Rejection	8 (8.2)	2 (6.3)
2 Rejections	12 (12.4)	1 (3.1)
3 Rejections	6 (6.2)	0 (0.0)
4+ Rejections	19 (19.6)	5 (15.6)

Table 4.7 reveals that the AS and PR groups differed only in number of rejections at the Primary Stage, with asylum-seekers receiving a greater number of rejections.

Table 4.7

Mean Differences in Continuous Demographic Variables by Residency Status

	Asylum-seekers		Refugees		
Variable	***n***	***M (SD)***	***n***	***M (SD)***	***Significance***
Age	98	34.57 (10.58)	33	35.72 (11.03)	$t(129)= 0.47$, $p=.64$
Time in Australia (yrs)	98	3.61 (4.40)	33	3.21 (3.64)	$t(129)=-0.46$, $p=.64$
Time since application (mths)	96	29.12 (49.14)	32	21.93 (39.06)	$t(126)=-0.19$, $p=.91$
Refugee camp pre-arrival (mths)	95	0.49 (3.8)	32	1.13 (6.36)	$t(125)= 0.67$, $p=.50$
Time in detention (mths)	97	0.88 (5.28)	32	0.00 (0.00)	$t(127)=-0.94$, $p=.35$
Rejection at primary stage	98	*Md*= 0 (0–1)	32	*Md*= 0 (0–1)	$U=1212$, $p=.04$*,
Rejection at RRT	97	*Md*= 0 (0–3)	32	*Md*= 0 (0–2)	$Z=-2.01$, $U=1231$, $p=.06$,
Rejection in court/s	97	0.45 (1.02)	32	0.41 (1.04)	$Z=-1.86$, $t(127)=-0.23$, $p=.82$
Rejection at Ministerial stage	97	0.35 (0.99)	32	0.34 (1.04)	$t(127)=-0.03$, $p=.97$
Total number of rejections	97	1.77 (2.61)	32	1.25 (2.76)	$t(127)=-0.97$, $p=.33$
Total number of applications	98	2.66 (2.57)	32	2.22 (2.66)	$t(128)=-0.84$, $p=.40$
Number of traumatic events	92	13.07 (5.45)	32	12.09 (5.01)	$t(122)=-1.02$, $p=.38$

* Significant at the 0.05 level

Analyses between the AS and PR groups across the categorical demographic variables found no significant difference for country of origin (χ^2[6]=8.43, p=.21), marital status (χ^2[3]=3.66, p=.30), level of education (χ^2[5]=10.07, p=.07), previous occupation (χ^2[6]=6.50, p=.37), mode of arrival (χ^2[1]=3.12, p=.08), or whether the subject could speak English (χ^2[1]=2.90, p=.09).

There were areas of difference, however. Where differences in demographic variables emerged as a function of residency status, the critical value of ±1.96 (corresponding to an alpha of 0.05) for the Adjusted Residual cell score was used as a *post hoc* analysis to inspect where differences lay (Pallant, 2007).

There was a disparity for sex, with asylum-seekers having a significantly higher male-to-female ratio (χ^2[1]=5.33, p=.02). Whilst significantly more refugees than asylum-seekers had all of their children in Australia (χ^2=13.70, p=.003), there was a non-significant trend toward only refugees having partners in Australia (χ^2[2]=5.75, p=.06).

A significant difference between the two groups for current occupation (χ^2[6]=26.38, p<.0001) was characterised by asylum-seekers not having work rights. However, income type (χ^2[6]=54.87, p<.0001) revealed differences between the two being only for type of welfare support (i.e., refugees were in receipt of Centrelink while asylum-seekers were in receipt of Red Cross-ASAS). There was also a difference in accommodation status (χ^2[3]=11.08, p=.01), with a significantly greater number of refugees living in private accommodation than asylum-seekers, who were predominantly housed by charities.

There was a significant difference between asylum-seekers and refugees with respect to religion (χ^2[5]=12.70, p=.03), with Christians (Protestant) being most likely to be granted PR.

Unsurprisingly, there was a significant difference in eligibility for Medicare between the two groups (χ^2[1]=29.38, p<.0001). All refugees had Medicare, in contrast to less than half (46%) of all asylum-seekers.

Although asylum-seekers did not differ from refugees in regard to medical diagnosis (χ^2[3]=6.85, p=.08) or prescribed medication (χ^2[7]=3.23, p=.86), as Table 4.8 demonstrates, a significant difference in mental health emerged. The AS group had a greater prevalence of major depression, PTSD and demoralisation, but not refugee trauma. A valid cut-off for the HSCL-Anxiety scale could not be established by the MINI, rendering this scale a measure of anxiety symptoms not specific to any one disorder. However, an independent samples t-test revealed that asylum-seekers returned significantly higher anxiety scores than refugees, t(126)=-2.71, p=.01.

Table 4.8

Prevalence of Clinical Disorders (Caseness) in Refugees and Asylum-seekers – Time 1

	Refugees (*n*=33)	**Asylum-seekers (*n*=95)**	**Total Sample (*N*=128)**	
Clinical measure	**(%)**	**(%)**	**(%)**	***Significance***
Major depression (HSCL Q11-25 ≥ 2.29)	30.3	61.1	53.1	$\chi^2(1)=8.11$, $p=.004$**
PTSD (HTQ Q1-16 ≥ 2.5)	27.3	52.1	45.7	$\chi^2(1)=6.08$, $p=.02$*
Refugee trauma (HTQ Q17-40 ≥ 2.5)	21.2	38.2	33.6	$\chi^2(1)=3.11$, $p=.12$
Demoralisation (Males ≥ 1.27 Females ≥ 1.55)	65.6	83.0	78.6	$\chi^2(1)=4.27$, $p=.04$*

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

4.4 Demographic Characteristics of the Sample – Phase II

The second phase comprised 56 participants who returned for a follow-up interview – a response rate of 43%. Follow-up data was collected an average of 15.7 months (*SD*=3.63) after the initial interview. At T2 the mean age was 37 years (*SD*=11.57).

Table 4.9 illustrates the parity between those followed-up and those not; the two groups differed only on number of traumatic events experienced, with the Phase II cohort reporting an average of two more traumatic events than the cohort lost to follow-up.

Similarly, none of the categorical variables at T1 differed significantly between the cohort that was retained and that which dropped out. However one variable, medical diagnosis, approached significance ($\chi^2[3]= 7.44$, $p=.059$) indicating that those who were re-interviewed were more likely to have had a co-morbid (i.e., physical and mental health) condition.

Table 4.9

Mean Differences in Continuous Independent Variables at Time 1 between Phase II Interviewee Cohort and Phase II Attrition Cohort

	Dropped-out (*N*=75)	**Followed-up** (*N*=56)	
Variable	***M* (*SD*)**	***M* (*SD*)**	***Significance***
Age	34.03 (9.98)	35.95 (11.51)	*t*(126)=-0.10, *p*=.32
Time in Australia (years)	3.63 (3.92)	3.35 (4.61)	*t*(126)=-0.90, *p*=.37
Total time since application	30.09 (45.38)	27.71 (49.69)	*t*(123)=0.52, *p*=.61
Time since PR (months)	5.44 (7.45)	5.40 (3.77)	*t*(31)=-0.02, *p*=.99
Refugee camp pre arrival (months)	*Md*=0.00 (0–10)	*Md*= 0.00 (0–36)	*U*=1824, *p*=.67
Time in detention (months)	*Md*=0.00 (0–48)	*Md*=0.00 (0–3.4)	*U*=1839, *p*=.32
Rejections at primary stage	0.43 (0.50)	0.38 (0.49)	*t*(125)=-0.69, *p*=.49
Rejections at RRT	0.50 (0.76)	0.36 (0.65)	*t*(124)=1.81, *p*=.24
Rejections at court	0.45 (1.06)	0.44 (0.98)	*t*(124)=0.34, *p*=.73
Rejections at Ministerial stage	0.31 (0.84)	0.40 (1.18)	*t*(124)=-0.30, *p*=.76
Total number of rejections	1.69 (2.58)	1.58 (2.75)	*t*(124)=0.48, *p*=.63
Number of applications	2.59 (2.46)	2.51 (2.78)	*t*(125)=0.44, *p*=.66
Number of traumatic events	11.88 (5.25)	13.98 (5.31)	*t*(119)=-2.20, *p*=.03*

* Significant at the 0.05 level

Table 4.10 sets out the descriptive statistics for three cohorts which emerged as a function of the prospective design and visa status change over time: those who were asylum-seekers at T1 and retained this status at T2 (*n*=17); those who had refugee status at T1 and therefore retained this status (*n*=13); and those who were asylum-seekers at T1 and had refugee status at T2 (*n*=26).

Between T1 and T2, five (29%) of the AS-AS cohort were granted work rights, and fewer were primarily reliant on family/friends (from 31% to 13%). However, this group was still more likely to rely financially on family/friends than the other two groups (χ^2[8]=29.01, *p*<.0001). Access to Medicare for the AS-AS cohort almost doubled (from 44% to 81%) between T1 and T2. Income through employment increased from approximately one third (35%), to half (54%) for the AS-PR group.

While accommodation type was not collected in demographic data at T2, the number of moves in abode was. There was not a significant difference in number of relocations between the three cohorts (*F*[2,46]=0.64, *p*=.53). Similarly, there was no difference between the groups in regard to change in income (i.e., more/less/the same) over time, χ^2(4)=7.82, *p*=.10.

Table 4.10

Differences between the Three Cohorts for Categorical Demographic Variables

Variable	AS-AS *n*	AS-AS Frequency (%)	AS-PR *n*	AS-PR Frequency (%)	PR-PR *n*	PR-PR Frequency (%)	*Significance*
Sex	17		26		13		$\chi^2(2)=1.83$, $p=.40$
Female		1 (5.9)		4 (15.4)		3 (23.1)	
Male		16 (94.1)		22 (84.6)		10 (76.9)	
Country	17		26		13		$\chi^2(8)=10.75$, $p=.22$.[a]
Sri Lanka		9 (52.9)		6 (23.1)		3 (23.1)	
Pakistan		4 (23.5)		11 (42.3)		2 (15.4)	
Zimbabwe		2 (11.8)		5 (19.2)		4 (30.8)	
Iraq		2(11.8)		2 (7.7)		2 (15.4)	
Afghanistan		-		2 (7.7)		2 (15.4)	
Iran		-		-		-	
Lebanon		-		-		-	
Religion	17		26		13		$\chi^2(8)=18.43$, $p=.02$*, Cramer's $V=.40$
Christian (Protestant)		5 (33.3)		4 (16.0)		6 (46.2)	
Christian (Roman Catholic)		1 (6.7)		10 (40.0)		1 (7.7)	
Muslim		6 (35.3)		9 (34.6)		5 (38.5)	
Buddhist		5 (29.4)		1 (3.8)		1 (7.7)	
Hindu				2 (7.7)			
Speaks English	17		26		13		$\chi^2(2)=0.23$, $p=.89$
Yes		15 (88.2)		24 (92.3)		12 (92.3)	
No		2 (11.8)		2 (7.7)		1 (7.7)	
Mode of arrival	13		26		13		$\chi^2(2)=2.83$, $p=.24$
Boat		1 (7.7)					
Plane		12 (92.3)		26 (100)		13 (100)	
Marital status	17		26		13		$\chi^2(4)=4.39$, $p=.36$
Married/ De facto		7 (41.2)		7 (26.9)		6 (46.2)	
Single/ Never mMarried		10 (58.8)		17 (65.4)		7 (53.8)	
Divorced/ Separated				2 (7.7)			
Widowed							
Location of partner.[b]	9		17		7		$\chi^2(4)=7.45$, $p=.11$
In Australia		5 (55.6)		10 (58.8)		7 (100)	
In homeland/ 3rd country		4 (44.4)		7 (41.2)			

Table Continues

[a] Iran and Lebanon omitted from analysis due to small numbers

[b] For those with a partner

Variable	AS-AS *n*	AS-AS Frequency (%)	AS-PR *n*	AS-PR Frequency (%)	PR-PR *n*	PR-PR Frequency (%)	*Significance*
Location of children[c]	9		17		7		$\chi^2(6)=12.90$, $p=.045$*, Cramer's $V=.30$
All children in Australia		4 (44.4)		7 (41.2)		6 (85.7)	
Some children in Australia						1 (14.3)	
All children in homeland/ 3rd country		5 (55.6)		10 (58.8)			
Level of education	16		26		13		$\chi^2(8)= 8.86$, $p=.35$
Tertiary		8 (50.0)		20 (76.9)		9 (69.2)	
Completed secondary		6 (37.5)		5 (19.2)		4 (30.8)	
Some secondary		1 (6.3)					
Completed primary				1 (3.8)			
Some primary		1 (6.3)					
No formal education							
Previous occupation	17		26		13		$\chi^2(12)= 20.26$, $p=.06$
Professional		6 (35.3)		10 (38.5)		6 (46.2)	
Business/ Self-employed		2 (11.8)		4 (15.4)			
Administrative				5 (19.2)			
Skilled/ Trade		6 (35.3)		1 (3.8)		2 (15.4)	
unskilled				3 (11.5)		1 (7.7)	
Student		2 (11.8)		2 (7.7)		4 (30.8)	
Nil work		1 (5.9)		1 (3.8)			
Current occupation – Phase I	17		26		13		$\chi^2(10)= 16.15$, $p=.10$
Professional							
Business/ Self-employed						1 (7.7)	
Skilled/ Trade				3 (11.5)		2 (15.4)	
Unskilled		5 (29.4)		6 (23.1)		5 (38.5)	
Student		1 (5.9)		1 (3.8)			
Nil work		5 (29.4)		8 (30.8)		5 (38.5)	
Nil work rights		6 (35.3)		8 (30.8)			
Current occupation – Phase II	17		26		13		$\chi^2(12)= 9.62$, $p=.65$
Professional				1 (3.8)		1 (7.7)	
Business/ Self-employed				1 (3.8)		1 (7.7)	
Skilled/ Trade		2 (11.8)		3 (11.5)		3 (23.1)	
Unskilled		9 (52.9)		11 (42.3)		6 (46.2)	
Student				1 (3.8)		1 (7.7)	
Nil work		5 (29.4)		9 (34.6)		2 (15.4)	
Nil work rights		1 (5.9)					

Table Continues

[c] For those with children

Variable	AS-AS *n*	AS-AS Frequency (%)	AS-PR *n*	AS-PR Frequency (%)	PR-PR *n*	PR-PR Frequency (%)	*Significance*
Income type – Phase I	16		26		13		$\chi^2(12)=40.89$, $p<.0001$***, Cramer's $V=.59$
Work		7 (43.8)		9 (34.6)		6 (46.2)	
Centrelink						7 (53.8)	
ASAS		2 (12.5)		8 (30.8)			
Hotham Mission		1 (6.3)					
Family/ friends		5 (31.3)		4 (15.4)			
Savings		1 (6.3)		4 (15.4)			
Other				1 (3.8)			
Income type – Phase II	16		26		13		$\chi^2(8)=29.67$, $p<.0001$***, Cramer's $V=.47$
Work		9 (56.2)		14 (53.8)		7 (53.8)	
Centrelink				12 (46.2)		6 (46.2)	
ASAS		4 (25.0)					
Hotham Mission		1 (6.3)					
Family/ friends		2 (12.5)					
Savings							
Other							
Accommodation – Phase I	17		26		13		$\chi^2(4)=9.44$, $p=.05$
Private rental		7 (41.2)		11 (42.3)		11 (84.6)	
Church/ charity		3 (17.6)		5 (19.2)		2 (15.4)	
Family/ friends		7 (41.2)		10 (38.5)			
Other							
Medicare - Phase I	16		25		13		$\chi^2(4)=18.02$, $p=.001$**, Cramer's $V=.35$
Has Medicare		7 (43.8)		13 (52.0)		13 (100)	
Ineligible for Medicare		9 (56.2)		10 (40.0)			
Has other health cover[d]				2 (8.0)			
Medicare - Phase II	16		26		13		$\chi^2(4)=10.68$, $p=.03$*, Cramer's $V=.32$
Has Medicare		13 (81.3)		26 (100)		13 (100)	
Ineligible for Medicare		3 (18.7)					
Has other health cover[e]							

Table Continues

[d] For example, those on student visas are required to have health insurance as part of their visa requirements.
[e] For example, those on student visas are required to have health insurance as part of their visa requirements.

Variable	AS-AS *n*	AS-AS Frequency (%)	AS-PR *n*	AS-PR Frequency (%)	PR-PR *n*	PR-PR Frequency (%)	*Significance*
Health status- Phase I	17		26		13		$\chi^2(6)= 10.78$, $p=.10$
Nil diagnosis		9 (52.9)		17 (65.4)		8 (61.5)	
Physical medical diagnosis		3 (17.6)		6 (23.1)			
Psychiatric diagnosis		3 (17.6)		2 (7.7)		1 (7.7)	
Dual diagnosis		2 (11.8)		1 (3.8)		4 (30.8)	
Health status- Phase II	16		26		11		$\chi^2(6)= 11.40$, $p=.08$
Nil diagnosis		3 (18.7)		9 (36.0)		8 (61.5)	
Physical medical diagnosis		6 (37.5)		9 (36.0)		3 (23.1)	
Psychiatric diagnosis		4 (25.0)		3 (12.0)			
Dual diagnosis		3 (18.7)		4 (16.0)		2 (15.4)	
Medication - Phase I	16		26		13		$\chi^2(14)= 18.69$, $p=.18$
Nil		12 (75.0)		20 (76.9)		8 (61.5)	
Antidepressants				1 (3.8)			
Antipsychotics		1 (6.3)					
Insulin/diabetes				3 (11.5)			
Antihypertensives		1 (6.3)				2 (15.4)	
Anxiolytics-sleepers		2 (12.5)		1 (3.8)		1 (7.7)	
Analgesics				1 (3.8)		1 (7.7)	
Other Medical						1 (7.7)	
Medication - Phase II	17		25		13		$\chi^2(14)= 13.94$, $p=.45$
Nil		6 (35.3)		12 (48.0)		8 (61.5)	
Antidepressants		2 (11.8)		1 (4.0)		1 (7.7)	
Antipsychotics		2 (11.8)					
Insulin/ diabetes		2 (11.8)		2 (8.0)			
Antihypertensives		3 (17.6)		3 (12.0)		1 (7.7)	
Anxiolytics-sleepers		2 (11.8)		4 (16.0)		1 (7.7)	
Analgesics				1 (4.0)		1 (7.7)	
Other Medical				2 (8.0)		1 (7.7)	
History of Torture	17		25		13		$\chi^2(2)= 0.69$, $p=.71$
Yes		8 (47.1)		15 (60.0)		7 (53.9)	
No		9 (52.9)		10 (40.0)		6 (46.1)	

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

Regarding health status, the AS-AS and AS-PR cohorts increased on all health categories over time. That is, incidence of physical, mental and co-morbid physical/ mental conditions increased at follow-up for both cohorts. However, cell numbers were too small to ascertain valid within-group significance levels. There was a trend toward an increase in prescribed medication (particularly antihypertensive medication) for the AS-AS and AS-PR group over time, while the PR-PR cohort remained unchanged.

4.5 Phase II

4.5.1 Between & within group differences

The three cohorts (AS-AS, AS-PR, PR-PR) did not differ significantly in regard to age, time in Australia, time in RDP, number of applications or number of rejections (at all stages). Furthermore, there were no differences in experiences of time spent in refugee camps, detention or number of traumatic events reported. Refer to Table 4.11.

Similarly, there were no differences across all categorical demographic variables for the three groups with the exception of religion ($\chi^2[6]=15.72$, $p=.02$), with (Catholic) Christians being more likely to be in the AS-PR cohort (refer to Table 4.10).

Table 4.11

Mean Differences in Continuous Independent Variables at Time 1 for the Three Cohorts

	AS-AS		AS-PR		PR-PR		
Variable	***n***	***M (SD)***	***n***	***M (SD)***	***n***	***M (SD)***	***Significance***
Age	17	38.00 (12.07)	26	35.38 (11.50)	13	34.38 (11.32)	$F(2,53)=0.41$, $p=.66$
Time In Australia (yrs)	17	4.60 (5.45)	26	2.74 (4.66)	13	2.94 (3.05)	$\chi^2(2)=2.10$, $p=.35$
Time since application (mths)	17	40.09 (64.71)	26	21.91 (46.10)	13	23.12 (31.54)	$\chi^2(2)=5.10$, $p=.08$
Rejection at primary stage	17	0.59 (0.51)	26	0.35 (0.49)	12	0.17 (0.39)	$\chi^2(2)=5.46$, $p=.07$
Rejection at RRT	17	0.65 (0.86)	26	0.27 (0.53)	12	0.17 (0.39)	$\chi^2(2)=4.32$, $p=.12$
Rejection at court	17	0.65 (1.12)	26	0.31 (0.88)	12	0.42 (1.00)	$\chi^2(2)=1.41$, $p=.49$
Rejection at Ministerial stage	17	0.76 (1.75)	26	0.15 (0.54)	12	0.42 (1.17)	$\chi^2(2)=3.34$, $p=.19$
Total number of rejections	17	2.65 (3.50)	26	1.08 (2.02)	12	1.17 (2.76)	$\chi^2(2)=4.97$, $p=.08$
Total number of applications	17	3.47 (3.57)	26	2.04 (2.05)	12	2.17 (2.76)	$\chi^2(2)=2.81$, $p=.25$
Refugee camp pre arrival (mths)	15	2.40 (9.30)	25	0.00 (0.00)	13	2.77 (1.00)	$\chi^2(2)=1.84$, $p=.40$
Time in detention (mths)	16	0.06 (0.25)	26	0.13 (0.66)	13	0.00 (0.00)	$F(2,52)=0.33$, $p=.72$
Number of traumatic events	17	13.59 (4.87)	25	15.28 (5.56)	13	12.00 (5.03)	$F(2,52)=1.75$, $p=.18$

Table 4.12

Prevalence of Clinical Disorders (Caseness) in Refugees and Asylum-seekers – Time 2

	Refugees (*n*=33)	**Asylum-seekers (*n*=95)**	**Total Sample (*N*=128)**	
Clinical measure	**(%)**	**(%)**	**(%)**	***Significance***
Major depression (HSC Q11-25 ≥ 2.29)	18.9	26.7	21.2	$\chi^2(1)=0.38$, $p=.54$
PTSD (HTQ Q1-16 ≥ 2.5)	10.8	20.0	13.5	$\chi^2(1)=0.77$, $p=.38$
Refugee trauma (HTQ Q17-40 ≥ 2.5)	10.8	14.3	11.8	$\chi^2(1)=0.12$, $p=.73$
Demoralisation (Males ≥ 1.27 Females ≥ 1.55)	41.7	66.7	47.9	$\chi^2(1)=2.25$, $p=.13$

Table 4.12 reveals a different trend to that of the between-group caseness at T1. No differences emerged between the AS and PR groups in prevalence of major depression, PTSD, refugee trauma or demoralisation at T2. Similarly, there was not a significant difference in anxiety scores at T2 between asylum-seekers and refugees, $t(50)=-0.89$, $p=.38$. Anxiety scores for both groups decreased, with asylum-seekers' scores decreasing more markedly.

Table 4.13

Symptom Scores at T1 and T2 by Change in Visa Status (Time 1 – Time 2)

		AS-AS		**AS-PR**		**PR-PR**	
Variable	***n***	***M* (*SD*)**	***n***	***M* (*SD*)**	***n***	***M* (*SD*)**	***Significance***
Depression – T1	15	*Md*=2.87 (1.20– 3.73)	25	*Md*=2.27 (1.13– 3.67)	13	*Md*=2.13 (1.00– 3.13)*	$\chi^2(2)=6.90$, $p=.03$* [a]
Depression – T2	15	*Md*=2.00 (1.13– 3.40)	25	*Md*=1.80 (1.00– 3.87)	12	*Md*=1.40 (1.00– 2.80)	$\chi^2(2)=4.66$, $p=.10$
Anxiety – T1	15	*Md*=2.30 (1.00– 3.80)	25	*Md*=1.70 (1.00– 3.30)	13	*Md*=1.90 (1.00– 2.80)	$\chi^2(2)=2.62$, $p=.27$
Anxiety – T2	15	*Md*=1.90 (1.00– 2.70)	25	*Md*=1.30 (1.00– 3.70)	12	*Md*=1.50 (1.00– 2.40)	$\chi^2(2)=1.15$, $p=.56$
PTSD – T1	15	2.73 (0.89)	25	2.19 (0.67)	13	2.01 (0.82)	$F(2,50)=3.47$, $p=.04$* [b]
PTSD – T2	15	*Md*=1.69 (1.00– 3.94)	25	*Md*=1.75 (1.00– 3.50)	12	*Md*=1.47 (1.06– 2.81)	$\chi^2(2)=1.34$, $p=.51$
Refugee trauma – T1	15	2.47 (0.86)	25	2.13 (0.67)	13	1.81 (0.66)	$F(2,50)=2.90$, $p=.06$
Refugee trauma – T2	14	*Md*=1.77 (1.08– 3.79)	25	*Md*=1.67 (1.00– 3.00)	12	*Md*=1.35 (1.13– 2.33)	$\chi^2(2)=2.57$, $p=.28$
Demoralisation – T1	15	2.11 (1.07)	25	1.93 (0.83)	13	1.65 (0.81)	$F(2,50)=0.93$, $p=.40$
Demoralisation – T2	12	1.56 (0.87)	24	1.32 (0.79)	12	1.23 (0.65)	$F(2,45)=0.60$, $p=.56$
Post-migration stress – T1	15	2.86 (0.56)	25	2.75 (0.57)	13	2.09 (0.80)	$F(2,50)=6.16$, $p=.004$** [c]
Post-migration stress – T2	15	2.48 (0.57)	25	2.19 (0.59)	12	1.83 (0.54)	$F(2,49)=4.29$, $p=.02$* [d]

Significant at the 0.05 level
‘ Significant at the 0.01 level

a AS-AS > PR-PR
b AS-AS > PR-PR
c AS-AS, AS-PR > PR-PR
d AS-AS > PR-PR

Table 4.13 presents a one-way ANOVA which was performed to explore the difference between the three cohorts on measures of demoralisation, post-migration stress, PTSD (T1) and refugee trauma (T1). Only PTSD and post-migration stress scores differed significantly between the cohorts at T1, although refugee trauma also approached significance, $F(2,50)=2.90$, $p=.06$. *Post hoc* comparisons using the Tukey HSD test indicated that The AS-AS group scored higher on PTSD than the PR-PR, and that both the AS-AS and AS-PR groups scored higher on post-migration stress than the PR-PR cohort at T1. A Kruskal-Wallis *H* test found a significant difference in depression scores, $\chi^2(2)=6.90$, $p=.03$ at T1 between the PR-PR and AS-AS cohorts.

At T2, scores on all but PTSD were highest for the AS-AS cohort. Refugees tended to return the lowest scores, with those who changed status from asylum-seeker to refugee predominantly scoring in the midrange. However, only post-migration stress reached significance.

A *post hoc* analysis performed with Tukey's HSD test revealed that all differences at both time points were between the AS-AS and PR-PR cohorts. This is curious given the AS-PR cohort had the same insecure visa status as the AS-AS cohort at T1. At T1 the PR-PR cohort also returned a significantly lower score on post-migration stress than the AS-PR group.

A Kruskal-Wallis *H* test was conducted for the remaining four measures at T2. No difference in symptom scores was found between the three cohorts for anxiety, depression, PTSD, or refugee trauma.

A repeated measures t-test was conducted for each of the three groups to ascertain within-group changes in post-migration stress and demoralisation over time. Figure 4.2 reveals no significant difference for the PR-PR group on post-migration stress ($t[11]=0.54$, $p=.60$) or demoralisation ($t[11]=1.82$, $p=.10$) but indicates a significant decrease in post-migration stress ($t[24]=4.05$, $p<.0001$) and demoralisation, ($t[23]=3.33$, $p=.003$) for the AS-PR group. A non-significant decrease in scores was also found for the AS-AS group at T2 for post-migration stress ($t[14]=2.08$, $p=.06$) and demoralisation ($t[11]=2.04$, $p=.07$), both of which approached significance.

A Wilcoxon Signed Rank Test was performed to explore changes over time in depression, anxiety, PTSD and refugee trauma for the three cohorts. No differences in the PR-PR group were found in measures of anxiety ($Z=-0.62$, $p=.53$), depression ($Z=-1.02$, $p=.31$), PTSD ($Z=-1.34$, $p=.18$) or refugee trauma ($Z=-1.34$, $p=.18$) over time. Scores on PTSD decreased significantly with a large effect size at T2 for both the

AS-AS group (Z=-2.85, p=.004, r=.52) and the AS-PR group (Z=-2.40, p=.02, r=.49), as did refugee trauma for the AS-AS group (Z=-2.01, p=.05, r=.37) and the AS-PR group (Z=-2.54, p=.01, r=.52). The AS-AS cohort also showed a significant reduction in depression scores over time (Z=-2.62, p=.01, r=.48).

In contrast with T1, at T2 there was no significant difference between the PR-PR (n=16) and AS-AS (n=36) groups on measures of depression (t[50]=-.81, p=.42), anxiety (U=239, p=.33, Z=-0.97), PTSD (U=260, p=.59, Z=-0.55), refugee trauma (U=231, p=.42, Z=-0.80), or post-migration stress (t[50]=-1.77, p=.08). The non-significant difference found at T1 between the two groups for demoralisation, remained, at T2 (U=205, p=.60, Z=-0.52).

A Spearman's rho correlation was performed as a *post hoc* analysis to investigate the influence of positive life changes (employment and social support) on depression (AS-AS), post-migration stress (AS-PR), demoralisation (AS-PR), PTSD (AS-AS; AS-PR) and refugee trauma (AS-AS; AS-PR) scores at T2. The only association found was in the AS-PR group, which was between employment and both PTSD (r= -.52, p=.03, n=18) and refugee trauma (r= -.50, p=.03, n=18).

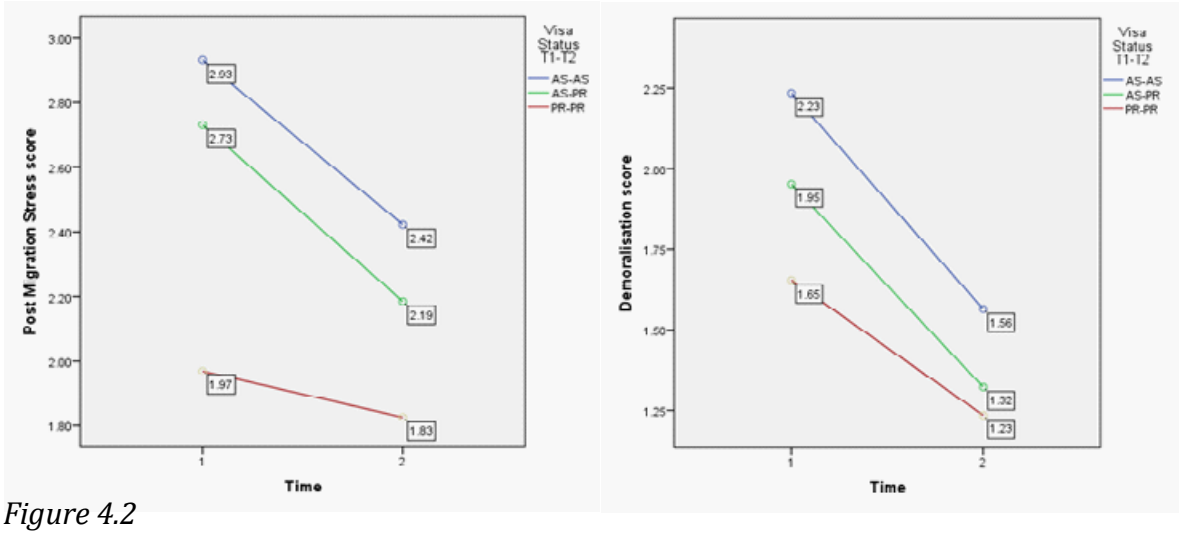

Figure 4.2

Change in Post-migration Stress and Demoralisation over time by Visa Status Change

4.6 Hypotheses

4.6.1 Hypothesis 1a & 1b

What is the prevalence of demoralisation (as measured by the PERI-D) in a community-based asylum-seeker population? How does this rate compare with other groups as defined by the literature, for example, refugees, migrants, and the general population?

Using the cut-off score of 1.27 for males and 1.55 for females (Levav et al., 2008) at T1, the prevalence of demoralisation for the total population (n=126) was 79%. The prevalence in the AS group (83%, n=94) was significantly greater than in the PR group (66%, n=32), $\chi^2(1)=4.27$, p=.04, phi=.18. However, there was not a significant difference in caseness of demoralisation between the two groups at T2, $\chi^2[1]=0.25$, p=.62, phi=.07.

The odds ratio (OR) was calculated and indicated that the relative risk for a diagnosis of demoralisation in asylum-seekers compared with refugees was 2.55 (*95% C.I.*=1.03–6.32, Z=2.03, p=.04). Compared with the general population, estimated at 25% by epidemiological studies (Link & Dohrenwend, 1980; Poulin et al., 2005), the OR for demoralisation in asylum-seekers was 14.65 (*95% C.I.*=7.65–29.22, Z=7.62, p<.0001).

4.6.2 Hypothesis 2 & 3

What are the social and demographic factors associated with demoralisation in a community-based asylum-seeker population? What are the clinical characteristics that predict whether there will be a demoralisation syndrome?

A correlation matrix (Spearman's rho for anxiety and depression and Pearson's product-moment correlation coefficient for the remaining four) was initially performed to ascertain the strength of relationship between the six measures. These are displayed in Table 4.14, indicating large inter-correlations between the clinical scales.

A Spearman's rho correlation matrix was then produced to ascertain which social, demographic and clinical item variables were significantly associated with demoralisation. These independent variables were then entered into a standard linear regression equation with missing values omitted pair-wise. This procedure was undertaken for the total sample and for the asylum-seeker and refugee sub-groups separately. For the total sample, 66.9% of the variance was explained by:

mode of arrival; Medicare (in)eligibility; PTSD diagnosis (MINI); major depression diagnosis (MINI); number of traumatic events experienced; having witnessed torture; having been tortured; and scores for anxiety, depression, refugee trauma and post-migration stress (F[11,37]=6.49, p<.001). A unique contribution was made by: refugee trauma score (t=2.40, p=.02), accounting for 5.15% of the variance in demoralisation scores; mode of arrival (t=2.30, p=.03, 4.7%); PTSD diagnosis (t=-2.07, p=.05, 4%) and depression score (t=2.09, p=.04, 3.9%). Refer to Table 4.15.

Table 4.14

Inter-correlations of Clinical Measures and Post-Migration Stress

	Anxiety	Depression	PTSD	Refugee Trauma	Demoralisation	Post-migration stress
Anxiety	-	.77*	.74*	.69*	.62*	.44*
Depression	-	-	.80*	.80*	.69*	.41*
PTSD	-	-	-	.85*	.68*	.49*
Refugee trauma	-	-	-	-	.76*	.52*
Demoralisation	-	-	-	-	-	.40*

* Significant at the 0.001 level (2-tailed)

For the AS group, a model comprising mode of arrival (i.e., boat arrival); depression score; refugee trauma score; PTSD diagnosis; Medicare (in)eligibility; number of traumatic events; and torture accounted for 62.1% of the variation in demoralisation scores, F(7,100)=23.44, p<.0001. Refugee trauma score and mode of arrival made the largest unique contributions to the model, each accounting for 5% of the variance. Depression score made the next largest unique contribution, with 4.4%.

As the numbers were significantly smaller for the refugee group (n=33), the regression analysis must be interpreted with caution. Two independent variables (HTQ PTSD diagnosis and HSCL major depression diagnosis) were removed from the model due to multicollinearity. The Adjusted R Square in the final model explained 66.4% of the variation in demoralisation scores for the refugee group, F(6,25)=11.21, p<.001. The predictor variables were: scores on depression, anxiety, PTSD, refugee trauma and post-migration stress; and a (MINI) diagnosis of major depression. However only refugee trauma score (t=3.25, p=.003,11.4%) and depression score (t=2.50, p=.02, 6.8%) made a unique contribution to the model.

While variation in demoralisation scores were predominantly accounted for by clinical measures, social and demographic factors also contributed. These included whether or not the participant had Medicare, experienced torture, number of traumatic events and mode of arrival (with boat arrivals being more vulnerable).

Table 4.15

Demographic, Social and Symptom Score Predictors of Demoralisation

	R Square	Significance	Part correlation
Total Sample	.67	$F(11,37)=6.79$, $p<.001$**	
Refugee Trauma score		$t=2.40$, $p=.02$*	.23
Mode of arrival		$t=2.30$, $p=.03$*	.22
PTSD Diagnosis (MINI)		$t=-2.07$, $p=.05$*	.20
Depression score		$t=2.09$, $p=.04$*	.20
Major Depression Diagnosis (MINI)			
Number of traumatic events experienced			
Score on measures of Anxiety			
Post-migration stress			
Medicare Ineligibility			
Witnessed torture			
Tortured			
Asylum-Seekers	.62	$F(5,78)=25.67$, $p<.001$***	
Refugee Trauma score		$t=3.78$, $p<.001$***	.23
Mode of arrival		$t=3.69$, $p<.001$***	.23
Depression score		$t=3.42$, $p=.001$**	.21
PTSD Diagnosis (HTQ)			
Number of Traumatic Events			
Medicare Ineligibility			
Tortured			
Refugees	.66	$F(6,25)=11.21$, $p<.001$***	
Refugee Trauma score		$t= 3.25$, $p=.003$**	.34
Depression score		$t=2.50$, $p=.02$*	.26
score on measures of Anxiety			
Post-migration stress			
PTSD			
Major Depression Diagnosis (MINI)			

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

Given the unique contribution refugee trauma made to demoralisation in both asylum-seekers and refugees, a *post hoc* one-way ANOVA was performed to examine potential differences in the response pattern of each group. A distinct pattern emerged whereby asylum-seekers scored significantly higher than refugees on particular HTQ items. These items described the following complaints: exhaustion ($F[1,121]=4.71$, $p=.03$), hopelessness ($F[1,125]=4.53$, $p=.04$), feeling people do not understand ($F[1,124]=18.55$, $p<.001$), feeling betrayed by someone trusted ($F[1,124]=6.71$, $p=.01$), mistrusting others ($F[1,120]=4.48$, $p=.04$), feeling powerless to help others ($F[1, 121]=19.27$, $p<.001$), thinking too much about past traumatic events ($F[1,47]=12.97$, $p=.001$), and 'feeling as though you are the only one who has suffered these events' ($F[1,67]=7.38$, $p=.01$).

At T2, 80.1% (Adjusted *R* Square, $F[6,41]=34.26$, $p<.001$) of the variance in demoralisation scores was attributable to: a (MINI) diagnosis of major depression or PTSD; total number of (MINI) diagnoses; and scores on refugee trauma, anxiety and post-migration stress. Of these, the only variable which made a unique contribution (7.7%) was refugee trauma ($t=4.36$, $p<.001$).

A Non-Demoralised Cohort

Twenty-seven of the 131 interviewed at T1 were predominantly asymptomatic (see Table 4.16). None were demoralised (i.e., did not meet caseness according to the cut-off applied) and only two met criteria for MDE and one, for PTSD. Surprisingly, more than half ($n=16$, 59%) were asylum-seekers. Furthermore, four were on a BVE and one was unlawful (i.e. had no visa). The remainder held a BVA, BVC or Student visa. Two had received more than six rejections in the RDP and five did not have Medicare. Four did not have work rights and a further six were unemployed. There was not a significant difference in nationalities represented in the non-demoralised cohort $\chi^2(4)=5.34$, $p=.25$, or visa type, $\chi^2(8)=8.91$, $p=.35$, $n=126$, Cramer's $V=.25$.

Of the 16 asylum-seekers who were not demoralised, two met criteria for MDE and one for PTSD. Another was manic, and one was psychotic (the retrospective diagnosis for the latter two was confirmed with the MINI at T2). Hence, 11 remained, enabling an examination of putative protective factors contributing to the non-demoralised profiles of these participants.

Overall, the number of traumatic events experienced was significantly fewer for the non-demoralised ($M=10.4$, $SD=3.60$, $n=27$) than the demoralised cohort ($M=13.5$, $SD=5.50$, $n=92$), $t(65)=-3.44$, $p=.001$, $n=92$). Furthermore, 8 of the aforementioned 11 participants in the non-demoralised cohort cited even fewer traumatic events, with an average of 7.9.

Torture appeared to be another factor that distinguished between the 11 non-demoralised asylum-seekers and their demoralised counterparts, with only two of the former reporting a history of torture. A Chi-Square test for independence indicated a significant association between torture and caseness for demoralisation with a medium effect size, $\chi^2(1)=8.75$, $p=.003$, $n=117$, phi=.27.

An independent samples t-test revealed non-significant difference in number of rejections between the demoralised ($M=1.69$, $SD=2.58$, $n=97$) and non-demoralised cohorts ($M=1.37$, $SD=2.82$, $n=27$), $t(39)=-0.53$, $p=.60$, despite moving in the expected direction.

The one participant who was not demoralised but had PTSD had been tortured, experienced 12 traumatic events and was on a BVE with nil Medicare or work rights. Regarding the two non-demoralised participants with MDE, both were on BVAs and, although neither had been tortured, one was without work rights whilst the other had been unable to find work and was ineligible for Medicare.

Despite a small-medium effect size, a Chi-Square test for independence (with Yates Continuity Correction) did not find a significant association between Medicare and caseness for demoralisation, $\chi^2(2)=3.97$, $p=.14$, $n=120$, Cramer's $V=.18$. Furthermore, no association was found between demoralisation status and work status, $\chi^2(2)=2.73$, $p=.26$, $n=119$, Cramer's $V=.15$.

A Chi Square test for independence (with Yates Continuity Correction) also failed to find an association between location of partner (i.e. Australia or homeland) and a diagnosis of demoralisation, $\chi^2(2)=0.05$, $p=.98$, $n=126$, Cramer's $V=.02$. Similarly, no association was found between location of children and caseness for demoralisation, $\chi^2(3)=3.47$, $p=.32$, $n=126$, Cramer's $V=.14$.

Finally, whilst not statistically significant ($\chi^2[1]=2.50$, $p=.11$, $n=120$, Phi=.11), none of the five boat arrivals were in the non-demoralised cohort.

Qualitative Data

The qualitative data highlights a number of protective themes for the 11 non-demoralised asylum-seekers and is presented below.

Participant #32 was very religious and drew strength from his faith. When asked if he felt hopeless about the future he stated *"I leave it to my God about my future, so I don't worry"*. He also stated that his religion *"says never suicide, so I'm not allowed to do that".*

Participant #79 had his wife with him and was living with friends at the time of the first interview.

Participant #82 cited nil difficulties since being in Australia (i.e., HTQ Part II b).

Participant #84, despite being on a BVE and not having Medicare, had work rights and a job. She also had her siblings and her three adult children with her. Although she felt anxious about the immigration decision, when asked about fears of repatriation she stated, *"I have positive thoughts"*. When asked whether she felt hopeless about the future, she commented, *"I always think there'll be a bright future".*

Participant #88. It is noteworthy that this participant who, *prima facie* had the most risk factors for a clinical diagnosis, was in the non-demoralised cohort:

he had been on a BVE for many years, cited nine traumatic events, had reportedly received nine RDP rejections, and was without work rights and Medicare. However, at interview, he informed that he had reliable part-time work through a friend, had another GP friend who had treated him *pro bono* for 15 years, lived with friends and was confident that he would ultimately be granted a protection visa.

Participant #92 stated that he engaged with friends and work to distract himself from fears of repatriation, stating, *"When you've lost your mind you've lost everything, so I try not to think about things. I get sad but I don't let myself to go depressed (sic)".*

Participant #103 had received a positive decision at the RRT prior to interview, but was not convinced that he could trust this decision and was still anxious about the final outcome. However he stated through an interpreter, *"Even if I don't have a visa, I am in paradise, comparing to my life in Baghdad. In Australia they value human beings".* He was being supported by the Red Cross and lived with family members.

Participant #105 had his wife and child with him. Although he missed his parents, he reported having "*good supportive friends*" in Australia. While he sometimes worried about repatriation, he was confident after his DIAC interview, stating, *"I'm honest and I don't have any fears".*

Participant #113 had received a positive decision at the RRT three weeks prior, although he was still on a BVA at the time of interview. He was living in private rental with his wife and children, who arrived two years after him.

Participant #124 had his family with him, which reportedly helped ward off loneliness.

Participant #128 spoke through an interpreter, saying that he had felt better in the weeks preceding the interview because of the hopeful words of his caseworker (Red Cross) and lawyer: *"Everyone is giving me support and hope that things are going to work out".* Although his wife and children remained in Afghanistan, he was living at Sanctuary (charity housing) and was financially supported by ASAS (Red Cross).

Demoralised Cases at Follow-up

Twelve of the original non-demoralised cohort (*n*=27) were re-interviewed. Of these, nine remained asymptomatic and only one subsequently met criteria for demoralisation, MDE and PTSD. Interestingly, this participant had been granted PR six months prior to the follow-up interview. On closer inspection, this participant had reported pre-existing physical health problems and was distraught about being separated from her adult children. One of her children had developed a mental health condition and two of the participant's other children were financially dependent on her and her husband, who were unable to send money back home. A precipitating factor for the participant's major depression appeared to be the Pakistani floods which had damaged their house, and a fatal bomb blast in the vicinity of their home which increased concerns for her children's safety.

One of the two remaining participants who had become demoralised at T2 also had been granted PR but cited the withdrawal of support during the transition to settlement as one of the negative changes since the first interview: *"The ASRC was very supportive while I was with them, with financial help and phone calls to check how you are, and then suddenly all this support is removed".* The other negative factor cited was being unable to find work in his previous profession (university lecturer) and having to do physical work instead: *"Am I going to die like this? It's demoralising to lose your career. I don't have direction now and feel very hopeless."*

The final participant who was demoralised at follow-up was an asylum-seeker who had been rejected at the RRT four months after the first interview and was awaiting a Federal Court hearing. He was well-connected with a church community which were housing him and his wife. He had been unable to find work and did not like relying on charity, but was engaged in voluntary work.

At T2 only two participants had changed status from meeting criteria for both MDE and PTSD, to being asymptomatic. Both were asylum-seekers. One was a young Iraqi on a BVC at both time points; he had a psychotic break one month after the first interview and subsequently became substance-dependent. At T2 (18 months later) he was asymptomatic and attributed this to a number of factors. He had since secured Medicare and work rights, had completed a course and had attained work. Most significant for him however, was the support received from ASRC staff who had advocated for him and the support from friends made through work.

The other non-demoralised participant at T2 (22 months later) was still on a BVE and maintained his Medicare and unemployment (but with work rights) status.

He had been on Red Cross' intensive support (CAS) program for nine months and was one of the few who described their DIAC case officer as actively supportive. Although he had significant financial problems, his social support had increased over time (e.g., attending the temple more regularly and doing community work). Possibly the most significant factor, however, and despite having received another rejection in the courts, was the belief that he would ultimately get PR due to his daughter's recent citizenship status.

Table 4.16

Case Summaries of Non-Demoralised Cohort at Time 1

Participant	Visa Status	PTSD I	MDE I	No. of Rejections	Torture	No. of Traumatic Events	Medicare I	Work Status I	Visa Status II	Medicare II	Work Status II	Demoralisation II	PTSD II	MDE II
3	PR	No	No	10	No	10	Yes	Work	-	-	-	-	-	-
4	PR	No	No	6	No	13	Yes	Work	PR	Yes	Work	No	No	No
8	No Visa	No	No	5	No	10	No	Work	PR	Yes	Work	No	No	No
32	BVE	No	No	2	No	7	Yes	Work	-	-	-	-	-	-
35	PR	No	No	0	-	8	Yes	No Work	-	-	-	-	-	-
46	BVA	No	No	0	No	10	Yes	Nil WR	PR	Yes	No Work	Yes	Yes	MDE
51	PR	No	No	0	No	11	Yes	No Work	-	-	-	-	-	-
59	PR	No	No	0	Yes	15	Yes	Work	-	-	-	-	-	-
61	PR	No	No	0	Yes	20	Yes	Work	-	-	-	-	-	-
79	BVA	No	No	1	No	9	Yes	No Work	BVA	Yes	No Work	Yes	No	No
82	Student	No	No	0	No	8	(other)	Work	PR	Yes	Work	No	No	No
84	BVE	No	No	3	No	10	No	Work	-	-	-	-	-	-
88	BVE	No	No	9	No	9	No	Nil WR	BVE	No	Work	No	No	No
92	BVA	No	No	0	No	9	Yes	Work	-	-	-	-	-	-
93	PR	No	No	0	No	8	Yes	Work	-	-	-	-	-	-
99	Student	Yes	No	0	Yes	13	(other)	Work	-	-	-	-	-	-
103	BVE	No	No	0	Yes	12	No	Nil WR	PR	Yes	Work	No	No	No
105	BVA	No	No	0	No	6	Yes	Work	BVA	Yes	Work	No	No	No
107	BVA	No	Yes	0	No	11	Yes	Nil WR	-	-	-	-	-	-
108	PR	No	No	0	No	12	Yes	No Work	-	-	-	-	-	-
113	BVA	No	No	1	No	11	Yes	Work	-	-	-	-	-	-
114	PR	No	No	0	No	13	Yes	Work	PR	Yes	Work	No	No	No
116	PR	No	No	0	No	4	Yes	-	PR	Yes	Work	No	No	No
119	BVA	No	Yes	0	-	6	No	No Work	-	-	-	-	-	-
124	Student	No	No	0	Yes	16	(other)	Work	PR	Yes	Work	No	No	No
126	PR	No	No	0	No	15	Yes	No Work	PR	Yes	No Work	No	No	No
128	BVC	No	No	0	No	5	-	-	-	-	-	-	-	-
TOTAL	27	27	27	27	25	27	26	25	12	12	12	12	12	12

Cluster analysis

Although a large proportion of the sample was demoralised, demoralisation was inter-correlated with the other four clinical measures (refer to Table 4.14). Hence, a *post hoc* data reduction analysis was conducted to explore the specific clinical (symptom) characteristics of the asylum-seeker population. A Hierarchical Cluster Analysis using Ward's Method was performed to explore possible taxonomies based on clinical clusters (by case) with items from the clinical scales as continuous independent variables (i.e., anxiety, depression, demoralisation, PTSD and refugee trauma). Variable values were standardised using *Z* scores but measures were not transformed. In order to satisfy the multicollinearity assumption, a Spearman's rho correlation matrix of all clinical scale items (*n*=92) was produced. Items which correlated >.6 and all items with duplicated content were removed. Where PERI and HSCL or HTQ items converged, the PERI-D item was removed based on both the scale being unvalidated in the forced migrant population and heterogeneity regarding time points (i.e., 'since applying for PR' *vs.* the 7-day timeframe of the HTQ/HSCL). Where HSCL and HTQ items were replicated, items with the higher mean score was retained. This process resulted in 19 items being eliminated: HSCL items 12, 17, 24; HTQ items 8, 13, 14, 23, 24; and PERI-D items 10, 12, 15, 16, 17, 19, 20, 22, 24, 26 and 27. After omitting the aforementioned items, a total of 73 scale-item variables remained. Boxplots were produced for each item and no extreme scores were found.

While a ratio of at least 2:1 (and preferably 5:1) case: IV is ideal, for many data reduction analyses (e.g., discriminant analysis, factor analysis, PCA) (Kline, 1994, p.73-4), there is no rule of thumb regarding the sample size necessary for cluster analysis (Donicar, 2002). The present cluster analysis was conducted with 73 independent variables and a sample size of 95 (excluding missing values). However, given the low case: IV ratio, results need to be interpreted with caution.

The cluster analysis dendogram suggested a two-cluster solution. Hence, the sample (*n*=88) was divided into two groups (*n*=48 and *n*=40) based on symptom score severity (Group 1 > Group 2) with no scale items distinguishing between the groups. A second level divided Group 1 (*n*=48) into a second two-cluster solution. This produced two groups (*n*=23 and *n*=25) which were distinguished by both severity (scores) and clinical scale items. PERI1 and HSCL22 were eliminated at the first and second level analysis, respectively, due to non-significance. The remaining 39 discriminating items are listed in Table 4.17.

A *K-means* cluster analysis was then performed on the categorical data such that missing values could be excluded pair-wise, resulting in no missing cases (n=95). All relevant categorical variables were entered (n=23) and three (*a priori*) clusters produced a solution with 31, 20 and 44 asylum-seeker cases in each group, respectively. Chi-square analyses revealed significant differences between the three clusters on the following variables: Sex (χ^2[2]=13.80, p=.001, n=95, Cramer's V=.38), Work status (χ^2[4]=11.32, p=.02, n=90, Cramer's V=.25), Visa status (χ^2[14]=108.4, p<.001, n=95, Cramer's V=.66), Medicare (χ^2[2]=12.16, p=.002, n=86, Cramer's V=.38), Medical diagnosis (χ^2[6]=24.5, p<.001, n=93, Cramer's V=.38) and Prescribed medication (χ^2[14]=98.79, p<.001, n=93, Cramer's V=.72).

The first cluster was characterized by those on a BVE who were working (53%) but without Medicare (70%). Cluster 1 also had the greatest proportion of those with a psychiatric diagnosis (23%). The second cluster was characterised by non-working individuals (85%) on a BVA or BVE, with a medical diagnosis (65%) and prescribed medication (predominantly anxiolytics/sleeping tablets - 30%) but without Medicare (63%). Cluster 2 also had the largest proportion of females (35%). The third cluster was characterised by individuals on a BVA or student visa without a medical or psychiatric diagnosis (72%) and not prescribed medication (90%). Cluster 3 had the greatest proportion of individuals with work (80%) and Medicare rights (70%).

Principal Components Analysis

Finally, two principal components analyses (PCA) were undertaken with the total sample. Due to the large number of scale items and in order to obtain a case: IV ratio of at least 2:1, the PCA was undertaken separately for demoralisation and depression/anxiety; and demoralisation and PTSD. An oblique rotation was performed with the PERI-D and HTQ PTSD items (1-16) and four factors emerged: Factor 1 – PTSD; Factor II – 5 of the 8 PERI-D subscales (dread; confused thinking; anxiety; physiological symptoms; and perceived physical health); Factor III – hopelessness/helplessness, sadness and loneliness; Factor IV – Poor Self-esteem.

Similarly, an oblique rotation performed with the PERI-D and HSCL items resulted in four factors. Factor I – the HSCL anxiety subscale items (1-10); Factor II – 5 of the 8 PERI-D subscales (dread; confused thinking; anxiety; physiological symptoms; and perceived physical health); Factor III – Poor self-esteem and hopelessness/helplessness; and Factor IV – melancholic depression symptoms (i.e., crying easily, anhedonia, suicidality, hopelessness and worthlessness).

Suicidality

In an effort to distinguish demoralisation from major depression in the current sample, a Spearman's rho correlation matrix for the total sample was performed to ascertain the relationship between suicidality (HTQ20) and the key features of demoralisation (hopelessness) and major depression (anhedonia and depressed mood), respectively.

Suicidality correlated moderately with the following items: HTQ14 ('feeling as if you don't have a future'), r=.46, p<.0001, n=127; HSCL17 ('feeling hopeless about the future'), r=.43, p<.0001, n=128; HTQ29 ('hopelessness'), r=.45, p<.0001, n=127; HSCL25 ('feeling of worthlessness'), r=.45, p<.0001, n=128; and HTQ13 ('crying easily'), r=.45, p<.0001, n=128. The highest correlation between the suicidality item and items from the demoralisation scale was with PERI12 ('Attacks of sudden fear or panic'), r=.41, p<.0001, n=127. The latter item was frequently responded to by participants in the context of concern about family back home or regarding the Department of Immigration. For example, one man [#47] said he felt this way, "*when refused the first time from DIAC and whenever I get a refusal by Immigration*".

Items pertaining to anhedonia had a weak to moderate correlation with thoughts of suicide, i.e., HTQ13 ('less interest in daily activities'), r=.35, p<.0001, n=127 and HSCL23 ('feeling no interest in things'), r=.40, p<.0001, n=128.

A Chi-square test of independence revealed major depression and demoralisation to be related $\chi^2(1)=26.62$, p<.0001), with a large effect size (phi=.48). Whilst two-thirds of those demoralised (n=99) also had major depression (n=65), only two in the depressed group (n=67) were not demoralised.

While there was no significant difference in scores on PERI9 ('completely helpless') and PERI10 ('completely hopeless') by residency status, asylum-seekers scored significantly higher on 'feeling hopeless about the future' (HSCL17) (t[126]=-2.83, p=.01), 'feeling as if you don't have a future' (HTQ14) (t[125]=-3.11, p=.002) and 'hopelessness' (HTQ29) (t[125]=-2.13, p=.04). They also scored significant higher on 'thought of ending your life' (HSCL20), t(98)=-2.88, p=.01. However, this item emerged as having the second lowest mean score for all 25 HSCL items (M=1.56, SD=0.99), and was the lowest of the 15 depression items. HSCL20 was the lowest scoring HSCL item for the PR group. The highest scoring HSCL items for the AS group were 'worry too much about things' (M=3.24, SD=1.02), 'feeling lonely' (M=3.14, SD=1.09) and 'feeling blue' (M=3.00, SD=1.07).

Table 4.17

Clinical Scale Items for Cluster-Specific Discrimination in Asylum-Seekers

	CLUSTER 1 (*n*=23)	**CLUSTER 2 (*n*=25)**	
Scale Item Descriptors	***M* (*SD*)**	***M* (*SD*)**	***Significance***
HTQ – PTSD			
1 – Intrusive memories	3.83 (0.39)	3.24 (1.88)	$F(1,46)=8.66$, $p=.01$**
2 – Re-experiences event	3.57 (1.00)	2.76 (1.17)	$F(1,46)=6.60$, $p=.01$*
4 – Feels detached from others	3.30 (1.06)	2.52 (0.92)	$F(1,46)=7.52$, $p=.01$**
5 – Emotionally numb	2.65 (1.19)	1.96 (0.89)	$F(1,46)=5.26$, $p=.03$*
6 – Easily startled	3.13 (0.97)	1.92 (0.95)	$F(1,46)=19.02$, $p<.0001$***
7 – Poor concentration	3.74 (0.54)	2.88 (0.97)	$F(1,46)=13.99$, $p=.001$**
10 – Irritable/ angry	3.65 (0.65)	2.32 (0.90)	$F(1,46)=34.13$, $p<.0001$***
15 – Avoids traumatic thoughts/ feelings	3.61 (0.58)	2.96 (1.02)	$F(1,46)=7.15$, $p=.01$*
16 – Sudden emotional/ physical reaction to trauma cue	3.35 (0.94)	2.68 (1.03)	$F(1,46)=5.50$, $p=.02$*
HTQ – Refugee Trauma			
19 – Exhaustion	3.78 (0.42)	3.00 (0.91)	$F(1,46)=14.11$, $p<.0001$***
20 – Bodily pain	3.48 (0.73)	2.00 (0.96)	$F(1,46)=35.69$, $p<.0001$***
21 – Physical problems	3.04 (1.07)	1.96 (1.06)	$F(1,46)=12.46$, $p=.001$**
22 – Poor memory	3.35 (0.83)	2.40 (1.00)	$F(1,46)=12.62$, $p=.001$**
26 – Unable to make daily plans	3.04 (1.15)	2.36 (1.04)	$F(1,46)=4.71$, $p=.04$*
33 – No-one to rely on	3.26 (0.96)	2.32 (0.99)	$F(1,46)=11.12$, $p=.002$**
36 – No trust in others	3.00 (1.00)	2.32 (0.99)	$F(1,46)=5.61$, $p=.02$*
37 – Powerless to help others	3.91 (0.29)	3.36 (0.91)	$F(1,46)=7.81$, $p=.01$**
HSCL – Anxiety & Depression			
1 – Suddenly scared, no reason	3.39 (0.84)	2.24 (1.17)	$F(1,46)=15.21$, $p<.0001$***
2 – Fearful	3.78 (0.42)	2.28 (1.02)	$F(1,46)=42.97$, $p<.0001$***
3 – Faintness/ dizzy/ weak	2.61 (1.08)	1.72 (0.84)	$F(1,46)=10.24$, $p=.002$**
4 – Nervous	3.52 (0.67)	1.88 (0.67)	$F(1,46)=72.88$, $p<.0001$***
5 – Heart racing	2.96 (1.22)	1.72 (0.84)	$F(1,46)=16.85$, $p<.0001$***
6 – Trembling	2.09 (1.04)	1.36 (0.49)	$F(1,46)=9.84$, $p=.003$**
7 – Tense/ keyed up	3.35 (0.83)	2.28 (1.28)	$F(1,46)=11.58$, $p=.001$**
8 – Headaches	3.39 (0.72)	2.32 (0.99)	$F(1,46)=18.11$, $p<.0001$***
9 – Panic spells	2.65 (1.03)	2.00 (0.87)	$F(1,46)=5.69$, $p=.02$**
10 – Restless	3.35 (0.94)	2.32 (1.15)	$F(1,46)=11.49$, $p=.001$**
11 – Low energy	3.22 (1.00)	2.44 (0.82)	$F(1,46)=8.75$, $p=.01$**
14 – Loss of sexual interest	3.22 (1.04)	2.20 (0.91)	$F(1,46)=12.99$, $p=.001$**
15 – Poor appetite	3.04 (0.98)	2.44 (0.87)	$F(1,46)=5.13$, $p=.03$*
18 – Feels blue (sad)	3.78 (0.52)	3.28 (0.94)	$F(1,46)=5.17$, $p=.03$*
21 – Feeling trapped	3.35 (1.03)	2.40 (1.26)	$F(1,46)=8.09$, $p=.01$**
23 – No interest in things	3.78 (0.67)	3.08 (0.95)	$F(1,46)=8.57$, $p=.01$**
25 – Feeling worthless	3.65 (0.89)	2.84 (1.18)	$F(1,46)=7.19$, $p=.01$*
PERI-D – Demoralisation			
5 – Evaluation of self compared to others	2.52 (1.44)	1.60 (0.91)	$F(1,46)=7.12$, $p=.01$**
9 – Helpless	3.30 (0.77)	2.64 (1.00)	$F(1,46)=6.64$, $p=.01$*
11 – Fears going crazy	2.78 (1.31)	2.00 (1.04)	$F(1,46)=5.28$, $p=.03$*
18 – Anxious	3.61 (0.58)	3.00 (1.00)	$F(1,46)=6.49$, $p=.01$*
23 – Anger expressed somatically	3.30 (0.82)	2.48 (1.19)	$F(1,46)=7.63$, $p=.01$**

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

Interestingly, 58% of asylum-seekers felt 'completely *helpless'* (PERI9) fairly or very often, compared to 36% feeling 'completely *hopeless*' (PERI10) fairly or very often. The rates for the PR cohort on these items were 33% and 36%, respectively. To further investigate, these items were transformed into categorical variables (item score ≥ 3) and put into a Chi-square analysis with major depression (diagnosis). Helplessness, but not hopelessness, predicted a diagnosis of major depression for asylum-seekers, $\chi^2(1)=6.89$, $p=.01$, $n=94$, Phi=.29.

4.6.3 Hypothesis 4

The longer individuals are in the refugee determination process, the greater the level of demoralisation, trauma, depression, anxiety and post-migration stress.

The relationship between time in the refugee determination process (RDP) and all six measures was investigated using Spearman's rho coefficient for the cross-sectional (Phase I) data (Table 4.18). No relationship was found, either for the total sample or when divided into AS and PR cohorts. As the distribution of time in the RDP was highly (positively) skewed, a further analysis was conducted after dividing time in RDP at the median point (into < 6 months and ≥ 6 months). A one-way between-subjects multiple analysis of covariance controlling for residency status was then conducted to examine whether asylum-seekers and refugees in the ≥ 6 month group returned higher scores on PTSD, refugee trauma, demoralisation and post-migration stress. However, results remained non-significant, $F(4,30)=.91$, $p=.75$, Wilks' Lambda=.89. Similarly, a Mann-Whitney *U* test found non-significant results for depression ($U=1924$, $p=.89$, $Z=-.14$), and anxiety ($U=1848$, $p=.60$, $Z=-.52$) symptom scores for the total population.

Table 4.18

Correlations of Time in the Refugee Determination Process by Symptom Scores

	Time in Refugee Determination Process		
Clinical scale	**Total (*n*=128)**	**Asylum seekers (*n*=95)**	**Refugees (*n*=33)**
	r	***r***	***r***
Anxiety	.00	-.00	.14
Depression	-.04	-.07	.20
PTSD	.01	-.01	.24
Refugee trauma	.04	-.01	.26
Demoralisation	.06	.02	.27
Post-migration stress	-.08	-.13	.03

Given the reduction in depression and PTSD symptom scores over time (*M*=16.3 months, *SD*=4.54) for the cohort which were asylum-seekers at both time points (*n*=15, see 4.5.1), a *post hoc* analysis was conducted to investigate sociodemographic variables which may have mediated this outcome. T2 scores were deducted from T1 scores for all symptom measures. T2 Medicare and work rights were subtracted from those at T1; these comprised binary variables of 0 = no work rights /no Medicare and 1 = work rights/ Medicare (or other health insurance i.e., required for international students). The new Medicare and work rights variables were coded as 0 = no change and 1 = change. A Spearman's rho was then performed on the AS-AS cohort between both change in Medicare status and work rights status, and T2-T1 scores for each of the symptom measures. A large negative relationship emerged between change in work rights status and PTSD (*r*= -.62, *p*=.013, *n*=15), refugee trauma (*r*= -.71, *p*=.004, *n*=14) and demoralisation (*r*= -.75, *p*=.005, *n*=12), indicating that being granted work rights was associated with a decrease in symptom scores on these indices at follow-up. A strong negative relationship also emerged between Medicare status and both anxiety (*r*= -.57, *p*=.025, *n*=15) and demoralisation (*r*= -.62, *p*=.033, *n*=12), suggesting that being granted Medicare was related to a reduction in symptoms of anxiety and demoralisation at follow-up for the AS-AS cohort.

4.6.4 Hypothesis 5

The greater the number of rejections in the refugee determination process, the greater the levels of demoralisation, trauma, depression and anxiety.

In the first instance, all subjects with no rejections (*n*=75) were removed from the analysis. The relationship between number of rejections and symptom scores on depression, anxiety, PTSD, refugee trauma, demoralisation and post-migration stress were then investigated using Spearman's rho correlation coefficient. Whilst no relationship was found for number of rejections and any of the clinical measures, when the analysis was repeated using a Pearson's product-moment correlation coefficient for PR (*n*=8) and AS (*n*=43) separately, a moderate positive correlation emerged between number of rejections and PTSD, *r*=.31, *p*=.046, with greater number of rejections being associated with higher PTSD scores in asylum-seekers.

A *post hoc* analysis was conducted to further investigate the relationship between PTSD and number of rejections for asylum-seekers. Caseness for PTSD was established by a cut-off score of 2.50, as validated by the MINI at T2. A Mann-Whitney *U* test revealed that asylum-seekers with PTSD (*Md*=5.0, *n*=23) had a greater number of rejections in the RDP than those without PTSD (*Md*=2.0, *n*=20),

U=141, Z=-2.20, p=.03, r=.34. The asylum-seeker cohort was initially divided into groups of 1-2 rejections (n=20) and ≥ 3 rejections (n=23) and a Chi-square analysis was conducted to investigate the difference between the two groups on caseness for PTSD. No difference was found, $\chi^2(1)=0.37$, p=.23. Further Chi-square analyses were then conducted to determine the number of rejections needed to predict a diagnosis of PTSD in the asylum-seeker cohort. Analyses revealed that ≥ 4 rejections (n=18) predicted PTSD with a medium effect size, $\chi^2(1)=4.37$, p=.04, phi=.32. This trend continued with increased power (effect size), up to ≥ 6 rejections (n=10), $\chi^2(1)=6.98$, p<.01, phi=.40.

4.6.5 Hypothesis 6

There will be a significant positive correlation between PTSD symptomatology and level of post-migration stress.

A Pearson's product-moment correlation coefficient was performed for PTSD scores (HTQ items 1-16) and PMLDC scores at T1, which revealed a moderate positive relationship, r=.49, p< .0001, n=127. This was then repeated with the PR and AS groups separately, which did not differ appreciably from the overall results: the PR group (n=33), r=.51 p=.002 and the AS group (n=94), r=.41, p<.0001.

To further explore differences in the profile of post-migration stressors in relation to PTSD symptomatology between the two groups at T1, a *post hoc* analysis was conducted. Due to all items on the PMLDC not being normally distributed, a Spearman's rho correlation was performed between PTSD scores and the 23 items of the PMLDC for asylum-seekers and refugees separately. The following items had a significant positive relationship with PTSD symptomatology in asylum-seekers (n=94): fear of repatriation (r=.24, p=.02), insufficient money to buy food, pay rent and buy necessities (r=.26, p=.01); difficulty obtaining government welfare (r=.26, p=.01); loneliness and boredom (r=.25, p=.02); isolation (r=.37, p<.0001); and lack of access to preferred foods (r=.26, p=.01).

In contrast, the following items were positively correlated with PTSD symptomatology for refugees (n=33): separation from family (r=.57, p=.001); unable to return home in an emergency (r=.39, p=.02); difficulty obtaining help from charities (r=.37, p=.03); poor access to counselling (r=.40, p=.02); loneliness and boredom (r=.53, p=.002); and isolation (r=.64, p<.0001).

Hence, the only post-migration difficulties shared between asylum-seekers and refugees were those of loneliness/boredom and isolation, with asylum-seekers returning higher scores for both loneliness/boredom (t[125]=-3.45, p=.001) and isolation (t[126]=-2.08, p=.04).

A Spearman's rho correlation conducted at T2 revealed a moderate positive relationship between PMLDC scores and PTSD for refugees, r=.43, p<.01, n=37, and a large positive relationship for asylum-seekers, r=.78, p=.001, n=15. Post-migration stress items for asylum-seekers and refugees at both time points are presented in Table 4.19.

Whilst the relationship between PTSD scores and post-migration stress strengthened over time for the AS-AS cohort (T1 – r=.56, p=.03; T2 – r=.78, p=.001, n=15), the relationship between symptom scores on the two measures weakened over time for the PR-PR cohort (T1 – r=.72, p=.006; T2 – r=.15, p=.65, n=13).

A *post hoc* analysis was conducted to examine changes over time for the items isolation and loneliness/boredom. A paired t-test was performed on these items for the three cohorts (AS-AS, AS-PR and PR-PR). The only significant difference that emerged was in the AS-PR cohort (n=25) for loneliness and boredom, which decreased significantly between T1 and T2 (t[24]=3.46, p=.002).

Table 4.19

Correlations between Post-migration Stressors and PTSD Symptom Scores by Residency Status

Item	Asylum-seekers		Refugees	
	T1 (n=94)	T2 (n=15)	T1 (n=33)	T2 (n=37)
Fear of repatriation	r=.24, p=.02*	r=.57, p=.03*		
Insufficient money	r=.26, p=.01*			r=.49, p=.002**
Difficulty obtaining government welfare	r=.26, p=.01*			
Lack of access to preferred foods	r=.26, p=.01*			
Separation from family			r=.57, p=.001**	
Unable to return home in an emergency		r=.53, p=.04*	r=.39, p=.02*	
Difficulty obtaining help from charities			r=.37, p=.03*	
Poor access to counselling			r=.40, p=.02*	
Loneliness and boredom	r=.25, p=.02*	r=.70, p=.003**	r=.53, p=.002**	r=.42, p=.01*
Isolation	r=.37, p<.0001***	r=.62, p=.01**	r=.64, p<.0001***	r=.51, p=.001**
Unemployment				r=.48, p=.002**
Poor access for long-term health problems		r=.71, p=.004**		

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

4.7 Qualitative Data

4.7.1 Content Analysis of HTQ-R Part II (b)

Six dominant themes emerged in response to the second open-ended question in the HTQ-R Part II:

What is the worst event/s that has happened to you since being in Australia?

The most ubiquitous theme was *Difficulties related to the refugee determination process*, with 60 coded references. The second most frequent theme was *Family separation and worry about family* (32), followed by *Nil work rights or unemployment* (27) and *Insufficient money* (22). *Accommodation difficulties* were raised by 18 participants and *Health care problems* (i.e., medical/mental health problems and not having Medicare) comprised 18 coded references.

A number of subdominant themes also emerged. Seven participants cited experiences relating to *Upheaval in homeland* (i.e., hearing bad news from back home e.g., the arrest, kidnapping, murder or sudden death of relatives/friends) and six reported that among their worst experiences in Australia was having been a victim of a *Physical assault*. *Immigration detention* was the worst event for five participants.

A number of sub-dominant themes emerged from the dominant theme of *Difficulties related to the refugee determination process*. These included:

- Not knowing how to navigate the refugee determination system.
- Having to re-tell traumatic experiences – to lawyers, case workers and at DIAC/RRT hearings.
- Negative experiences with RDP personnel (i.e., DIAC officials and RRT members).
- Negative experiences of the RRT – e.g., being required to provide evidence that was inaccessible, or having presented evidence and not being believed.
- Delays in being notified about determination decisions.
- Uncertainty about the outcome of the RDP and associated worries about being refused.
- Fears of being deported to homeland and consequential harm.
- RDP rejections.

4.7.2 Deductive content analysis of interviews

Themes included in the analysis emerged from the HTQ-R Part II. An initial analysis of the 15 most commonly used words relating to the experience of seeking asylum provided partial convergent validity for the *a priori* themes extracted for the content analysis. These are shown in Table 4.20.

The following *a priori* themes were explored based on previous research (Ahearn, 2000) and the narrative content of the 187 interviews:

RDP related: Waiting; Uncertainty; Worry.

Psychosocial: Work & Structured Activity; Medicare; Accommodation.

Health, Well-being & Coping: Mental health; Medical & Somatic issues; Hopelessness; Helplessness; Hope; Family Separation & Loneliness; Loss.

Protective factors: Support & Community Connectivity; Religion.

Table 4.20

The 15 Highest Indexed Words of the Asylum-Seeker Experience

Word	Count
Family	294
Money	163
Friends	115
Problems	108
Working	104
Waiting	93
Decision	77
Sleep	72
Worry	71
Detention	69
Future	67
Community	65
Support	61
Refused/Rejected	58/57
Stress	58

Refugee Determination Process

Elaborating on the aforementioned themes pertaining to the RDP, many participants spoke of difficulties in giving evidence salient to their case, and contact with RDP personnel and the broader system.

A number of participants spoke of their perception of Australia as a country which welcomed asylum-seekers and expressed their shock and despair when confronted with the realities of the legal procedures for seeking asylum. The long waiting period and the initial rejection for unsuccessful applicants were the first blows to the hopes with which they arrived. Hence, feelings toward the Australian authorities were mixed. Whilst many expressed relief and gratitude for finally feeling safe, this was undermined by insecurity about whether safety would be ongoing. A 27-year-old man who had been at the Primary Stage for 14 months remarked, "*I am not safe in Pakistan. Here I am feeling safe but life is not determined*".

A popular belief for those not interviewed at the Primary Stage (DIAC) was that, if only they had the opportunity to meet with government officials, they would be granted refugee status. A 50-year-old Sri Lankan man who had been in the RDP for 13 years stated, "*If I had an interview I am 100% confident that I could convince them and prove myself to the case officer*". A newly arrived Pakistani man of a similar age stated, "*We felt helpless, like we were dead people. I wanted an interview with DIAC so I could tell my story and the emotions. You can't tell them that on your documents*".

However, an equally common experience for those who participated in an interview or RRT hearing only to have their case rejected, was one of devastation: *"[I thought], I've got an interview at RRT – then hope will return again. I had a 3-hour [RRT] interview and believed I was successful. After I heard the news … I cried and cried*". (25-year-old Sri Lankan male)

A number of participants spoke about strained relationships with their DIAC case officer or negative experiences at DIAC interviews. A 40-year-old Iraqi man relayed the following experience: "*The officer said 'How come we granted you a student visa when you're from Iraq? ... We shouldn't have granted you a visa because you're from Iraq and you won't go back…*'".

There was also a pervasive sense that DIAC officers and RRT members did not believe participants' stories. For one Zimbabwean man, the worst experience in Australia was "*Preparing for the DIAC interview and seeking legal assistance – trying to tell my story to people who don't understand and don't believe you*". There were however, a few exceptions which highlighted the compassion and fairness of some

DIAC officers: "*The DIAC officer was very helpful. She understood my situation about the paperwork being submitted by my lawyer was all wrong (sic). She gave me a chance to correct the gaps in the forms. I still send her a Christmas card … I am very grateful to her*" (36-year-old Assyrian Iraqi male).

While grievances against personnel were prominent, more common were complaints against a system that was experienced as impersonal, impenetrable and to which the applicant felt invisible and impotent. A number of individuals expressed the need for a more expedient process and for applicants to be kept informed of the progress of their case in order to relieve the stress resulting from prolonged uncertainty and powerlessness. The following comments highlight the failure of the system to deliver decisions within its own timeframe. A 40-year-old Iraqi man stated, "*The DIAC interview went for 4 hours. They asked me 200 questions. They apply the law how they want. They say 90 days but it is more and there's nothing the applicant can do. There's no enforcement of the DIAC timeline*". Another concurred:

> *"DIAC do not understand the importance of keeping to deadlines because it makes planning difficult and it's not a healthy state of mind, walking down to the mailbox – it's a bit of a stress. You are powerless to the system. I did my research – by law DIAC says its 90 days, so why's it taking longer? They have the power so you don't want to ask or be annoying them. If they say I have to hand in my application on time and don't then it will go against me. Where's the accountability to them?"* (26-year-old Zimbabwean male)

Another pervasive systemic issue raised was of participants' cases being refused on the basis of inaccurate country information**,** as illustrated by a young Afghani man during his RRT hearing: "*I provided him the biggest proof, but the other thing that shattered me was when he said 'Quetta is like paradise for Hazara people'*". Similarly, a Sri Lankan truck driver who fled after being abducted by the Tamil Tigers stated: "*The RRT don't know what terrorism is… There was a man who was murdered in King Street [Melbourne]. This happens all the time in Sri Lanka but no-one hears about it [in Australia] because there's no media reports*".

Hence the issue of what constitutes sufficient and 'well-founded' evidence was hotly contested. One 28-year-old Pakistani man stated, "*They wanted proof from my brother in Italy which was given, but then they asked for documents from the Italian Government*". Participants were particularly frustrated by the RRT's apparent inability to grasp that 'solid' evidence cannot always be attained. Reasons for this included the risk of endangering others who remain in the homeland, sources

with corroborating information being uncontactable, and difficulties with inter-governmental relations.

One Sri Lankan woman described her experience at the RRT: "*We didn't have evidence in Sri Lanka because it's not safe to get evidence. This is why we had to leave … We are not thinking about collecting evidence; we are just thinking to leave the country for our lives "*. Another asylum-seeker reported that DIAC had given him time to collate his evidence but then rejected his case before the submission date.

The other dominant theme was the impact of the RDP on mental health – in particular, re-traumatisation resulting from repeatedly having to tell one's story. A 23-year-old Hazara man reported that he had fewer mental health symptoms prior to the DIAC interview: "*Now my sleeping time is decreasing and I feel worse. I'm scared to leave home and be with people. It's hard for me to make Immigration appointments*". Another described increased re-experiencing symptoms and emergent psychotic symptoms since his RRT hearing 10 days prior.

Others raised concerns about the influence of psychological symptoms on RRT decision-making processes. For example, a 30-year-old Tamil man with multiple hospitalisations for psychosis stated, "*I went to RRT and was mentally ill but there was no doctor. I was acting like a normal man but it was not normal … the RRT thought I was a liar because when I am anxious I can't talk because of my mental health issues. I tried to cover up my medical situation and sickness because I thought this would go against me*". A Sri Lankan Muslim described dissociative symptoms, common in traumatic memory: "*There are so many things I could tell the RRT but I couldn't remember at the time and I didn't want to say that because it would be like I changed my story*".

In relation to this, a participant reflecting on his experience, recommended systemic changes to take into account the needs of traumatised individuals giving evidence for their cases:

> *"It's re-traumatising. Someone has to be there for us in the room to help them [DIAC officials, RRT] understand the process of trauma. It's worse than the physical trauma, having to re-live it over and over. It's not enough having the legal system educated about trauma. You need a psychiatrist's input in the process – a qualified psychiatrist, a professor, with equal authority as the legal member".* (48-year-old Tamil male)

Anxiety and fear were particularly triggered by notifications of negative RDP decisions and having to report to DIAC on a regular basis, which one participant

described as being "*under surveillance; I'm on parole*". A Tamil man who had been on a BVE for most of his 14 years in the RDP stated, "*Every time I go to DIAC it's like the gallows because I wonder if they'll put me in detention and repatriate me*". A Sri Lankan female reported recurrent nightmares of the Australian Government telling her to "*Go Back*".

After having been through such an intense and often protracted period of uncertainty, finally securing permanent protection did not necessarily guarantee emotional safety. Despite having had PR for 22 months, one young Zimbabwean was still hypervigilant at night, fearful that DIAC would "*come to get*" her. A 22-year-old Zimbabwean man stated, "*The fear of repatriation is still there – just because you have a document, you can't take this away*". Others found it difficult to trust that the Government would not change their mind and repatriate them, as described by this Iraqi man: "*I'm worried that the Government will come up with new regulations. Just because I've got the RRT positive decision, still I'm not sure I am safe*".

Waiting

The waiting was extremely anxiety-provoking due to participants' fate being decided by bureaucratic forces outside their control, as illustrated by a Tamil man on a 3-monthly BVE: "*Only the person who has the wound knows the pain of the wound. This is our life. We're existing. We are not living actually*". He went on to say, "*They [DIAC] mentally kill people… they don't need weapons. But you can't do nothing [sic], you just shut up and wait*".

Many participants described the indeterminate waiting as being the most difficult part of the RDP to deal with. A 48-year-old Tamil man on a BVA stated, "*Being in the lurch is the worst thing you can do to someone. If they can give an answer and not prolong it [it will be good]*". A 60-year-old Tamil man who was interviewed at the Primary Stage and had not heard an outcome after four months, reported that the delay was "*making me traumatic [sic]… the waiting is making me psycho... I thought I would get a quick response and thought I wouldn't feel depressed and lonely, but the frustration is there because of the delay. I didn't think the process of determination would take this long".*

A young Tamil man, who was in detention for three years prior to being released on a BVE, stated "*For 7 months I'm waiting. You're given certain time in life – it's not like money, when it's going, it's gone*". A middle aged Iraqi student also commented, "*My life spins around DIAC ... Everything's waiting …"*

A number of asylum-seekers felt that they would cope better if given a timeframe for a decision on their case, as highlighted by this 51-year-old Pakistani

man: "*If something is clear we can manage, but it's unclear. We are waiting*". For those who were given a timeframe, each day exceeding it was nerve-wracking:

> "*I wouldn't have minded if they say it will be [another] two weeks – then you're not waiting at least. It should be able to be prioritized – it's the rest of our life. Three months is already a long time but at the end of the day you have a 3-month window for planning your future, work ... After that you are hanging around waiting – especially if you have no work rights. But after* that *you get on edge, wondering how long it will take".* (26-year-old Zimbabwean male)

Many had heard stories of other asylum-seekers having waited for years for PR. A 22-year-old Pakistani remarked, "*I am worried that there are many people who are waiting for a decision for 8 or 10 years. These are the years I am waiting for my future*". It was common to know others who had been granted PR while they themselves continued to wait, as for this 22-year-old Afghani man: "*My friends have all got visas. I'm the last one who hasn't…*". This compounded difficulties, sometimes breeding resentment and suspicion about who were the "genuine refugees" within their own communities. A number of participants spoke of their ethnic or faith communities not accepting them, or "looking down on" them until they acquired refugee status.

Uncertainty

Associated with waiting, living in limbo and not being able to plan one's future was a common theme. Approximately one third of all participants expressed concerns about the impact of protracted uncertainty on their lives. Many spoke of being unable to make plans due to their uncertain short-, medium- and long-term future, as illustrated by this 37-year-old Sri Lankan woman: "*We can't plan for the future – we don't know what will happen tomorrow for us*". A man who had been in the RDP for 6 years, having initially arrived on a student visa explained: *"After waiting for 3 months not being able to plan, not having that independence …and it can be a bit depressing… You're putting yourself on hold. You can't have grand plans because you are waiting for a decision"* (26-year-old Zimbabwean male).

This lack of certainty manifest in the minutiae of asylum-seekers' lives, as illustrated by this 53-year-old Sri Lankan man on departure grounds, having been in the RDP for 13 years: "*I can't decide on anything without thinking what's going to happen tomorrow. Say, fixing my car – why do I spend even $20?"*

The mental anguish caused by the uncertainty was frequently expressed, as captured by a 45-year-old Tamil man: "*What is this life? I feel sorry for myself … because of the uncertainty; I can't stop thinking or shut it off*".

Fears about deportation were common, particularly for those on departure grounds. In response to a question about how often he feels anxious, a 59-year-old Sri-Lankan man on 3-monthly renewal of his BVE, stated "*Always – because there is no concrete foundation. They can take me at any time*". An Afghan refugee who has his wife and four children with him commented, "*Earlier when my status was not known I would worry that if we were deported, what may happen to us*".

Prolonged uncertainty also appeared to exacerbate mental health conditions, especially for those with PTSD. A 27-year-old man who was targeted by the Taliban for his work with an NGO in Pakistan talked about re-experiencing symptoms, saying "*they keep coming into my mind because I have no status here … at the present moment I don't know what will happen to me*". Prior to getting PR, a 47-year-old Sri Lankan woman described the impact of 6 years in the RDP: "*When in limbo I was feeling very unsecure [sic] because the Government kept me a long time in limbo so I find it hard to cope with other people. They don't understand my mental problems*".

One Sri Lankan man, a 12-year veteran of the RDP who spent much of that time on a BVE without work rights or Medicare, reflected on the years of living in limbo from the vantage point of having had PR for 16 months. He stated, "*Getting PR has settled all the other problems caused by uncertainty. The uncertainty … it's like a wrecking ball*". A 38-year-old compatriot concurred: "*It's up and down. When there's a negative decision, everything collapses*".

The proverbial emotional rollercoaster of the RDP expressed by the majority of participants is eloquently encapsulated by the following:

> *"The uncertainty leads to a point where one feels very disappointed. The cycle of hope and uncertainty. All the things work in your mind – what's happened in your past and all. The process of ups and downs when I think about my family and relationship to my refugee status. I worry when the decision is to be made and it's uncertain every time. When you've told someone about you, it's up to others to make decisions about you".* (27-year-old Pakistani male)

Worry

Worry was a pervasive theme, although the focus of worries differed between refugees and asylum-seekers.

For refugees, themes of being employed below their level of qualification, qualifications not being recognised, confronting discrimination in the workforce, having to return to study to upgrade qualifications, and family reunion, were common. Many of these themes are summed up by a well-educated man who had

worked for the Ministry of Foreign Affairs in a Middle Eastern nation:

> *"There are still lots of problems. The most important thing was getting PR and mentally I feel more comfortable but my mind is still busy with problems: 1) family reunion – I am overloaded with responsibilities and my mind is busy, and I'm worried I'm going crazy. 2) I need a financial loan. Did I waste my life doing studies?"* (37-year-old Hazara male)

Waiting for the approval of applications to sponsor loved ones was also a significant issue for refugees, as this Pakistani man disclosed: "*Before I was waiting for myself and now I am waiting for my children for an unlimited time*".

Worry was linked to perceived personality changes in several participants. To one man on a BVE reflected on the changes in him since lodging his application:

> *"It's been 5-6 years so I'm worried it [stress] will affect my health long term because it's been so hard and I've been bottling up so much… I was not a worrying person at all but suddenly when things go wrong now I start worrying. This has changed my nature, the man within me. I am not the person I was; I am a totally different person".* (49-year-old Sri Lankan male)

Interestingly, several refugees reported a reduction in their level of resilience since commencing the RDP, as observed by a Sinhalese man: "*I worry too much about small things now…I'm now in the habit to worry about things*". Furthermore, on receiving a positive decision after many years, a 57-year-old Tamil man commented, "*I was happy after the RRT but it only lasted about one month and now I am back to the worry*".

Worrying about family in the homeland was a pervasive theme for both asylum-seekers and refugees. This was compounded by profound feelings of impotence to assist loved ones in any practical way, as illustrated by this 24-year-old Hazara man: "*I am thinking about my family – watching the news every day knowing there's killing. I'm so far away from them I can't even take care of them*". Keeping abreast of the news in the homeland was extremely common.

> Physical symptoms were also frequently associated with chronic worry. When reflecting on anxiety symptoms, one participant despaired, "*I know they will go up again in the last week before the decision. As soon as you start worrying the headaches and nightmares get worse*". (48-year-old Tamil male).

Psychosocial

Work

Due to the strong work ethic of many, being unable to access employment was a significant problem, as highlighted by this 50-year-old Iraqi man: "*I would like to work, not to stay without work. That's hard – I am used to work, my whole life. I like work. I have too much time to think and feel lonely and depression [sic]*". Without work and compounded by boredom, many fell prey to incessant worry about their legal situation and families back home. One Hazara man asserted that having "*no job or work added to this worry about so many things*". Another participant claimed that the only time his concentration was not impaired was when he was working, reportedly due to the distraction it provided from visa worries.

Furthermore, asking for financial and material support, being financially dependent on others and not being able to send money back home was deeply shaming and associated with feelings of worthlessness and guilt. Unemployment put many in a double bind – not only did this mean financial disadvantage for participants' families, but it also limited the likelihood of visa success if they could not afford a private lawyer to represent them in the appeals process.

Employment also offered social connectivity – a sense of contributing to the community, an identity, sense of efficacy and respite from unrelenting worry.

However, a number of participants did not have work rights for years, as described by a 47-year-old Pakistani man: "*In 14 years my suffering was very great. The main thing with asylum-seekers is cutting off their work rights. They're not giving them a way out*". The burden of poverty and damaged identity took its toll for many. A 36-year-old Sri Lankan man stated, "*Having no work rights affects your feeling about yourself*". A 59-year-old Tamil man stated, "*Actually, my good life is ruined … I am a person with a lot of skills*". An Iraqi doctor who found work as a nursing assistant, commented, "*I have the confidence but I don't have the resources … I have little opportunities to be useful*". A psychiatrist of one asylum-seeker allegedly informed his client that, whilst his patient had depression, if he was able to get work his condition would likely remit. Many participants drew the same conclusions: "*I could earn money and help others. If I can do volunteer work I'd have a relaxed mind. Now I have a mind full of stress*" (42-year-old Sinhalese female).

Indeed, most sought distraction by "*Trying to keep myself busy and avoiding to think [sic] much about the decision*", as did this young Zimbabwean woman. The combination of a thwarted work ethic and boredom was one of the primary

perpetuating factors in chronic anxiety. As this man described,

> *"I am frustrated because I didn't have a job or anything to occupy my mind so that caused me mental stress … I don't want to be worthless like that. God has created us to do good work – don't be idle. But lying in bed … I feel no interest in things because your mind is not clear and it is worrying… I don't want to get simple money from the Government. That's not the real way. I want to work to earn money".* (47-year-old Tamil male)

Unemployment also perpetuated a feeling of helplessness: "*Not having a job is the biggest problem. Without it, it is hard to help yourself*" (48-year-old Iraqi female). Conversely, being permitted to work bolstered resilience: "*When I do work and show my efforts to everyone, then they know who I am and what I can do for this country*" (41-year-old Pakistani male). Another asylum-seeker attributed a decrease in blood-sugar and cholesterol levels to having secured employment.

Some participants without work rights risked working illegally in order to provide for their families, while others opted to not risk detention. Those who worked illegally described levels of extreme stress, hypervigilant about the possibility of being caught and/or victimised (e.g., as taxi drivers) and not being able to report incidents to police due to their insecure legal status. Those with work rights but on departure grounds were generally unable to secure work due to employers wanting permanent staff. Of those unable to work for whatever reason, several engaged in voluntary work.

Medicare

The inaccessibility of free or rebated health care was a significant issue for those ineligible for Medicare. In addition to medical services, such individuals are also precluded from accessing counselling in the community through Medicare-registered counsellors in private practice, and (frequently) counselling through community health centres due to not having a health care card.

Notwithstanding this, the burden of health care was greatly reduced for those on ASAS or linked in with the Red Cross. A 47-year-old Sinhalese woman spoke of her experiences trying to access health care and of the 'gap' filled by Red Cross: "*At least treat me as a human being until I get the final decision. It was the same with Medicare – in 2002 we needed to get surgery for my son's amputated finger. We did not have Medicare, but the Red Cross paid for it*".

Another participant was not so fortunate, having received a $20,000 bill for cancer treatment which was ultimately paid through money raised by friends and a

contribution from a faith-based organisation. Many others spoke about chronic or even minor health conditions deteriorating over time due to inaccessible health care. In the words of a young Zimbabwean man who could not afford a $50 consultation with the GP: "*They asked if I had Medicare. When I said no they said 'sorry we can't help you'. It's pretty disadvantaged without Medicare*".

A 62-year-old Sri Lankan man whose mental health symptoms were surprisingly low despite being on a BVE and having been in the RDP for 15 years, could possibly be explained by the fact that he had regular cash-in-hand work through a friend and health care through alternative means. He reported that a GP friend had been treating him *pro bono* for 15 years because he did not have Medicare.

Accommodation

Unstable accommodation was a problem for many and ranged in severity from sleeping on the street and train stations, to living in rooming houses, transient crisis accommodation and couch-surfing. One young Iraqi man stated, "*I was living in King Street [in a rooming house]. There were druggies around and I was not feeling safe. Two people just got out from jail. There was fighting all the night – constantly there were ambulances and police*".

Insufficient money precluded most from the private rental market. This forced many to live off the charity of friends, family or faith-based organisations.

Health, Well-being & Coping

Mental health

There were many references to mental health symptomatology, predominantly fitting within the categories of anxiety, major depression and PTSD. However symptoms in the psychotic range were also described, including delusions, hallucinations, paranoia and dissociation.

Many participants attributed their mental health problems to being subject to the various conditions associated with the refugee determination process. A 60-year-old Tamil man (who did not meet the criteria for MDE), reported: "*Delay in determination of my case is making me depressed. I can't find a job also because of my age, and my qualifications are from Sri Lanka and aren't acceptable here. Loneliness, joblessness, lack of income makes me worry and very depressed*". A young Zimbabwean who also did not meet criteria for MDE, stated: "*I didn't feel depressed or lonely when I first came here. The process of applying for protection triggered depression in me that*

I didn't know was there". A Sri Lankan man on departure grounds and being treated for major depression despaired, "*before the last rejection I was waiting to hear for 12 months. My depression symptoms went up when rejected before*". Another, Sinhalese man, spoke of his "*mental power going down*" after waiting for more than 10 years for a positive outcome.

While, for a number of participants, mental health conditions or symptoms pre-dated their arrival in Australia, there was the distinct impression that anxiety and depressive symptoms in particular were reactive rather than endogenous in nature, as exemplified by this 45-year-old Sri Lankan man: "*I got the visa and other people who got the visa – 80-90% of problems go away*". This quote came from a participant who presented as hypomanic with suicidal intent at his first interview. By his own admission, he acknowledged, "*Last time my mind wasn't well*". However, at the follow-up interview (22 months later, having had PR for 4.5 months), not only did he no longer meet a criteria for any mental health disorder, he also reported that his cholesterol problems had resolved and his diabetes medication had been halved.

Those who were suicidal were typically suffering from a psychotic disorder (e.g., Major Depression with psychotic features) or spoke of suicidal ideation and suicide attempts during a period of immigration detention (i.e., those on TPVs). Suicidality was more commonly expressed as a pragmatic decision rather than one stemming from existential despair or major depression. For example a Tamil man disclosed: "*I only worried about my case, for being deported. It's better to commit suicide. I know what is there*"; and "*I don't want to be a burden to this country. If I am a failure, I will suicide myself [sic] in my country*". A Pakistani man who arrived in Australia with his wife stated, "*After we got the DIAC rejection letter it was very shockful [sic]. After that my wife was all the time crying and had to see a doctor for depression. We didn't want to be alive at that time. My wife said many times 'if we have to go back to Pakistan I will kill myself'*".

Medical and somatic issues

In addition to mental health symptoms, many cited somatic complaints such as sleep disturbance, headaches and concentration difficulties as being directly linked to the vicissitudes of the refugee determination process: "*Back home I didn't have sleep problems. But I do now because of the worry and anxiety – the uncertainty of the future*". (35-year-old Afghani male)

Among those experiencing physical symptoms and conditions, diabetes, high blood pressure, bodily pain and poor appetite/weight loss were the most common

(*n*=12-13). However, sleep disturbance (*n*=50) and headaches (*n*=25) were the most commonly reported somatic problems. Other conditions and symptoms included digestive problems (*n*=10), nightmares (*n*=10), dermatological conditions (*n*=4), heart problems/chest pain, ulcers, memory problems (*n*=6), dizziness/weakness, respiratory difficulties and vitamin deficiencies (especially, vitamins B and D).

Despite the high prevalence of mental and physical suffering, adhering to a prescribed pharmacological regimen was very unpopular. Many stated their reluctance to take medications, or would take them erratically depending on their current state of mental or physical distress. This pattern paralleled the use of psychiatry and counselling appointments, whereby participants would engage in treatment at times of acute need, and cease contact when their situation had stabilised. Re-engagement was most common around the times of RDP rejections and many participants stated that they ceased seeing their counsellor once they were granted PR.

Helplessness and hopelessness

Whilst related, these two themes need to be distinguished. Many participants felt helpless – as in powerless to change their situation, their 'hands being tied'. However, a firm belief in the authenticity of their story and a desire to contribute to Australia appeared to protect many from unrelenting hopelessness. For example, an Iraqi man who had been waiting for 18 months stated, "*I have the confidence but I don't have the resources… I have little opportunities to be useful*". Another man on a BVE who had been in the RDP for 14 years wished to contribute to society, but lamented, "*I'm tied, like in a jail cell*".

Similarly, many others did not feel useless, but powerless, as for this 24-year-old Zimbabwean man: "*It's not that I am worthless but because of the circumstances*". Specifically relating to the contribution of denied work rights to feelings of helplessness, an Iraqi woman reflected the thoughts of many others in stating, "*not having a job is the biggest problem. Without it, it is hard to help yourself".* However, an extension of the experience of helplessness was the inability to support family back home.

Whereas helplessness was associated with a lack of autonomy and frustrated ambitions to work, study and re-build a life, hopelessness was associated with the RDP process itself. Furthermore, feelings of hopelessness seemed to fluctuate more than helplessness and were more closely associated with RDP rejections rather than time in the RDP.

When asked about how often they felt completely hopeless, many participants reported that this was dictated by the progress of their legal case at the time, "*because it all depends on our case*". Hence, examples of common responses regarding hopelessness were: "*whenever I go to the courts*"; "*after the RRT rejection*" and "*only when I got a [rejection] letter from Immigration*". A young Zimbabwean man who had had PR for 3 months after achieving a successful outcome at the RRT, stated, "*I always had hope that things would work out. The only exception was the negative decision*".

Hope

Hope was sustained by a number of factors, including support from others (such as case managers, lawyers and DIAC case officers) and changes to circumstances to improve the likelihood of a positive outcome for one's case (such as a child getting citizenship, a DIAC interview request, or police checks having commenced). However, hope was often tenuous, and fluctuated: "*Two weeks ago I was very flat, but then we got our daughter's Citizenship. Now I have hope again…. this strengthens our case with the Minister*" (36-year-old Sinhalese male). After being asked to submit forms for health and police checks, a Pakistani man stated, "*My friends say 'you're a completely different person now. You are positive now*'".

Particularly for those early in the process and yet to receive their first rejection, the conviction of the authenticity of their claims translated to the belief that this would result in a positive decision, especially if they had been interviewed by DIAC about their story. Conversely, a young Pakistani man at the Primary Stage, stated "*I was refused the first time – I did not have an interview so did not have a chance. She gave us lots of hope and after that took it away. They asked me to write a letter but they didn't then consider it*".

Others took comfort in the fact that, as long as they hadn't been repatriated, hope remained. One Sri Lankan man found hope in the knowledge that his case had not been forgotten: "*The only satisfaction is that they are looking at my file, so I'm not just another number*". However, there were also indications that multiple rejections eroded hope over time, as indicated by this 26-year-old Zimbabwean man: "… [re: hopelessness] *only in the 2-3 weeks since my Ministerial rejection. For previous rejections I was more hopeful*".

For those with children, this relationship kept them "strong". One Sri Lankan man commented, "*Contact with my kids keeps me alive*". For others, children provided the means to keep fighting: "*I don't like the fight for a visa but I will because*

of my children. Every day we're feeling not good, not happy. Sometimes I wishing (sic) everyone died in the tsunami. … Because I don't know what will happen to us" (37-year-old Sri Lankan female).

Hope was also attenuated by personality factors and internal resources. For example, a 27-year-old Zimbabwean man declared, "*I'm a positive person, when things don't work out, I try to comfort myself*". A 23-year-old Hazara man, despite mental health symptoms, stated, "*In the back of my mind I still think maybe something good will still happen to me, so I fight against these things because I don't want to be a 'psych' patient*".

Family separation and loneliness

The combination of poverty, not having work or structured activity to distract from the worry and uncertainty, and loneliness was a heavy burden for most, particularly those who did not have family with them. Loneliness stemmed not only from being separated from immediate family, but also extended family and social networks to re-connect individuals to their pre-migration identities. A Roman Catholic Pakistani man stated, "*It is very hard to live alone when you used to live in an extended family and community. My wife cries at night because she misses her children and grand-children. She says 'better to die in our country than to be without children'*".

A sense that those from the Australian culture could not understand the pain caused by such separation was common. While many spoke of developing friendship networks over time, a common theme of not discussing details of their circumstance or sharing worries remained. For some, this was a way of avoiding thinking further about their problems, but for others it was driven by a belief that others would not understand or could not do anything to alleviate the pain. For example, one man remarked, "*I'm just a lonely person. It's something that a counsellor doesn't help because they can't bring my wife*" (31-year-old Zimbabwean male).

A number of participants were not able to contact family members due to the possibility of putting them in greater danger, because they were incommunicado due to destroyed telecommunication infrastructure, or because family members had disappeared for one reason or another. The magnitude of anguish caused by such separation is reflected in the following comment by a 34-year-old single Iraqi man: "*I am used to the war, but the more problem [sic] is missing my family … I am missing my family and nothing is going quickly. The sadness is always there*".

Loss

The sense of loss was pervasive: material loss, loss of status and identity, loss of family and loss of hopes and dreams. A common expression used to describe the

refugee and asylum-seeker life was "*starting from zero*".

Post-migration losses were often felt to compounded pre-migration loss, as illustrated by the following:

> *"I feel like I'm in an open jail. No-one is here for me. In 15 years I haven't seen my family. I haven't seen my daughter since she was born. I lost my mother on Mother's Day. I wonder why I am living. Because I'm living I have to tolerate all this problem [sic]. I was in the biggest refugee camp in Sri Lanka with my family. I lost everything. Property, money, everything."* (57-year-old Tamil male).

Many spoke about the death of parents and other relatives and not being able to attend their funeral because of visa conditions. Others were unable to attend weddings of children in the homeland or be present for the birth of grandchildren. One Pakistani woman lamented, "*It is important in our culture for the mother of the pregnant woman to be there for the pregnancy and birth, but I am not there*". Many young men and women on student visas had to discontinue their course due to troubles in their homeland resulting in cessation of financial support, or being unable to meet the demands of their studies due to chronic worry about their asylum cases and family back home interfering with concentration and memory.

For those granted PR, after the elation of having won permanent protection, a period of unanticipated grief was the rule rather than the exception. Reflecting on coming to terms with this grief, a 36-year-old Sri Lankan man shared, "*Even though I've got PR I feel like I have lost 15 years that I can't get back. 15 years of regrets is a very long time*".

It was sometimes hard to distinguish depression from grief reactions, as illustrated by this 50-year-old Sri Lankan man: "*It's a big ask to go to court, get the documents, it's a big stress. I feel whatever I say, they don't believe me. I feel like the best part of my life is wasted, that alone can be a depression [sic]*".

Protective Factors

Support and community connectivity

The theme of support was significant both in terms of its presence and absence. Friends took on the role of family in some cases. For example, a 26-year-old single woman from Zimbabwe stated that the neighbours in her apartment block "*are surrogate family – they remember and celebrate birthdays and Christmas, and socialise*". In many cases, friends were a source of sustenance: "*Friends will help keep me distracted but when I'm on my own all the time I have these thoughts. When I am*

alone I cry. I don't feel like eating, but my friends force me to" (27-year-old Pakistani male). For those who were able to ask for and accept support, this helped ameliorate mental suffering. One Zimbabwean man remarked, "*Friends are an important support; the only thing to keep my sanity is being able to talk to people*".

Support from NGOs was also an important lifeline in many cases, with a number of participants citing the Red Cross, ASRC, counsellors, caseworkers and housing workers as contributing to the attenuation of social isolation and loneliness caused by separation from family and friends in the homeland. As one Sri Lankan woman described, "*I have more hope and Red Cross and ASRC are helping me a lot. Without the support I cannot do it on my own. I feel less stress now than before and feel I am coping better*".

One participant, an Afghani Muslim, found meaning in being a "mediator" and trying to "*bridge the gap between the generations in the community – teaching the younger generation how to respect the elders according to their religion and culture*". In some cases local communities provided written support for asylum-seekers. One woman spoke about the importance of community support in keeping the hope alive in asylum-seekers:

> *"It depends on their personality and if they're strong and how much support they have in the community. I am very strong and have beautiful friends. I built a community and they helped me. People would give me their clothes. Three hundred and fifty letters were written from my community – to the Melbourne MP, the Minister, local MP all describing who I was as a person. That's the way I got the visa. I had my own veggie garden, so I would make dinner for others. These are the two reasons why I got the visa: who I am and community power"* (48-year-old Sri Lankan female).

Notably, one of the few negative comments regarding community support came from an Afghani man who had arrived by boat with his wife and four children. He was the only participant who was being held in community detention, which raises questions about the different experiences asylum-seekers have of community support (or lack thereof), even between those in community detention and those who live freely in the community. He stated, "*…in the Hazara community it's ok but the rest of the community is like they are deaf and blind*". Perhaps in line with this, others who felt disconnected from the community were those not engaged in (paid or voluntary) work: "*My hands are tied. It's inhumane. I am not allowed to contribute to society. I want to work hard*"; and "*I was doing a good job in my home country. So*

here I feel like a useless person, not a part of things. I have no friends or family here… I am just walking and talking and eating and sleeping – it's not a life" (24-year-old Hazara male).

Religion

For 16 participants, religion was spontaneously cited as a buffer against feelings of hopelessness, as one Catholic Tamil said, "*Religion strongly gives courage and willpower. I have faith in religion and… I have my willpower*". Another theme was that of support offered by faith communities: "*Without the support I cannot do it on my own. I feel less stress now than before and feel I am coping better. I also go to the temple for religious activities. This is very important"* (41-year-old Sinhalese Buddhist male). Another Sri Lankan Buddhist reflected on the inner peace offered by his faith: "*Religion makes people cool and calm down. It's important because it helps you keep control of yourself and also gives support*".

Adherence to a religious faith for some was a protective factor against suicide due to suicide being forbidden, particularly for Muslims and Catholics. However religion was also protective in the comfort it provided, as one 47-year-old Pakistani man reflected: "*It helped when I lost hope… If not for my activities in the mosque I may have suicided*". Rituals, reading and memorising the Qur'an, pastoral counselling and time spent with faith communities also offered means of coping with mental health symptoms: "*I go to the mosque to stop the depression and to forget … to be with my community*" (50-year-old Iraqi male).

For some Muslims, the belief that their future was left to the will of Allah relieved them of worry and anguish, whilst others had faith that their prayers for permanent protection would be answered, as captured by this Pakistani Christian, who stated, "*I have hope … I keep that in front of my thought. My faith and prayers help*".

Positive and negative life events at follow-up

The most commonly cited negative changes at follow-up were unemployment/ job loss (n=10) and nil contact with, or worry about, family in home country (n=15). The most commonly cited positive changes were employment/increased work hours (n=12), connectivity to support network/community linkages (n=13) and getting PR (n=15).

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CHAPTER 5: Discussion

5.1 Quantitative Results of Exploratory Research Questions

5.1.1 Overview of findings

PTSD and depression

Previous research has identified PTSD and major depression (MDE) as the two most prevalent disorders in refugee populations, with elevated rates of both in asylum-seekers (Fazel et al., 2005; Steel, Chey, et al., 2009; Steel et al., 2002). The present study adds further evidence of there being higher rates of MDE and PTSD in asylum-seekers than refugees.

The rate of MDE in this study – refugees, 30%; asylum-seekers, 61%; total, 53% – was within the range of other studies employing the HSCL-25. It is noteworthy that when the 1.75 cut-off was applied – the cut-off used in many studies (e.g., Mueller et al., 2010) – the prevalence was 82% for asylum-seekers and 52% for refugees, with a total prevalence of 75%. The MINI-validated prevalence of 61% is still high compared to findings of meta-analyses, although these have also reported discrepancies, ranging from 6% (Fazel et al., 2005) to 50% (Steel, Chey, et al., 2009).

The high prevalence of MDE compared to the aforementioned studies may be attributed to the present sample of asylum-seekers meeting criteria for four key risk factors known to inflate rates of major depression in asylum-seekers compared to refugees. These are: being externally displaced (i.e., living in exile); having experienced a large number of traumatic events; little time having passed since being displaced; and a history of torture (Gerritsen et al., 2006; Loutan et al., 1999; Porter & Haslam, 2005; Steel, Chey, et al., 2009).

Although there was not a significant difference in depression scores for tortured asylum-seekers compared to those without a history of torture, this *was* the case for refugees. However, the proportion of asylum-seekers with a torture history in the non-demoralised group was significantly lower – only 19% compared with 42% for the total asylum-seeker sample. The tortured asylum-seeker cohort had significantly higher rates of PTSD than those not tortured. Furthermore, of the total population, 47% reported a history of torture, placing the total sample in the higher risk category for MDE and anxiety, even after accounting for the relatively small sample size and sampling method (Steel, Chey, et al., 2009). Furthermore, adjusted prevalence estimates of major depression are reported to be 55% in populations where ≥40% of the sample have a torture history (Steel, Chey, et al., 2009).

The prevalence of PTSD in asylum-seekers in this study (52%) is similar to that reported elsewhere (Hallas et al., 2007, 51%; Mueller et al., 2010, 50%; Silove et al., 2006, 52%; Van Velsen et al., 1996, 52%). Despite the fact that participants comprised a convenience sample – which is known to inflate prevalence of psychiatric symptoms – similar rates of PTSD and major depression have been found by Silove et al. (2006; 2007). Silove et al. found a prevalence of 51% for PTSD and 60% for major depression in their prospective study of 73 asylum-seekers undertaking the RDP, employing random sampling. Their sample was strikingly similar to that of the present study: 51% reported a history of torture; 8% had arrived by boat; and an average of 7 (of 16) traumatic events were reported. However, participants had only been in Australia for one third as long as the present sample. Given that time in Australia had no association with the clinical scales in the present study, this is unremarkable. What is significant, however, is the evidence provided by the present study that points to PTSD being associated with asylum claim rejections extending beyond the primary stage of the RDP (i.e., the scope of the Silove et al. study), into the appeals process. This suggests that the appeals process may function as a perpetuating or exacerbating factor for PTSD in asylum-seekers.

Also in keeping with the literature (Mollica, Wyshak, & Lavelle, 1987; Silove, 2002; Silove et al., 1998; Silove, Steel, Susljik, et al., 2007), despite the differing rates of MDE and PTSD for asylum-seekers and refugees, no significant differences in number of pre-migration traumatic events were found. However, the mean number of traumatic events reported (M=12.8, SD=5.36) was as high or higher than what has been reported elsewhere (Mollica, Wyshak, & Lavelle, 1987; Mueller et al., 2010; Schwarz-Nielsen, 2009; Steel et al., 1999), indicating that the sample of asylum-seekers in the present study were comparable to asylum-seekers globally, in their exposure to trauma.

The high rate of psychiatric morbidity in the refugee cohort was somewhat surprising given their secure residency status. However, previous studies have demonstrated that severity of symptoms may persist for extended periods, as sequelae to post-traumatic environments (Steel & Silove, 2000). This was evidenced by participants' narratives, ranging from concerns that the Government may change its policy and repatriate them, to feeling that the determination process had changed them as a person. As one participant stated, *"I'm now in the habit to worry about things".*

Nosology

The cluster analysis reflected the majority of symptoms observed in asylum-seekers by ASRC clinicians, which were also mirrored by the qualitative data. The

cardinal symptoms were: hyperarousal; memory problems; somatic complaints (bodily pain and headaches); fear and nervousness; being unable to make daily plans; and helplessness and powerlessness. Interestingly, hopelessness did not distinguish between those in the most and least symptomatic clusters. Furthermore, helplessness, but not hopelessness, predicted a diagnosis of depression in asylum-seekers, and many asylum-seekers spoke of feeling powerless rather than 'useless' or 'worthless', unless they also met criteria for MDE.

Beyond this, the cluster analysis did little to distinguish between clinical profiles, contributing an artificial demarcation between 'high' (Gp1) and 'less high' (Gp2) symptom groups. For example, there were two in Gp 1 who did not meet (full) criteria for PTSD, and there were only four in Gp 2 who did not have MDE.

Hence, a high degree of distress was almost universal, with little differentiation in symptom scores within the asylum-seeker cohort regarding clinical item endorsement. Alternatively, the non-demoralised group offered the possibility of a more sensitive gauge for ascertaining mental health status. The finding of particular interest was that this cohort comprised a greater number of asylum-seekers than refugees, including those on visas associated with greater socioeconomic and psychosocial disadvantage. The PERI-D has previously been found to be more useful for detecting cases of major depression in the community than brief psychiatric screening scales (Roberts & Vernon, 1981). Given that the current sample was a non-help-seeking population, the PERI-D may have some merit as a screening tool for caseness of MDE in community-based forced migrants in Western settings.

Approximately one third of all participants expressed concerns about the impact of protracted uncertainty on their lives, with one describing it as "a wrecking ball". Lazarus and Folkman (1984) found that event uncertainty causes mental confusion, impaired coping and poor adjustment. Commonly reported deficits of memory and concentration in the present sample may have their origins in the protracted strain of coping with an uncertain future. In particular, drawing on Lazarus and Folkman's model, the fluctuation between employing coping strategies for anticipating an event's occurrence (i.e., being repatriated) and coping strategies for an events 'non-occurrence' (i.e., being granted permanent residency) can be particularly damaging and may play a role in the cognitive deficits reported by asylum-seekers[ii].

The particular mental health symptoms with which forced migrants often present share commonalities with what has been termed 'Chronic and Multiple

ii Refer to Qualitative Data (4.7)

Stress Syndrome' (or 'Ulysses Syndrome') in illegal immigrants (Carta et al., 2005). Those affected by this syndrome present with atypical depressive symptomatology combined with anxiety, somatoform and dissociative symptoms. However, the condition is observed to be progressive, as the immigrant encounters the obstacles that take place during the migration process: for example, the (dangerous) journey, the distance from their own environment and family, frequent unemployment and housing difficulties. Thus, it has been proposed that this syndrome constitutes an autonomous category situated between adjustment disorders and PTSD (Achotegui, 2002, cited in Carta et al., 2005).

The point of departure between ('illegal') immigrants and asylum-seekers is the presence of avolition in the former and the absence of loss of meaning or purpose in life for the latter. Whereas undocumented immigrants are described as living in a type of 'twilight state', having lost a yearning or striving toward legal legitimacy, asylum-seekers are characterised by a conative striving for permanent residency. In this way, demoralisation syndrome appears to characterise the illegal immigrant (as described by Carta et al, 2005), but not the asylum-seeker (Refer to Table 1.1, Criteria A & C). Similarly, the concept of Post Traumatic Demoralisation Syndrome (PTDS), which has 'absence of meaning in life' as its core feature, does not explain the symptom profile seen in the asylum-seekers in this sample.

A more recent and asylum-seeker-specific model – the ADAPT model – predicts that PTSD symptoms will persist or remit based on conditions of threat or safety in the post-migration environment (Silove & Steel, 2006). The findings of this study provide partial support for this theory. As has been found in other prospective studies (Davis, 2006; Ryan, Benson, et al., 2008; Silove, Steel, Susljik, et al., 2007), there was a significant reduction in all clinical indices for asylum-seekers who were subsequently granted PR at follow-up. While a secure residency status for asylum-seekers has been established as significant to recovery from trauma-related psychiatric symptoms, the present findings also suggest that other factors may attenuate clinical symptoms. While previous research has shown that high levels of psychiatric morbidity are maintained over time for individuals who retain asylum-seeker status (Ryan, Benson, et al., 2008; Silove, Steel, Susljik, et al., 2007), the present study found a significant decrease in symptoms – including PTSD – in this population. Positive life changes such as increased social support and securing employment, appeared to partially explain this unexpected finding. Evidence suggests that post-migration stressors associated with PTSD may not emerge within the initial months of the RDP (Silove et al., 2006). Hence, another explanation may

be that PTSD was skewed in the direction of lowered scores due to more than half of the AS-AS cohort having been in the RDP less than four months – and one third not having received a rejection. However this would have only been the case at baseline and does not explain the decrease in symptoms at follow-up, an average of 15 months later.

The non-demoralised group

The non-demoralised group comprised 21% of the total sample at baseline. This sub-group was differentiated from the majority by having experienced fewer traumatic events and having a lower prevalence of torture. Unexpectedly, however, the number of rejections in the RDP did not distinguish between the non-demoralised group and the rest of the sample. Similarly, visa type, Medicare, employment status (work, no work or nil work rights) and whether or not the participant had their partner and/or children with them did not predict whether or not they would be in the non-demoralised group. This is contrary to previous findings where unemployment (Bandeira et al., 2010; Briggs & Macleod, 2010; Lavik et al., 1996; Lie, 2002; Silove et al., 1997) and family separation (Ryan, Dooley, et al., 2008) predicted poorer mental health outcomes.

It is possible that insufficient power may have masked true differences between the cohorts for psychosocial variables that had more than two categories (i.e., children or partner in Australia, visa type, accommodation type). However, when groups were reduced to two categories (e.g. the Medicare variable after removing the 'other' category), significance was still not reached.

Another possible explanation for this finding is that the division was based on caseness for demoralisation, not other disorders. There were individuals who did not meet criteria for PTSD or MDE who were demoralised and associations between symptomatology and psychosocial factors were seen elsewhere. For example, participants whose income was associated with living off family/friends and ASAS, had higher scores on depression and post-migration stress than those who were working or in receipt of Centrelink benefits. In fact, those without Medicare scored significantly higher on all six measures, whilst those without work rights reported higher levels of post-migration stress than both those who were working *and* those who were unemployed but with work rights. Furthermore, the cluster analysis grouped together those on a BVE without Medicare (but with work) and with a psychiatric diagnosis. It also grouped those on a BVA or student visa who (predominantly) had Medicare, employment and nil medical or psychiatric

diagnoses. Medicare ineligibility was also a (non-unique) predictor of demoralisation in asylum-seekers.

The increased rate of Medicare eligibility and work rights for those who retained asylum-seeker status played a role in the decline of psychiatric symptoms observed in this cohort and the AS-AS cohort at follow-up. Further to this, the qualitative data clearly indicated the emotional toll exerted by the preclusion of work (rights) and/or Medicare, with many participants (and, reportedly, their medical practitioners) drawing causal links between their mental (especially concentration and memory) and somatic (especially insomnia and headaches) symptoms.

5.1.2 Aim 1a & 1b

a) What is the prevalence of demoralisation (as measured by the PERI-D) in a community-based asylum-seeker population? b) How does this rate compare with other groups as defined by the literature, for example, refugees, migrants and the general population?

The prevalence of demoralisation in the present sample was extremely high, with (cross-sectionally), 66% of refugees and 83% of asylum-seekers meeting criteria at T1 and 42% and 67%, at T2, respectively. At baseline, there was not a significant difference in mean demoralisation scores between asylum-seekers and refugees, but there was a significant difference for a diagnosis of demoralisation, with asylum-seekers being 2.5 times more likely to meet the cut-off for demoralisation.

Although the odds ratio for demoralisation in asylum-seekers compared to the general population was 14.65 (*95%, C.I.*=7.65–29.22), a study of Jewish Russian immigrants found rates at the level of, or above, the cut-off. Flaherty et al. (1986) reported a mean demoralisation score of 1.49 for immigrants with high-level social support and 1.74 for those with low-level support. Given that mental health symptomatology has been found to be greater in asylum-seekers than refugees, it is likely that the cut-off used for demoralisation in this, and other studies of non-Western populations, is not valid in this population. This may also account for the large discrepancy between rates of demoralisation (79%, T1) and MDE (53%, T1) in this study. Concerns have also been raised by others about the construct validity of measures that attempt to operationalise demoralisation (Blazer et al., 1989; Slavney, 1999).

5.1.3 Aim 2

What are the social and demographic factors associated with demoralisation in a community-based asylum-seeker population?

Contrary to findings of previous studies (Butterworth et al., 2006; Gilboa et al., 1990; Gutkovich et al., 1999; Iversen & Morken, 2004; Ryan, Benson, et al., 2008), none of the usual demographic variables predicted demoralisation (i.e., sex, age, socioeconomic status, unemployment and marital status). This may indicate that demoralisation differs between forced migrants and other populations (e.g., immigrants). Another possibility is that there was insufficient power to uncover certain demographic influences due to the small number of females (*n*=21) and refugees (*n*=33).

Other social and demographic factors emerged as predictors, however. Although the number was small (*n*=5), arriving by boat was sufficient to account for 5% of variance in demoralisation scores. Not having Medicare also contributed to demoralisation, as did high number of traumatic events and a history of torture.

Given the pervasive themes of loneliness and missing family, it was curious that being separated from partners and children did not emerge as significant markers of demoralisation or other mental health indices. One possibility is that the support provided through the ASRC mitigated against loneliness and isolation. In transcultural psychiatry, studies have consistently found an inverse relationship between the extent of demoralisation and the degree of sociocultural integration (de Figueiredo, 2007; Flaherty et al., 1988; Gilboa et al., 1990), with those less integrated in their social groups being more demoralised than those more integrated, even when the former have fewer stressful life events (de Figueiredo, 2007).

With the 'invisible' backdrop of support the ASRC appeared to provide, its influence in ameliorating psychiatric morbidity was not systematically factored into this study. However, the qualitative data contributed an understanding to the palpable difference support made to the lives of many participants. A notable example was the young Iraqi man who was on a BVC at both time points and experienced a psychotic break one month after the first interview. At T1 he was demoralised and met criteria for both MDE and PTSD; at T2 he was asymptomatic. He was one of only two who were fully symptomatic at T1 and wholly asymptomatic at T2. He attributed his improvement to emotional support and employment. Like PTSD, Post Traumatic Demoralisation Syndrome is thought to be mediated by the individual's coping capacity and 'toxicity' of the specific traumatic event, as

well as by the nature of the 'recuperative milieu' in which one lives post-trauma (Parson, 1990).

Another possible explanation for separation from family not emerging as a significant marker of demoralisation or other mental health indices is that, for most, leaving one's family behind is a pre-condition of seeking asylum in a country like Australia due to the significant risk and cost associated with bringing one's entire family. Therefore, whilst individuals missed family and were lonely, this may not have been a contributory factor to mental illness due to these factors being anticipated or expected.

5.1.4 Aim 3

What are the clinical characteristics that predict whether there will be a demoralisation syndrome?

There was significant overlap in symptomatology between disorders, lending support to the analogy of demoralisation being a thermometer for psychological distress. Demoralisation, like elevated body temperature, is an indicator that something is wrong; however, as with fever, it does not tell *what* is wrong (Frank, 1973). Threatening life events have been found to be associated with increased PERI-D scores (Marchesi & Maggini, 2007), which is consistent with the view that demoralisation is a normal reaction in response to overwhelming stress (Clarke & Kissane, 2002; de Figueiredo, 2000; Slavney, 1999). From this standpoint, it is not surprising that 79% of the total sample were demoralised.

Of the clinical scales, depressive symptoms and refugee trauma scores predicted demoralisation in both asylum-seekers and refugees. In fact, refugee trauma was the single best predictor of demoralisation at both time points, as well as being able to differentiate between asylum-seekers and refugees in relation to demoralisation. For example, while exhaustion and frequent thoughts about why experiences had happened returned the highest item scores for both groups, the asylum-seeker profile was characterised by feelings that others do not understand and feeling powerless to help others (usually family in homeland). An elevated item for refugees reflected their focus on rebuilding a life and career: feeling they had fewer skills than they had before.

The cluster analysis indicated a pan-distress syndrome rather than capturing a pattern of symptoms particular to any one established disorder. Symptoms that characterised the top 25% of asylum-seekers who were most distressed comprised 9 of the 16 PTSD items (three each of Criteria B, C and D). The anxiety subscale (in its

entirety) distinguished between those most symptomatic and those less so, possibly due to the weighting of somatic symptoms in this scale. Depressive symptoms also characterised this group, including feelings of worthlessness, but not self-blame or guilt. Therefore, an absence of guilt/blame in the presence of worthlessness is suggestive of a sub-category of depression – thereby distinguishing itself from typical MDE by the absence of features typically associated with MDE, such as suicidality. The items which did not distinguish between the most unwell group and the remainder may have been a function of their being globally under-endorsed (e.g, suicidality) or over-endorsed (e.g., sleep disturbance, worry and loneliness).

The other feature of the high-symptomatic cluster of participants was the psychosocial items from the refugee trauma subscale. These were: helplessness, feeling unable to make daily plans, feeling powerless to help others, having no-one to rely on and not trusting others. These are largely consistent with the key post-migration stress predictors of demoralisation: isolation, loneliness/boredom and discrimination.

Despite extremely high levels of demoralisation, the present sample did not neatly fit 'demoralisation syndrome' as defined by Kissane et al. (2001). Whilst becoming demoralised in response to constraint by forces over which one has little or no control (e.g., DIAC), this cannot be defined in a clinical or pathological sense. The distress that characterised this population did not so much reflect an inability to cope, as a feeling that their skills and their desire to contribute to society were being arbitrarily thwarted. Furthermore, the state of having 'given up' was absent, even in spite of high levels of expressed hopelessness and helplessness. Neither did the sample meet de Figueiredo's (de Figueiredo & Frank, 1982) criteria of subjective incompetence; participants were goal-focused and felt they had skills to offer but were immobilised by external constraints, primarily imposed by visa conditions. Therefore, the high demoralisation scores and prevalence may simply reflect the cross-validity of items on the PERI-D with psychic distress rather than demoralisation syndrome *per se*. In contrast, findings from research with detained asylum-seekers suggest that demoralisation syndrome may have greater explanatory power for this population, with numerous reports of impaired capacity for initiative and goal-directed activity over time (Coffey et al., 2010). This may be a key difference between the two asylum-seeker populations in regard to psychiatric morbidity, course and prognosis.

With the exception of two participants, those who were depressed were also demoralised. Furthermore two-thirds of those who were demoralised were

depressed. Significant overlap between major depression and demoralisation (employing the PERI-D) has also been found in a refugee and migrant sample (Briggs & Macleod, 2010). The current study found that those who were not demoralised scored below the MDE cut-off and all those who met caseness for demoralisation scored above the MDE cut-off. This was the case for both the total sample and for the refugee and asylum-seeker cohorts separately. Hence, the unidirectional nature of the relationship between MDE and demoralisation found in this study suggests demoralisation occupies a place at the milder end of a depressogenic continuum (Rickelman, 2002) rather than being a discrete psychiatric category in its own right, as has been proposed by some (Clarke et al., 2003). The present findings may be suggestive of demoralisation being akin to a minor or atypical depression – that is, transient but with the potential to erode the internal resources of the sufferer, making them vulnerable to major depressive disorder when faced with unremitting stress over a protracted period.

The findings relating to the hallmark features of MDE and demoralisation in this sample were particularly interesting and lend support to the suggestion that suicidal ideation may be a distinguishing feature between MDE and demoralisation in forced migrants (Briggs & Macleod, 2006). Further to this, for asylum-seekers, the strongest association between suicidality and the demoralisation scale item of 'Attacks of sudden fear or panic' was almost universally attributed to fears of asylum claims being rejected. Suicidal ideation in this context is very different to that of an endogenous depression, and is more indicative of an exogenomorphic depression (de Figueiredo, 1993) generated from environmental stress extrinsic to the individual.

The final comment in relation to the utility of demoralisation to explain symptomatic distress in asylum-seekers regards time. It is understood that individuals may move back and forth within the demoralised state. However, Demoralisation syndrome has been defined as a degenerative disorder of despair (Kissane, 2004). Demoralisation scores in asylum-seekers in particular, did not increase over time. Therefore, these data together reject demoralisation syndrome as an explanatory construct for community-based asylum-seekers.

5.2 Quantitative Results of Predictive Hypotheses

5.2.1 Hypothesis 4

It is expected that the longer individuals are in the RDP, the greater the symptoms of PTSD, depression, anxiety, demoralisation and post-migration stress.

This hypothesis was not supported. Time in the RDP was not significantly associated with any of the clinical measures or post-migration stress for either asylum-seekers or refugees at baseline. There have been mixed findings regarding the positive association with psychiatric morbidity and time spent in the RDP, but most studies have been conducted in the context of participants living in asylum-seeker reception centres (e.g., Drožđek et al., 2003; Schwarz-Nielsen, 2009).

While a decrease in symptoms over time was predictable for the AS-PR group, surprisingly, the most vulnerable cohort (those who retained asylum-seeker status at T2) also showed a significant reduction in PTSD, depression and refugee trauma symptoms. In spite of the small sample (n=15), effect sizes were moderate to large for these measures (excepting demoralisation). Previous prospective studies have found a decrease in symptom scores for asylum-seekers who are subsequently granted protection (Davis, 2006; Ryan, Benson, et al., 2008; Silove, Steel, Susljik, et al., 2007). To the author's knowledge, this is the first study of community-based asylum-seekers that has found a decrease in symptom scores for individuals who have retained an insecure residency status.

Given the high demoralisation scores at baseline, it is possible that increased symptomatology over time was masked by a ceiling effect in the PERI-D. This is unlikely to be the case for the other measures, however, given their lower prevalence rates at baseline. Another possibility is that two time points were not sufficient to build a symptom profile, particularly given the complexity of asylum-seekers' lives. Monitoring symptoms (and their drivers) at a greater number of time points may have clarified this clinical picture. Furthermore, if symptomatology is more strongly associated with rejections than time, non-significant findings are not surprising in a sample wherein almost 60% of participants had not received a rejection at the time of their first interview.

5.2.2 Hypothesis 5

It is expected that higher rates of rejections throughout the RDP will be associated with higher scores on PTSD, depression, anxiety, demoralisation and post-migration stress.

In relation to differences between refugees and asylum-seekers pertaining to the RDP, the two cohorts differed only in number of rejections at the Primary Stage and number of rejections at the RRT (i.e., the first stage of the appeals process), with asylum-seekers receiving a greater mean number of rejections at both stages.

Because the majority of the sample (59%) comprised participants who had not received a rejection at the time of interview (i.e., the PR group having been successful at the primary stage and the asylum-seekers group not having received a decision), this reduced the sample size considerably, thus reducing the power to find a significant effect between mental health indices and number of rejections. While no relationship was found for five of the six measures, a significant effect was found for PTSD in the asylum-seeker cohort. There was a clear dose-response effect between number of rejections and the presence of PTSD, with four or more rejections being associated with an increased likelihood of having a diagnosis of PTSD. Intriguingly, there were two individuals with eight and nine rejections respectively, who did not have PTSD. One was psychotic and the other was working for a friend and receiving *pro bono* medical care from a GP friend.

Qualitative data and anecdotal evidence[iii] also points to a cyclical rather than linear pattern of distress, primarily driven by RDP rejections. This was underscored by the qualitative data, whereby participants described particular junctures when symptoms peaked, primarily being when notified of negative DIAC decisions (i.e., rejections). As one participant stated, *"When there's a negative decision, everything collapses".* Furthermore, hopelessness seemed to fluctuate more than helplessness and was more strongly associated with RDP rejections than time in the RDP. A study by Sultan and Sullivan (2001) observed that, in detained asylum-seekers, psychological distress and psychiatric disability increased through successive stages after negative decisions of asylum claims at the Primary and RRT stages.

Hence, the pattern of distress observed in the present study is better characterised as a dialectic of hope-hopelessness which follows the rhythm of applications, rejections and subsequent re-applications throughout the appeals process. While time may appear to be the mediating factor, the findings here suggest that it is the number of rejections that is associated with greater vulnerability to psychiatric morbidity, such as PTSD. It is therefore possible that the causative factor for increased psychiatric morbidity in detained asylum-seekers is the number of rejections, or the combined influence of rejections and the duration of time in a noxious setting.

iii For example, it is common for ASRC counsellors to report clients will return for support after receiving a rejection and cease counselling once they have regained emotional stability.

5.2.3 Hypothesis 6

There will be a significant positive correlation between PTSD symptomatology and level of post-migration stress.

The present findings are consistent with other studies (Schweitzer et al., 2006; Silove et al., 1993; Silove et al., 1997; Silove et al., 1998) that have reported a positive relationship between PTSD and level of post-migration stress, particularly in relation to poor access to health care, fear of repatriation, loneliness, boredom and isolation.

Moderate associations were found between post-migration stress and PTSD symptoms for both refugees and asylum-seekers at baseline. However, in keeping with findings of previous studies (Gerritsen et al., 2006; Silove et al., 1998), the asylum-seeker cohort reported significantly higher rates of post-migration stress than refugees. The relationship between PTSD symptoms and post-migration stress decreased for refugees over time, but strengthened for asylum-seekers. Whilst PTSD scores decreased over time for individuals who retained asylum-seeker status, this trend was not replicated for post-migration stress.

Of the six post-migration stress items associated with PTSD in asylum-seekers at baseline, three decreased and three increased in effect over time. Those which abated were: having insufficient money, difficulty obtaining government welfare, and lack of access to preferred foods. Each of these items is likely to reflect stress related to initial adaptational difficulties. For example, individuals eligible for financial support through Red Cross' ASAS program must wait a period of 6 months after lodging their application for protection.

The three post-migration stress items associated with PTSD for asylum-seekers which increased in effect over time were: fear of repatriation, loneliness/boredom, and isolation. At T2, problems with poor medical access for long-term health problems and being unable to return home in an emergency also emerged. Conversely, for refugees, associations between loneliness/boredom, and isolation decreased over time. In keeping with the qualitative data, at T2, two new items associated with PTSD emerged for refugees – these being unemployment, and having insufficient money. Interestingly, separation from family and not being able to return to one's homeland in an emergency was related to PTSD for refugees at baseline but not at follow-up. This may reflect a natural decline in symptoms secondary to greater integration and social and community connectivity. The qualitative data indicated that making and deepening friendships reduced general emotional distress. Another possible explanation may be that these stressors manifest in different ways – such

as transmuting from anxiety-related (e.g. PTSD) symptoms to depressive symptoms – as issues of grief and loss emerge, following the initial elation and relief associated with securing permanent residency.

The association between fear of repatriation and PTSD in asylum-seekers has been reported by others (Hondius et al., 2000; Mann & Fazil, 2006; Steel & Silove, 2000) and provides a plausible explanation as to why PTSD symptoms are frequently seen to remit in asylum-seekers after being granted PR. This is underscored by a finding by Momartin, et al. (2003) that, of four distinct trauma dimensions, only 'Threat to Life' predicted PTSD status.

5.3 The Role of Protective Factors in Psychiatric Morbidity

Many commentators have criticised trends toward (over-)medicalising trauma responses in cross-cultural populations (P. J. Bracken, et al., 1995; Steel, Bateman Steel, et al., 2009; Summerfield, 1999; Watters, 2001). Furthermore, focusing on psychiatric symptomatology may lead to a failure in understanding what factors may protect survivors of violence from subsequent dysfunction (Ehrenreich, 2003). The protective factors that emerged have also been well-documented in the literature. In particular, the results from this study suggest that being granted the right to work, securing employment and having access to subsided health care, contributes significantly to reduced psychiatric morbidity and post-migration stress.

Data gathered in relation to the most commonly cited negative changes that had taken place at the follow-up interview were unemployment/job loss (n=10) and nil contact with/worry about family in home country (n=15). The most commonly cited positive changes were employment/increased work hours (n=12), connectivity to support network/community linkages (n=13) and getting PR (n=15).

5.3.1 Social support and connectivity

The theme of support was salient in relation of its presence or absence for almost all participants. For asylum-seekers coming from collectivist cultures into an individualistic society, the separation from family, culture and community can magnify feelings of isolation. As aforementioned (see 5.1.4), support offered by both professionals and community members played a significant role in ameliorating loneliness and emotional suffering. Further to this, Kramer and Bala (2004) commented that social support can help people to share their experience and perception of their situation, and receive validation. In particular they recommended that refugee centres engage workers with whom refugees can build relationships and act as guides "as they try to make sense of their ambiguous environment" (p.40).

In various ways, many participants expressed gratitude to friends, neighbours, church communities and other "surrogate family" whose support enabled them to keep their "sanity". In some cases communities played a direct role in participants' legal cases, writing letters to advocate for the granting of permanent protection.

Hence, the qualitative data points to support – in whatever form – as a kind of lifeline for asylum-seekers burdened by the stress of living in limbo for protracted periods away from their usual support networks. Variables measuring support *a priori* were unfortunately absent and subsequent data was not gathered in a uniform way. Yet, based on a solid body of research (Clarke & Kissane, 2002; Flaherty et al., 1986; Gerritsen et al., 2006; Renner et al., 2007; Schweitzer et al., 2002), the most likely explanation for the decrease in symptom scores at follow-up, (in addition to gaining work rights, Medicare and employment) was the presence of significant social support.

Contrary to the experiences of most participants was that of the only participant living in community detention at the time of interview. He felt that the broader community was "deaf and blind" to his plight. Although there may be a number of factors which contributed to his feeling of alienation (such as not being able to speak English), it does raise questions about the psychosocial impact of community detention on asylum-seekers and the potential for discrimination which may compound pre-existing mental health problems. Findings to this end have been documented in the literature. Most notably the controversial 'dispersal policy' in the UK is believed to undermine informal support networks and impede integration (Watters & Ingleby, 2004).

5.3.2 Gainful employment

As expected, there was a significant difference in employment status between asylum-seekers and refugees, with approximately one quarter of all asylum-seekers not having work rights at baseline. This translated to a greater level of post-migration stress for those without work rights, even when compared with those who had work rights but were unemployed. In spite of more than one third of the sample having worked in a professional capacity prior to arriving in Australia, those who were permitted to work were almost exclusively employed in unskilled positions.

At follow-up an additional five of the AS-AS cohort were granted work rights. A reduction in trauma and post-migration stress for this cohort was associated with changes to work status over time, with lawful paid work being associated with lower trauma post-migration stress scores. Previous research has also found that

employment mitigates against psychological distress and psychiatric symptoms (Begley et al., 1999; Dupont et al., 2005; Gorst-Unsworth & Goldenberg, 1998; Laban et al., 2005; Lavik et al., 1996; Ryan, Benson, et al., 2008). A strong negative relationship emerged between work rights status and PTSD, refugee trauma, demoralisation and post-migration stress. A strong negative relationship also emerged between Medicare status and both anxiety and demoralisation. Briggs (2011) found employment had a reductive impact on both major depression and demoralisation. While the present study found no difference between the non-demoralised sub-group and the rest of the sample on employment status, it is likely that residency status was masking an effect for asylum-seekers (i.e., asylum-seekers and refugee participants being conflated in these analyses).

The quantitative data did not reflect depressive symptomatology (in particular) as strongly as did the qualitative data regarding the issue of work rights and employment. However, a similar discrepancy was reported in an Austrian study (Renner et al., 2007) of asylum-seekers in three ethnic groups. The study stressed the emotional impact of participants being denied work rights in spite of a non-significant relationship between work permits and ability to cope with trauma. The qualitative thematic content regarding work in Renner et al.'s (2007) study closely resembled that expressed by participants in the present study, including work providing distraction from pernicious worry in addition to increased self-efficacy and being able to provide for family.

5.3.3 Religion

Religion was not specifically explored in the quantitative analyses and did not emerge as a significant demographic variable in any of the exploratory analyses (e.g., predictors of demoralisation). The one exception was its role in distinguishing between residency status, with Christians' being more likely to be granted PR at both time points – itself an interesting finding. However, the most enlightening data pertaining to religion was of a qualitative nature. For 16 participants, religion was spontaneously cited as a buffer against feelings of hopelessness. Adherence to a religious faith was cited by some as a protective factor against depression (and for some, suicide). Reading the Qur'an, having pastoral counselling and interacting with faith communities provided a means of coping with mental health symptoms. Religion has been found to help individuals cope with trauma and demoralisation (Kaplan et al., 2008; S. B. Kleinman, 1990; Levav, et al., 2008; Renner et al., 2007). Other investigators have found that a belief that one's fate is in the hands of God or is predetermined in some way may relieve anxiety and help individuals accept

and tolerate difficult conditions, including long-term uncertainty (Kramer & Bala, 2004). This was certainly the case for some participants. For example, for some Muslim participants, the belief that their future was left to the will of Allah relieved them of worry and anguish, while others had faith that their prayers for permanent protection would be answered.

5.4 Cross-cultural Considerations

The findings from the present study raised questions not only about the prevalence of psychiatric morbidity but the transcultural meaning of this.

Many commentators have criticised the application of the Western individualistic and pathology-focused mental health paradigm to non-Western cultures (Dana, 2007; Summerfield, 1999), and the dilemmas of the cross-cultural validity of Western classifications compound this issue. Previous investigators have identified the presence of culture-specific trauma symptoms. Thus, the impact of traumatic events may not be fully captured by Western-oriented criteria (Loutan et al., 1999).

A particular challenge raised by this study relates to distinguishing between PTSD, MDE and traumatic loss. Loss is associated with major depression, anxiety and somatic complaints (Ahearn, 2000). Accordingly, the HSCL-25 item 'Feeling blue' was almost universally attributed to missing family (partners, children, parents and extended family) due to geographical separation. Furthermore, Gonsalves (1993) has claimed that grief-related decompensation is experienced by all refugees to some extent. In this study, the only participant who *became* symptomatic at T2 (with both PTSD and MDE) reported escalating grief about being separated from her adult daughters.

Hence, the quantitative data did not always capture the subjective experience of those suffering from psychiatric symptoms. Momartin et al. (2002) also found that, although loss of identity, trust and beliefs did not emerge in a principal components analysis, most participants reported being preoccupied with these subjective feelings. Yet such experiences are not necessarily defined as traumas according to DSM-IV criteria (Momartin et al., 2002).

While PTSD is a common diagnosis in this population, specific patterns of trauma have yet to be elucidated (Van Velsen et al., 1996). Indeed, this study shed little light on the existence of a specific cluster of symptoms – PTSD or otherwise. The present findings were unable to accurately predict a diagnosis of PTSD,

suggesting that PTSD may not be a homogeneous, transcultural condition, and that specific trauma types may lead to different patterns of reaction (Van Velsen et al., 1996).

Co-morbid PTSD and depression was established in 40% and 16% of the present sample, for Phases I and II, respectively. Phase I prevalence is similar to that found by others (Fazel et al., 2005; Momartin et al., 2004b; Shalev et al., 1998). However, both lower (Mollica et al., 1999; Van Velsen et al., 1996) and higher (Fazel et al., 2005) rates have been reported for displaced refugees and victims of persecution.

Psychiatric co-morbidity has important prognostic implications. Whilst this study did not specifically or systematically examine functional impairment, co-morbid PTSD and major depression is considered to be a risk factor for higher levels of PTS symptoms and psychosocial dysfunction, with afflicted individuals being found to have poorer functioning (Shalev et al., 1998). Forced migrant populations are believed to be at increased risk for functional impairment (Momartin et al., 2004a; Van Velsen et al., 1996). Furthermore, it may be that a wider constellation of traumatic stress symptoms that include elements of PTSD and major depression define a broader posttraumatic affective syndrome that is specifically associated with risk of long-term disability in this population (Momartin et al., 2004a).

5.5 Strengths and Limitations of the Current Study

A number of strengths and limitations warrant mentioning in relation to the present study. One of the strengths of this study was its filling a gap in the literature pertaining to the influence of rejections in the RDP on psychiatric morbidity. Another gap in the literature related to examining demoralisation syndrome as a possible explanatory construct for the symptom profile seen in community-based asylum-seekers negotiating the RDP. Few prospective studies have been undertaken with asylum-seekers, and fewer still have specifically examined the impact of the RDP on the mental health of asylum-seekers. Structured interviews were used to validate self-report scores against DSM-IV criteria due to self-report measures being associated with inflated rates of disorder. Employing this validation measure went some way to minimise this risk, particularly given the small sample size relative to other studies exploring epidemiological questions. All participants were interviewed at both time points by the same clinician, thereby ensuring internal validity. Although the Phase II participants were small in number (n=56), this cohort did not differ significantly from those who withdrew from the study, thereby giving greater validity to the generalisability of findings across the larger sample (n=131).

Asylum-seekers are a difficult population to research given the lack of accessible registers and transience, therefore random sampling is difficult to implement. Consequently, this study is limited by all the factors associated with non-random sampling. Furthermore the sample size was modest. Hence, the rates of disorder observed, although similar to those identified amongst convenient samples of asylum-seekers and refugees studied elsewhere in Australia (Silove, Steel, Susljik, et al., 2007), cannot be regarded as representative of the prevalence of trauma-related affective disturbances in the general asylum-seeker population living in urban Australian communities.

Potential error due to the measures employed, warrants mentioning. The adapted version of the MINI did not screen for lifetime prevalence of major depression or DSM-IV MDD Criteria C (i.e., clinically significant distress or impairment). Hence, such omissions may have resulted in an over- or under-estimate of MDE.

The use of English language instruments in a linguistically diverse population may have resulted in greater levels of measurement error. For example, many did not understand the dissociative item ('being split in two') and the majority asked for an explanation of 'feeling blue'. As with other studies (e.g., Söndergaard, Ekblad, & Theorell, 2001), 'feeling blue' seemed to be more associated with missing and being separated from family than the Western interpretation (i.e., emotional mood). These problems of validity persist despite the HSCL-25 and HTQ-R being widely used in refugee and asylum-seeker populations. Furthermore, while these instruments have been previously used with the five broad nationalities in this study, this does not guarantee they were valid measures for this sample. Furthermore, settings of previous studies utilising these measures have varied markedly, from Western countries, to refugee camps. However, the qualitative aspect of the study, and the fact that surveys were all completed in an interview context, meant that random error regarding explanations and subsequent interpretations of particular items were minimised.

Another problematic term is 'torture', due to the variability of definitions. Whilst the definition of torture in the study context was explained at interview, interpretation of the (28) torture items on the checklist may have remained open to interpretation. Furthermore, it is possible that the torture checklist itself inflated prevalence of torture by a broader definition than employed by other studies. For example, prevalence may be skewed by the high endorsement of particular items – particularly 'beatings' (57%) and 'threats/ humiliation' (67%), which may

not have taken place within a context of systematic and state-sponsored violence, notwithstanding the trauma incurred by the experience.

A significant source of error is likely to have been introduced by the use of interpreters. While every attempt was made to book the same interpreter for the same participant at both time points, this rarely occurred. Furthermore, sometimes phone interpreters were necessary (due to few interpreters being available for a particular language, or at the request of the participant). The use of interpreters was also problematic in other ways. For example, one participant stated that he truncated his answers and did not seek clarification because he did not feel comfortable with the interpreter.

Related to this issue was the underrepresentation of non-English-speaking participants, with 90% of participants being adequately proficient in English. The majority of asylum-seekers who arrive by boat and who have been detained do not speak English. Therefore the generalisability of the findings can only be extended to English-speaking asylum-seekers. These individuals are usually more educated and better able to negotiate the refugee determination system and access services. Therefore the prevalence of disorders and interaction of symptoms with demographic variables may have been different if a greater number of non-English-speaking asylum-seekers were able to be recruited. The issue of generalisability is also relevant to gender, with women comprising only 16% of the sample.

An additional issue to consider is that of recall error and reporting bias, with the possibility of symptoms being overstated due to the potential for responses to positively influence asylum claims. Prior to each interview every participant was informed of the aims of the study and that data would be pooled for the purposes of examining group trends only. Furthermore, differences in item endorsement for refugees and asylum-seekers were specific to their situation, suggesting that asylum-seekers were not indiscriminately over-reporting symptoms. This is consistent with previous findings (e.g., Silove et al., 1998; Silove, Steel, Susljik, et al., 2007). Data central to some of the research questions relied on self-report without the availability of corroborating information. This was particularly the case for the number of rejections in the RDP that participants were asked to recall, sometimes after several years in the refugee determination process.

Finally, it must be stated that the refugee and asylum-seeker groups may have been non-equivalent on factors other than their residency status. For example, it may be that there were specific selection biases that led the asylum-seeker group to remain in contact with the ASRC and remain in the study which may have accounted

for the significant improvement in this group over time. Similarly, factors associated with sample attrition may also have been associated with prognostic outcomes. The loss of statistical power due to the attrition over time may also have contributed to some of the unexpected prospective findings.

5.6 Conclusions and Future Directions

The present study endeavoured to elucidate the clinical profile of individuals negotiating the refugee determination process; some of whom achieved permanent residency while the majority continued to wait and hope. To safeguard against objectifying participants and their struggles, a qualitative component was central to understanding not only symptomatology in response to a complex and (often) protracted legal process, but the meaning made of this by participants. Indeed, the themes that emerged from participants' stories – of loss, separation, stress, coping, social supports and trauma – are the most frequently investigated themes by researchers into the mental health of forced migrants (Ahearn, 2000).

Many of the findings support a solid body of research attesting to the deleterious mental health consequences of being engaged in a protracted refugee determination process and the associated socioeconomic deprivation. In particular, several key post-migration stressors predicted PTSD symptomatology, several of which have been found within other populations of asylum-seekers in Australia (Silove et al., 1993; Silove et al., 1997; Silove et al., 1998). Given the high prevalence of psychiatric morbidity, arguably the most concerning finding of this study is that the population was a non-clinical sample of non-help-seeking forced migrants. Participants were intentionally recruited through the casework programme of the ASRC, rather than the counselling programme. Relatively few participants were receiving counselling and many had declined it. Yet, the prevalence of psychiatric morbidity was multi-fold higher than the rates reported by general-population epidemiological studies, both in Australia and internationally.

Whilst the prevalence of psychiatric morbidity in this sample is consistent with previous studies of community based asylum-seekers (Silove et al., 1997; Silove & Steel, 1998; Silove et al., 1998; Silove, Steel, Susljik, et al., 2007), such rates are still lower than that of asylum-seekers held in immigration detention centres. Broadly speaking, rates of mental health problems in asylum-seekers residing in reception centres tend to fall somewhere between the two.

The unexpected decrease in symptom scores for those who were asylum-seekers at both time points has not been found previously. The positive implications

are obvious, although causation requires a more thorough investigation. Being granted work rights and Medicare eligibility was associated with a reduction in some symptom scores and, given its well-documented protective effect, social support and community connectivity also likely played a role. A safe, 'recuperative milieu' is a prerequisite for the remission of PTSD symptoms (Parson, 1990; Silove, 2005; Silove et al., 2006).

The two prospective studies that are most similar in design to the present studies recruited through community leaders (Nickerson et al., 2011) and immigration agents (Silove, Steel, Susljik, et al., 2007). While it cannot be assumed that participants in the former studies were in receipt of less social support, the common factor shared by all in the present study was the ASRC: a 'one-stop shop' offering both material and psychosocial support. However, not all participants were equally engaged with the centre and, in retrospect, this would have been an important variable to have intentionally examined.

The absence of association between mental health symptoms and time (cross-sectionally) was unexpected. Thus, the assumption that individuals deteriorate over time – what anecdotal reports have suggested – may be inaccurate. The linear relationship between time and symptom severity that has been documented in the literature of detained asylum-seekers was not found in this sample. The reality is likely to be more complex, particularly in a community sample – in contrast to a detained population – where there is a greater range of putative mediating environmental factors.

Therefore, the construct underpinning the trajectory seen in community-based asylum-seekers is considered to be more cyclical in nature; akin to a hope-hopelessness dialectic. That the number of rejections was found to be a predictor of PTSD lends support to this hypothesis. Furthermore, that post-migration index items decreased over time for refugees but increased for asylum-seekers lends support to the ADAPT model, which postulates that post-migration stress compounds past trauma and therefore prolongs mental disorders among asylum-seekers (Silove & Steel, 2006; Silove, Steel, Susljik, et al., 2007). In particular, the findings suggest the possibility that asylum-seekers may be vulnerable to significantly worsened mental health after reaching a certain threshold of rejections within the RDP appeals process. In this population, that number was four. In the detained population, liminality for deteriorating mental health tends to be around three months (Green & Eagar, 2010). While rates of suicidality in community-based and detained asylum-seekers are not equivalent, a greater insight into the mechanisms that mediate

mental health in community-based asylum-seekers is needed. This has particular salience and currency given the Federal Government's undertaking to process all prospective asylum-seekers under a single onshore system, and to release asylum-seekers from detention – many of whom will require intensive support for psychiatric sequelae resulting from prolonged captivity.

That post-migration stress scores were significantly higher for those with a history of torture provides further support for the ADAPT model. Being Medicare ineligible and being denied the right to work were also significantly related to post-migration stress. It is likely that previous trauma experiences may combine with post-migration psychosocial disadvantage to mediate greater PTSD morbidity, a contention supported by previous research (Robjant, Robbins, et al., 2009; Silove, 2000; Steel, Frommer, et al., 2004)

Finally, whilst the symptom profile of asylum-seekers may be strikingly similar throughout the world, diagnostic uncertainty is common (McColl & Johnson, 2006). As was the case with previous research into demoralisation in refugee populations (Briggs, 2011; Briggs & Macleod, 2006; Briggs & Macleod, 2010), this study was not able to demonstrate demoralisation to be a more relevant diagnosis than major depression for refugee and asylum-seekers with mental health problems. Hence, the findings lead to the conclusion that 'demoralisation syndrome' does not capture the symptoms observed; yet the question of taxonomy remains a dilemma. It is likely that current psychiatric or psychological nosologies of ill-heath do not explain the often profound and complex suffering embodied – often literally, through somatisation – by asylum-seekers.

Future research with a greater focus on protective factors would do well to operationalise and investigate psychosocial supports, including the presence of a 'healing milieu' in the lives of asylum-seekers. This would go some way to filling a research gap resulting from the findings of this study. Prospective studies aiming to replicate findings may wish to increase the number of time points for which clinical data is collected – while detailing the significant RDP markers (e.g., when the application was lodged; when a response was received) – to establish more robust associations between time and symptoms, should they exist. Future research into the resourcefulness and resilience of particular individuals (e.g., the 21% of non-demoralised individuals in this study) may assist with the development of screening tools to ascertain those most/least vulnerable to psychological conditions, and facilitate greater understanding of personal characteristics and coping styles that may be developed in those most vulnerable.

Whilst investigation of gender was beyond the scope of this study, it is important to note that previous research has identified female gender as an important risk factor for poor mental health (e.g., Dohrenwend et al., 1980; Laban et al., 2004; Ryan, Benson, et al., 2008). Given this, future research examining putative gender-specific psychiatric and somatic markers may seek to better delineate the needs of male and female asylum-seekers. Such investigations may further assist in the development of gender-specific treatment approaches and/or services.

Overall, asylum-seekers are a deeply traumatised and psychologically disturbed population, with rates of mental ill-health being multi-fold higher than the general population. Participating in society through the provision of work rights and having access to subsidised health care is one of the most effective ways to minimise the functional impairment associated with chronicity of mental ill-health in asylum-seekers. Thus, facilitating a healing social milieu to ameliorate psychological distress at both community and governmental levels is warranted and this study demonstrates the importance of social solutions to mental ill-health in asylum-seekers.

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APPENDICES

Appendix 1: Participant information sheets

Appendix 1A: Phase I

INFORMATION TO PARTICIPANTS INVOLVED IN RESEARCH

You are invited to participate

You are invited to take part in a student research project about **mental health in people seeking asylum as someone who is seeking asylum.** This research is a joint project between a Clinical Psychology Masters student at Victoria University and the Asylum Seeker Resource Centre. It is being conducted by student researcher, Debbie Hocking, as part of a Doctorate degree in Clinical Psychology at Victoria University under the supervision of Dr. Gerard Kennedy from the Department of Psychology.

Project explanation

The health problems of people seeking asylum is not fully understood - this research aims to improve our understanding. In particular, the research aims to explore how you feel about your experiences of being an asylum seeker, and the ways in which your experiences may have had an impact on your health and well-being. By understanding the experiences of asylum seekers, the difficulties that are experienced, and their effect on health and well-being, it is hoped that people seeking asylum may be better helped in the future.

What will I have to do?

If you agree to help with this research, I will collect some information about your background such as how old you are, where you came from, your health history, how long you have been here and if your family are with you. I will then ask you to answer 4 lists of questions about your mental and physical health and your experiences after arriving in Australia. The questions will take about an hour to do and I will help you do them. At a later time (weeks or perhaps a few months), I may ask you to come back to talk more about your experiences – to tell more of your story to do with the things that the questions asked about.

Would you be willing to be contacted for stage 2 of the project? If so, please include a contact phone number on the Consent Form attached.

What will I have to do?

By joining in this study you will be helping the Asylum Seeker Resource Centre to learn more about the health needs of people seeking asylum like yourself. This will allow the Asylum Seeker Resource Centre to better work out the best ways to help people seeking asylum in the future.

How will the information I give be used?

The data collected will be only for research purposes for the Asylum Seeker Resource Centre and the completion of a Doctorate degree in psychology. No names will be collected or stored. No information that can identify you will be released to anyone other than myself (as student researcher) and my supervisor at Victoria University.

The information is not part of the legal process at ASRC so participating in this study will neither help nor harm your legal case.

What are the potential risks of participating in this project?

I do not believe that there are any risks to you in joining in this research. But, if you do get upset when answering the

questions or interview, a counsellor from the Asylum Seeker Resource Centre will be available while the research study is going, and after it's finished.

How will this project be conducted?

Anybody coming to the Asylum Seeker Resource Centre over the age of 18 years will be asked to participate in the research by their case worker. If you think you would like to participate you will meet the researcher. If you would like to, you can also bring along someone else (for example a family member or close friend). The Information sheet and consent form will be explained and you will have the chance to ask questions. If you want to, you can agree to participate and sign the form. If you don't want to participate there is no problem and your care or service from the Asylum Seeker Resource Centre will not be affected in any way. If you can't make up your mind you are free to take the information away and consider it at home. If you join in the research and sign the consent form you will then do the 4 lists of questions. If you agree for us to contact you for an interview, I may call you to come in for this interview to talk more about your experiences.

Who is conducting the study?

The study is being done by a Clinical Psychology student at Victoria University, Debbie Hocking, her Research Supervisor, Dr. Gerard Kennedy and Associate Professor Suresh Sundram from the Asylum Seeker Resource Centre. Please note that the student researcher and her supervisor both work independently of the Asylum Seeker Resource Centre

If you have any questions or worries about joining in this research-study, you can ask Mary Harvey (Coordinator, Counselling Program) or Associate Professor Suresh Sundram (psychiatrist) at the Asylum Seeker Resource Centre on (03) 9326 6066 (ASRC reception). Alternatively, you can contact the Student Researcher, Debbie Hocking on (03) 9386 6764 or debbie.hocking1@live.vu.edu.au or the **Principal Researcher** Dr. Gerard Kennedy on (03) 9919 2481 or gerard.kennedy@vu.edu.au.

If you have any questions or complaints about the way you have been treated, you can contact the Secretary, Victoria University Human Research Ethics Committee, Victoria University, PO Box 14428, Melbourne, VIC, 8001 phone (03) 9919 4781.

THANK YOU FOR YOUR TIME

Appendix 1B: Phase II

INFORMATION TO PARTICIPANTS INVOLVED IN RESEARCH

You are invited to participate

You are invited to take part in a student research project about **mental health in people seeking asylum as someone who is seeking asylum.** This research is a joint project between a Clinical Psychology Masters student at Victoria University and the Asylum Seeker Resource Centre. It is being conducted by student researcher, Debbie Hocking, as part of a Doctorate degree in Clinical Psychology at Victoria University under the supervision of Dr. Gerard Kennedy from the Department of Psychology.

Project explanation

The health problems of people seeking asylum is not fully understood - this research aims to improve our understanding. In particular, the research aims to explore how you feel about your experiences of being an asylum seeker, and the ways in which your experiences may have had an impact on your health and well-being. By understanding the experiences of asylum seekers, the difficulties that are experienced, and their effect on health and well-being, it is hoped that people seeking asylum may be better helped in the future.

What will I have to do?

If you agree to help with this research, I will collect some information about your background such as what treatment you have received since the first interview, what your visa status is and if your family are with you. I will ask you to answer 4 lists of questions about your mental and physical health and your experiences after arriving in Australia. I will then ask you a series of questions about your mental/emotional health. The interview will take about two hours.

What will I gain from participating?

By joining in this study you will be helping the Asylum Seeker Resource Centre to learn more about the health needs of people seeking asylum like yourself. This will allow the Asylum Seeker Resource Centre to better work out the best ways to help people seeking asylum in the future.

How will the information I give be used?

The data collected will be only for research purposes for the Asylum Seeker Resource Centre and the completion of a Doctorate degree in psychology. No names will be collected or stored. No information that can identify you will be accessed by anyone other than me (as student researcher) and my supervisor at Victoria University.

The interview information is not part of the legal process at ASRC so participating in this study will not help or hurt your legal case.

What are the potential risks of participating in this project?

I do not believe that there are any risks to you in joining in this research. But, if you do get upset when answering the questions or interview, a counsellor from the Asylum Seeker Resource Centre will be available while the research study is going, and after it's finished.

How will this project be conducted?

Anybody coming to the Asylum Seeker Resource Centre over the age of 18 years will be asked to participate in the research by their case worker. If you think you would like to participate you will meet the researcher. The Information sheet and consent form will be explained and you will have the chance to ask questions. If you want to, you can agree to participate and sign the form. If you don't want to participate there is no problem and your care or service from the Asylum Seeker Resource Centre will not be affected in any way. If you can't make up your mind you can take the information away and think about it at home. If you join in the research and sign the consent form you will then do the 4 lists of questions and the interview questions about hour health and wellbeing since the first interview. You can withdraw from the study at any time.

Who is conducting the study?

The study is being done by a Clinical Psychology student at Victoria University, Debbie Hocking, her Research Supervisor, Dr. Gerard Kennedy and Associate Professor Suresh Sundram from the Asylum Seeker Resource Centre. Please note that the student researcher and her supervisor both work independently of the Asylum Seeker Resource Centre.

If you have any questions or worries about joining in this research-study, you can ask Julie Morsillo (Coordinator, Counselling Program) or Associate Professor Suresh Sundram (psychiatrist) at the Asylum Seeker Resource Centre on (03) 9326 6066 (ASRC reception). Alternatively, you can contact the Student Researcher, Debbie Hocking on (03) 9386 6764 or debbie.hocking1@live.vu.edu.au or the **Principal Researcher** Dr. Gerard Kennedy on (03) 9919 2481 or gerard.kennedy@vu.edu.au.

If you have any questions or complaints about the way you have been treated, you can contact the Secretary, Victoria University Human Research Ethics Committee, Victoria University, PO Box 14428, Melbourne, VIC, 8001 phone (03) 9919 4781.

THANK YOU FOR YOUR TIME

Appendix 2: Consent and confidentiality forms

Appendix 2A: Caseworker confidentiality sheet

Research Confidentiality

Regarding disclosure of client information to researchers

As a case worker your support is sought to facilitate a research project aimed at conceptualising mental health issues in asylum seekers at the ASRC. This project will be overseen by Mary Harvey (Counselling Program co-ordinator) and Debbie Hocking (Clinical Psychology Masters research student, Victoria University).

As an integral part of this research, we ask that you provide all new and current ASRC client members with a *Participant Information Sheet*, which outlines the research aims and process. The research process will include gathering demographic information (no names) either directly from the participants, or via Case Workers. Whilst it is envisaged that demographic data ideally will be gathered directly from client members by the student researcher, time constraints (for both participants and the student researcher) may require the demographic information to be sought prior or subsequently to the research interview. Should this be the case, an authority form for the *Release of Information* will be available.

Any other information outside the required demographic data for research purposes must not be disclosed by Case Workers to researchers at ASRC, and the aforementioned demographic data may only be made available for research purposes if a *Release of Information* form is signed by the consenting participant.

Below is a confidentiality agreement which we require you to sign and return to Mary Harvey. If you have any queries regarding confidentiality for this research, please let Mary know so that she and/or Debbie Hocking can address these with you.

ASRC Case Worker Confidentiality Agreement

I, _____, hereby commit to respecting the privacy and maintaining confidentiality with regards to all client information obtained in my role as a Case Worker at the Asylum Seeker Resource Centre.

I understand that any disclosure of clients' details for research purposes must be done only after consultation with Mary Harvey &/or Debbie Hocking, and authorisation for release of information is obtained from the client.

I have read the above information and agree to abide by ASRC's Research Confidentiality Agreement as it pertains to research conducted within the ASRC. I declare that I have no conflict of interest in my work as case worker at the ASRC and will disseminate information pertaining to the aforementioned research involving asylum seekers at the ASRC in a neutral manner and according to briefing guidelines provided by Mary Harvey and Debbie Hocking.

Case Worker Signature: _____

Name: _____

Date: _____

Appendix 2B: Participant consent form – Phase I

CONSENT FORM FOR PARTICIPANTS INVOLVED IN RESEARCH

INFORMATION TO PARTICIPANTS:

We would like to invite you to be a part of a study into **"Conceptualising Mental Health in Asylum Seekers"**, being conducted at Victoria University by **Dr Gerard Kennedy** and Debbie Hocking

CERTIFICATION BY SUBJECT

I _____[Participant's name] of_____[suburb], certify that I am at least 18 years old and that I am voluntarily giving my consent to participate in the study.

I certify that the objectives of the study, together with any risks and safeguards associated with the procedures listed hereunder to be carried out in the research, have been fully explained to me by **Debbie Hocking,** and that I freely consent to participation involving the use on me of these procedures:

- Complete a questionnaire on my mental and physical health, and my post-migration experiences

I **do / do not** (please circle the response you would like) freely consent to being contacted to participate in an interview at a later date to give a more detailed account of my experiences in relation to the completed questionnaire.

Phone number: _____ (include if you consent to a later interview)

I certify that I have had the opportunity to have any questions answered and that I understand that I can withdraw from this study at any time and that this withdrawal will not jeopardise me in any way.

I have been informed that the information I provide will be kept confidential.

Signed:_____

Date: _____

Any queries about your participation in this project may be directed to the researcher
Dr. Gerard Kennedy on 9919 2481.

If you have any queries or complaints about the way you have been treated, you may contact the Secretary, Victoria University Human Research Ethics Committee, Victoria University, PO Box 14428, Melbourne, VIC, 8001 phone (03) 9919 4781

Appendix 2C: Participant consent form – Phase II

CONSENT FORM FOR PARTICIPANTS INVOLVED IN RESEARCH

INFORMATION TO PARTICIPANTS:

We would like to invite you to be a part of a study into **"Conceptualising Mental Health In Asylum Seekers"**, being conducted at Victoria University by **Dr Gerard Kennedy** and Debbie Hocking

CERTIFICATION BY SUBJECT

I _____[Participant's name] of_____[suburb],
certify that I am at least 18 years old and that I am voluntarily giving my consent to participate in the study.

I understand that the objectives of the study, any risks and safeguards associated with the procedures listed below to be carried out in the research, have been fully explained to me by **Debbie Hocking,** and that I freely consent to participation involving the use of these procedures:

- Complete questionnaires on my mental and physical health, and my post-migration experiences
- An interview with Debbie Hocking who will ask questions about my mental and emotional health

I understand that participating in this interview will not help or harm my legal case in any way.

I understand that I have had the opportunity to have any questions answered and that I can withdraw from this study at any time and that this withdrawal will not jeopardise me in any way.

I have been informed that the information I provide will be kept confidential.

Signed:_____

Date: _____

Any queries about your participation in this project may be directed to the researcher
Dr. Gerard Kennedy on 9919 2481.

If you have any queries or complaints about the way you have been treated, you may contact the Secretary, Victoria University Human Research Ethics Committee, Victoria University, PO Box 14428, Melbourne, VIC, 8001 phone (03) 9919 4781

Appendix 3: Questionnaire measures

Appendix 3A: Demographic questionnaires – Phase I

Conceptualising mental health in asylum seekers – research project
Demographic Information Sheet

1. **D.O.B:**_____/_____/_____ ***or*** **Age (must be at least 18 years) :**_____

2. **Sex:** please tick ✓ **F** ☐ **M** ☐

3. **Date arrived in Australia:** _____/_____/_____

4. **Country of origin:** Afghanistan ☐ China ☐ Iraq ☐
   Sri Lanka ☐ Other ☐ Please state_____

5. **Nationality/Ethnic group/Cultural group:** _____

6. **Language/s:** _____

7. **Religion:** _____

8. **Marital Status:** Never Married ☐ Married ☐ Divorced ☐ Widowed ☐
   Engaged ☐ Other ☐ Please state_____
   If you have a partner, where is your partner? _____

9. **Number of Children you have?** 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more ☐

10. **Are your children with you in Australia?** Yes ☐ No ☐ Some ☐ If so, how many?___

11. **Level of Education:** No education ☐ Some primary ☐ Finished primary ☐ Some secondary
    Finished secondary ☐ Tertiary ☐ (uni/TAFE) Other ☐ Please state_____

12. a) **What was your job before Australia?** _____
    12. b) **What is your job/occupation now?** _____

13. **What is your source of income now?** 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more ☐

14. **What is your accommodation status?** 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more ☐

15. **When did you first apply for asylum in Australia?** _____

16. **How many times have you been to RRT?** 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more ☐

17. **How many 417 applications have you made?** 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more ☐

18. **Did you stay in a Refugee Camp before arriving in Australia? Yes ☐ No ☐**
    If **Yes**, what country/s? _____ For how long? _____

19. **Were you held in detention in Australia when you arrived? Yes ☐ No ☐**
    If **Yes**, where? _____ For how long? _____

Appendix 3A: Demographic questionnaires – Phase II

Conceptualising mental health in asylum seekers – research project
Demographic Information Sheet

#: _____ *Phase I* interview Date: _____ *Phase II* interview Date: _____

4. **D.O.B:_____/_____/_____ & Age (must be at least 18 years) :_____**

2. **Religion (if changed):** _____

3. **Marital Status:** Never Married ☐ Defacto/ Married ☐ Divorced ☐ Widowed ☐
Engaged ☐ Other ☐ _____

4. **If you have a partner, where is your partner?** _____

5. **Do you still have the same number of children?** Yes ☐ No ☐ If No _____

6. **Do you still have the same number of children in Australia?** Yes ☐ No ☐ If No _____

7. **Have you begun or stopped studying since the last interview?** Yes ☐ No ☐ If Yes _____

8. **Do you have:** ***Medicare*** Yes ☐ No ☐ ***Work Rights***: Yes ☐ No ☐

9. **Are you currently working?** Yes☐ No☐ Job: _____
Hours/fortnight _____

10. **What is your source of income now?** _____

How much money are you earning now (since the last I/v)? More ☐ Less ☐ same ☐

11. **Are you living in the same place you were?** Yes ☐ No ☐ If No, _____

12. **What Visa are you now on?** BVA ☐ BVE ☐ BVC ☐ Student ☐ PR ☐

13. **What stage of the legal process ?** DIAC ☐ RRT ☐ Court ☐ 417 ☐
Interview? Y/N

What has happened in your legal case/process since the last interview?

_____
_____
_____
_____
_____

14. **Have you spent time in detention since the last interview? Yes ☐ No ☐**
If **Yes**, where? _____ For how long? _____
What was the reason?_____
_____
_____
_____

15. **Have you seen a doctor since the last interview? Yes ☐ No ☐**
    If yes, what for (Diagnosis/symptoms) ?

    When were theses diagnoses made or when did the symptoms start?

16. **Have you been prescribed medication since the last interview? Yes ☐**
    No ☐

    Name of med? _____ Dose:_____ When prescribed:_____

    Name of med? _____ Dose:_____ When prescribed:_____

    Name of med? _____ Dose:_____ When prescribed:_____

    Name of med? _____ Dose:_____ When prescribed:_____

17. **Have you had counselling or seen a psychiatrist since the last interview?**
    Yes ☐ No ☐ (Who saw? Length of time & frequency? Was this helpful etc.)
    _____
    _____
    _____
    _____

18. **What other changes have occurred since the last interview? For example**
    - Bad/Good news from back home
    - death/birth of family member
    - changes in support networks
    - change in role at home/in your community etc.

Positive	Negative

Appendix 3B: Hopkins Symptom Checklist (HSCL-25)

HOPKINS SYMPTOM CHECKLIST-25

HSCL-25

Name: _____ **Date** _____ **Clinician** _____

Date of Birth _____ **Sex**_____ **Marital Status** _____

Arrival Date _____

Psychiatric Diagnosis _____

INSTRUCTIONS

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

	PART I ANXIETY SYMPTOMS	Not at all	A little	Quite a bit	Extremely
1.	Suddenly scared for no reason				
2.	Feeling fearful				
3.	Faintness, dizziness or weakness				
4.	Nervousness or shakiness inside				
5.	Heart pounding or racing				
6.	Trembling				
7.	Feeling tense or Keyed up				
8.	Headaches				
9.	Spell of terror or panic				
10.	Feeling restless or can't sit still				

	PART II DEPRESSION SYMPTOMS	Not at all	A little	Quite a bit	Extremely
11.	Feeling low in energy, slowed down				
12.	Blaming yourself for things				
13.	Crying easily				
14.	Loss of sexual interest or pleasure				
15.	Poor appetite				
16.	Difficulty falling asleep, staying asleep				
17.	Feeling hopeless about future				
18.	Feeling blue				
19.	Feeling lonely				
20.	Thought of ending your life				
21.	Feeling of being trapped or caught				
22.	Worry too much about things				
23.	Feeling no interest in things				
24.	Feeling everything is an effort				
25.	Feeling of worthlessness				

SCORING

Responses are summed and divided by the number of answered items to generate the following scores:

1. For the responses to each item, assign the following numbers:

1 = *"Not at all"*
2 = *"A little"*
3 = *"Quite a bit"*; and
4 = *"Extremely"*

2. Add up item scores and divide by the total number of the answered items.

Anxiety Score= ITEMS 1-10 ☐
10

DSM IV Depression Score= ITEMS 11-25 ☐
15

TOTAL Score = ITEMS 1-25 ☐
25

Individuals with scores on anxiety and/or depression and/or total greater than 1.75 are considered symptomatic.

Note: ≥ 1.75 is now considered a scientifically valid cut-off point.

HARVARD TRAUMA QUESTIONNAIRE

Revised
(HTQ-R)

CambodianVersion (English only)

NAME:_____

DATE: _____

DATE OF BIRTH: _____

ARRIVAL DATE: _____

PSYCHIATRICDIAGNOSIS:_____
_____
_____
_____

INSTRUCTIONS

We would like to ask you about your past history and present symptoms. This information will be used to help us provide you with better medical care. However, you may find some questions upsetting. If so, please feel free not to answer. This will certainly not affect your treatment. The answer to the questions will be kept confidential.

PART 1: TRAUMA EVENTS

Please indicate whether you have experienced any of the following events (check YES or NO)

		YES	NO
1.	Lack of shelter		
2.	Lack of food or water		
3.	Ill health without access to medical care		
4.	Confiscation or destruction of personal property		
5.	Combat situation (e.g. shelling and grenade attacks)		
6.	Forced evacuation under dangerous conditions		
7.	Beating to the body		
8.	Rape		
9	Other types of sexual abuse or sexual humiliation		
10.	Knifing or axing		
11.	Torture, i.e., while in captivity you received deliberate and systematic infliction of physical or mental suffering		
12.	Serious physical injury from combat situation or landmine		
13.	Imprisonment		
14.	Forced labor (like animal or slave)		
15.	Extortion or robbery		
16.	Brainwashing		
17.	Forced to hide		
18.	Kidnapped		
19.	Other forced separation from family members		
20.	Forced to find and bury bodies		
21.	Enforced isolation from others		
22.	Someone was forced to betray you and place you at risk of death or injury		
23.	Prevented from burying someone		
24.	Forced to desecrate or destroy the bodies or graves of deceased persons		
25.	Forced to physically harm family member, or friend		
26.	Forced to physically harm someone who is not family or friend		
27.	Forced to destroy someone else's property or possessions		
28.	Forced to betray family member, or friend placing them at risk of death or injury		
29.	Forced to betray someone who is not family or friend placing them at risk of death or injury		
30.	Murder, or death due to violence, of spouse		

31.	Murder, or death due to violence, of child		
32.	Murder, or death due to violence, of other family member or friend		
33.	Disappearance or kidnapping of spouse		
34.	Disappearance or kidnapping of child		
35.	Disappearance or kidnapping of other family member or friend		
36.	Serious physical injury of family member or friend due to combat situation or landmine		
37.	Witness beatings to head or body		
38.	Witness torture		

Part 2: Personal Description

Please indicate what you consider to be the most hurtful or terrifying events you have experienced, if any. Please specify where and when these events occurred.

_____

_____

_____

_____

_____

_____

_____

_____

Under your current living situation (i.e. refugee camp, country of resettlement, returned from exile, etc.) what is the worst event that has happened to you, if different from above. Please specify where and when these events occurred.

_____

_____

_____

_____

_____

_____

_____

Part 3: Head Injury

If you answer yes to the following trauma events, please indicate if you lost consciousness and for how long.

	Experienced		Loss of consciousness?		If Yes, for how long?	
	Yes	No	Yes	No	Hours	Minutes
1.Beatings to the head						
2.Suffocation or strangulation						
3. Near drowning						
4. Other types of injury to the head (e.g. shrapnel, burns, etc.)						
5. Starvation						

If Yes: Normal weight: Starvation weight:

If Yes, Were you near death due to starvation? Yes: No

PART 4: TRAUMA SYMPTOMS

The following are symptoms that people sometimes have after experiencing hurtful or terrifying events in their lives. Please read each one carefully and decide how much the symptoms bothered you <u>in the past week</u>.

		(1) Not at all	(2) A little	(3) Quite a bit	(4) Extremely
1.	Recurrent thoughts or memories of the most hurtful or terrifying events				
2.	Feeling as though the event is happening again				
3.	Recurrent nightmares				
4.	Feeling detached or withdrawn from people				
5.	Unable to feel emotions				
6.	Feeling jumpy, easily startled				
7.	Difficulty concentrating				
8.	Trouble sleeping				
9.	Feeling on guard				
10.	Feeling irritable or having outbursts of anger				
11.	Avoiding activities that remind you of the traumatic or hurtful event				
12.	Inability to remember parts of the most hurtful or traumatic events				
13.	Less interest in daily activities				
14.	Feeling as if you don't have a future				

		(1) Not at all	(2) A little	(3) Quite a bit	(4) Extremely
15.	Avoiding thoughts or feelings associated with the traumatic or hurtful events				
16.	Sudden emotional or physical reaction when reminded of the most hurtful or traumatic events				
17.	Feeling that you have less skills than you had before				
18.	Having difficulty dealing with new situations				
19.	Feeling exhausted				
20.	Bodily pain				
21.	Troubled by physical problem(s)				
22.	Poor memory				
23.	Finding out or being told by other people that you have done something that you cannot remember				
24.	Difficulty paying attention				
25.	Feeling as if you are split into two people and one of you is watching what the other is doing				
26.	Feeling unable to make daily plans				
27.	Blaming yourself for things that have happened				
28.	Feeling guilty for having survived.				
29.	Hopelessness				
30.	Feeling ashamed of the hurtful or traumatic events that have happened to you				
31.	Feeling that people do not understand what happened to you				
32.	Feeling others are hostile to you				

		(1) Not at all	(2) A little	(3) Quite a bit	(4) Extremely
33.	Feeling that you have no one to rely upon				
34.	Feeling that someone you trusted betrayed you				
35.	Feeling humiliated by your experience.				
36.	Feeling no trust in others.				
37.	Feeling powerless to help others.				
38.	Spending time thinking why these events happened to you				
39.	Feeling that you are the only one that suffered these events.				
40.	Feeling a need for revenge.				

Torture History

Now I would like to ask you about events that many people consider torture. I will ask you whether an event occurred. Please answer yes or no.

Event	YES	NO
1. Beating, kicking, striking with objects		
2. Threats, humiliation		
3. Being chained or tied to others		
4. Exposed to heat, sun, strong light		
5. Exposed to rain, body immersion, cold		
6. Placed in a sack, box, or very small space		
7. Drowning, submersion of head in water		
8. Suffocation		
9. Overexertion, hard labor		
10. Exposed to unhygienic conditions conducive to infections or other diseases		
11. Blindfolding		
12. Isolation, solitary confinement. If yes, how many		
13. Mock execution		
14. Made to witness others being tortured		
15. Starvation		
16. Sleep deprivation		
17. Suspension from a rod by hands and feet		
18. Rape, mutilation of genitalia		
19. Burning		
20. Beating the soles of the feet with rods		
21. Blows to the ears		
22. Forced standing		
23. Throwing urine or feces at victim or being made to throw it at other prisoners		
24. Medicine administration (non-therapeutic)		
25. Needles under toes or fingernails		
26. Writing confessions numerous times		
27. Shocked repeatedly by electric instrument		
28. Other (specify)		

Part 5: Scoring Part IV Trauma Symptoms

1. Assign the following numbers for each answered item.

1 = *"Not at all"*
2 = *"A little"*
3 = *"Quite a bit"*
4 = *"Extremely"*

2. Add up item scores and divide by the total number of the answered items.

DSM-IV Score = ITEMS 1-16
16

TOTAL Score = ITEMS 1-40
40

Individuals with scores on DSM-IV and/or total ≥ 2.5 are considered symptomatic for PTSD. See manual for additional information.

Appendix 3D: Psychiatric Epidemiology Research Interview-Demoralisation Scale (PERI-D) asylum-seeker version

PERI-D Scale

Question	Circle the answer that best fits for you
1. Since applying for your protection visa, how often have you felt confident?	**0 –** very often **1 –** fairly often **2 –** sometimes **3 –** almost never **4 –** never
2. Since applying for your protection visa, how often have you felt useless?	**0 –** never **1 –** almost never **2 –** sometimes **3 –** fairly often **4 –** very often
3. Think of a person who feels that they are a failure generally in life. Is this person -	**0 –** not at all like you **1 –** very little like you **2 –** somewhat like you **3 –** much like you **4 –** very much like you
4. Think of a person who feels they have much to be proud of. Is this person -	**0 –** very much like you **1 –** much like you **2 –** somewhat like you **3 –** very little like you **4 –** not at all like you
5. In general, if you had to compare yourself with the average man/woman your age, what grade would you give yourself?	**0 –** excellent **1 –** good **2 –** average **3 –** below average **4 –** a lot below average
6. In general, how satisfied are you with yourself?	**0 –** very satisfied **1 –** somewhat satisfied **3 –** somewhat dissatisfied **4 –** very dissatisfied
7. How often have you had times when you couldn't help wondering if anything was worthwhile any more?	**0 –** never **1 –** almost never **2 –** sometimes **3 –** fairly often **4 –** very often
8. Since applying for your protection visa, how often have you felt that nothing turns out for you the way you want it to?	**0 –** never **1 –** almost never **2 –** sometimes **3 –** fairly often **4 –** very often
9. Since applying for your protection visa, how often have you felt completely helpless?	**0 –** never **1 –** almost never **2 –** sometimes **3 –** fairly often **4 –** very often
10. Since applying for your protection visa, how	**0 –** never

often have you felt completely hopeless about everything?	**1 –** almost never **2 –** sometimes **3 –** fairly often **4 –** very often
11. Since applying for your protection visa, how often have you feared going crazy; losing your mind?	**0 –** never **1 –** almost never **2 –** sometimes **3 –** fairly often **4 –** very often
12. Since applying for your protection visa, how often have you had attacks of sudden fear or panic?	**0 –** never **1 –** almost never **2 –** sometimes **3 –** fairly often **4 –** very often
13. Since applying for your protection visa, how often have you feared something terrible would happen to you?	**0 –** never **1 –** almost never **2 –** sometimes **3 –** fairly often **4 –** very often
14. Since applying for your protection visa, how often have you felt confused and had trouble thinking?	**0 –** never **1 –** almost never **2 –** sometimes **3 –** fairly often **4 –** very often
15. Since applying for your protection visa, how often have you had trouble concentrating or keeping your mind on what you were doing?	**0 –** never **1 –** almost never **2 –** sometimes **3 –** fairly often **4 –** very often
16. Since applying for your protection visa, how often have you been bothered by feelings of sadness or depression – feeling blue?	**0 –** never **1 –** almost never **2 –** sometimes **3 –** fairly often **4 –** very often
17. Since applying for your protection visa, how often have you felt lonely?	**0 –** never **1 –** almost never **2 –** sometimes **3 –** fairly often **4 –** very often
18. Since applying for your protection visa, how often have you felt anxious?	**0 –** never **1 –** almost never **2 –** sometimes **3 –** fairly often **4 –** very often
19. Since applying for your protection visa, how often have you been bothered by nervousness, being fidgety or tense?	**0 –** never **1 –** almost never **2 –** sometimes **3 –** fairly often **4 –** very often
20. Since applying for your protection visa, how often have you been bothered by feelings of restlessness?	**0 –** never **1 –** almost never **2 –** sometimes

	3 – fairly often **4 –** very often
21. Since applying for your protection visa, how often have you feared being left all alone or abandoned?	**0 –** never **1 –** almost never **2 –** sometimes **3 –** fairly often **4 –** very often
22. Think of a person who is the worrying type – you know a worrier. Is this person _____?	**0 –** not at all like you **1 –** very little like you **2 –** somewhat like you **3 –** much like you **4 –** very much like you
23. When you get angry, how often do you feel uncomfortable, like getting headaches stomach pains, cold sweats and things like that?	**0 –** never **1 –** almost never **2 –** sometimes **3 –** fairly often **4 –** very often
24. Since applying for your protection visa, how often has your appetite been poor?	**0 –** never **1 –** almost never **2 –** sometimes **3 –** fairly often **4 –** very often
25. Since applying for your protection visa, how often have you been bothered by cold sweats?	**0 –** never **1 –** almost never **2 –** sometimes **3 –** fairly often **4 –** very often
26. Since applying for your protection visa, how often have you had trouble with headaches or pains in the head?	**0 –** never **1 –** almost never **2 –** sometimes **3 –** fairly often **4 –** very often
27. Since applying for your protection visa, how often have you felt you were bothered by all different kinds of ailments in different parts of your body?	**0 –** never **1 –** almost never **2 –** sometimes **3 –** fairly often **4 –** very often
	TOTAL =

Appendix 3D: Psychiatric Epidemiology Research Interview-Demoralisation Scale (PERI-D) PR version [∞]

PERI-D Scale

Question	Circle the answer that best fits for you
1. Since getting PR, how often have you felt confident?	**0 –** very often **1 –** fairly often **2 –** sometimes **3 –** almost never **4 –** never
2. Since getting PR, how often have you felt useless?	**0 –** never **1 –** almost never **2 –** sometimes **3 –** fairly often **4 –** very often
3. Think of a person who feels that they are a failure generally in life. Is this person -	**0 –** not at all like you **1 –** very little like you **2 –** somewhat like you **3 –** much like you **4 –** very much like you
4. Think of a person who feels they have much to be proud of. Is this person -	**0 –** very much like you **1 –** much like you **2 –** somewhat like you **3 –** very little like you **4 –** not at all like you
5. In general, if you had to compare yourself with the average man/woman your age, what grade would you give yourself?	**0 –** excellent **1 –** good **2 –** average **3 –** below average **4 –** a lot below average
6. In general, how satisfied are you with yourself?	**0 –** very satisfied **1 –** somewhat satisfied **3 –** somewhat dissatisfied **4 –** very dissatisfied
7. How often have you had times when you couldn't help wondering if anything was worthwhile any more?	**0 –** never **1 –** almost never **2 –** sometimes **3 –** fairly often **4 –** very often
8. Since getting PR, how often have you felt that nothing turns out for you the way you want it to?	**0 –** never **1 –** almost never **2 –** sometimes **3 –** fairly often **4 –** very often
9. Since getting PR, how often have you felt completely helpless?	**0 –** never **1 –** almost never **2 –** sometimes **3 –** fairly often

[∞] For those who retained the same status at T2 (e.g. did not get PR after first interview), each item began with "Since the last interview…."

	4 – very often
10. Since getting PR, how often have you felt completely hopeless about everything?	**0 –** never **1 –** almost never **2 –** sometimes **3 –** fairly often **4 –** very often
11. Since getting PR, how often have you feared going crazy; losing your mind?	**0 –** never **1 –** almost never **2 –** sometimes **3 –** fairly often **4 –** very often
12. Since getting PR, how often have you had attacks of sudden fear or panic?	**0 –** never **1 –** almost never **2 –** sometimes **3 –** fairly often **4 –** very often
13. Since getting PR, how often have you feared something terrible would happen to you?	**0 –** never **1 –** almost never **2 –** sometimes **3 –** fairly often **4 –** very often
14. Since getting PR, how often have you felt confused and had trouble thinking?	**0 –** never **1 –** almost never **2 –** sometimes **3 –** fairly often **4 –** very often
15. Since getting PR, how often have you had trouble concentrating or keeping your mind on what you were doing?	**0 –** never **1 –** almost never **2 –** sometimes **3 –** fairly often **4 –** very often
16. Since getting PR, how often have you been bothered by feelings of sadness or depression – feeling blue?	**0 –** never **1 –** almost never **2 –** sometimes **3 –** fairly often **4 –** very often
17. Since getting PR, how often have you felt lonely?	**0 –** never **1 –** almost never **2 –** sometimes **3 –** fairly often **4 –** very often
18. Since getting PR, how often have you felt anxious?	**0 –** never **1 –** almost never **2 –** sometimes **3 –** fairly often **4 –** very often
19. Since getting PR, how often have you been bothered by nervousness, being fidgety or tense?	**0 –** never **1 –** almost never **2 –** sometimes **3 –** fairly often **4 –** very often

20. Since getting PR, how often have you been bothered by feelings of restlessness?	**0 –** never **1 –** almost never **2 –** sometimes **3 –** fairly often **4 –** very often
21. Since getting PR, how often have you feared being left all alone or abandoned?	**0 –** never **1 –** almost never **2 –** sometimes **3 –** fairly often **4 –** very often
22. Think of a person who is the worrying type – you know a worrier. Is this person _____?	**0 –** not at all like you **1 –** very little like you **2 –** somewhat like you **3 –** much like you **4 –** very much like you
23. When you get angry, how often do you feel uncomfortable, like getting headaches stomach pains, cold sweats and things like that?	**0 –** never **1 –** almost never **2 –** sometimes **3 –** fairly often **4 –** very often
24. Since getting PR, how often has your appetite been poor?	**0 –** never **1 –** almost never **2 –** sometimes **3 –** fairly often **4 –** very often
25. Since getting PR, how often have you been bothered by cold sweats?	**0 –** never **1 –** almost never **2 –** sometimes **3 –** fairly often **4 –** very often
26. Since getting PR, how often have you had trouble with headaches or pains in the head?	**0 –** never **1 –** almost never **2 –** sometimes **3 –** fairly often **4 –** very often
27. Since getting PR, how often have you felt you were bothered by all different kinds of ailments in different parts of your body?	**0 –** never **1 –** almost never **2 –** sometimes **3 –** fairly often **4 –** very often
	TOTAL =

Appendix 3E: Post Migration Difficulties Checklist (PMLDC)

Post Migration Living Difficulties Checklist

Please circle the number which best fits your concern for each question below:

	Protection concerns	No Problem	Slight problem	Moderate problem	Serious problem	Very Serious problem
1	Worry about family in home country	**1**	**2**	**3**	**4**	**5**
2	Separation from family	**1**	**2**	**3**	**4**	**5**
3	Fear of repatriation	**1**	**2**	**3**	**4**	**5**
4	Unable to return home in an emergency	**1**	**2**	**3**	**4**	**5**
5	Interviews by immigration officers	**1**	**2**	**3**	**4**	**5**
6	Conflict with immigration officers	**1**	**2**	**3**	**4**	**5**
	Access to health and welfare					
7	Unemployment	**1**	**2**	**3**	**4**	**5**
8	Insufficient money to buy food, pay rent and buy necessities	**1**	**2**	**3**	**4**	**5**
9	Difficulty obtaining government welfare	**1**	**2**	**3**	**4**	**5**
10	Bad working conditions	**1**	**2**	**3**	**4**	**5**
11	Difficulty obtaining help from charities	**1**	**2**	**3**	**4**	**5**
12	Worry about not getting medical treatment	**1**	**2**	**3**	**4**	**5**
13	Poor access to emergency care	**1**	**2**	**3**	**4**	**5**
14	Poor access for long-term health problems	**1**	**2**	**3**	**4**	**5**
15	Poor access to dental care	**1**	**2**	**3**	**4**	**5**
16	Poor access to counselling	**1**	**2**	**3**	**4**	**5**
	Resettlement experiences					
17	Communication difficulties	**1**	**2**	**3**	**4**	**5**
18	Discrimination	**1**	**2**	**3**	**4**	**5**
19	Loneliness and boredom	**1**	**2**	**3**	**4**	**5**
20	Discrimination by other ethnic groups	**1**	**2**	**3**	**4**	**5**
21	Isolation	**1**	**2**	**3**	**4**	**5**
22	Conflict with other ethnic groups in Australia	**1**	**2**	**3**	**4**	**5**
23	Lack of access to preferred foods	**1**	**2**	**3**	**4**	**5**

Appendix 3F: MINI (revised MDE Module)

HUG/ programme santé migrants
Evaluation de l'état de santé des requérants d'asile lors de l'ESF ***étiquette patient***

Mini English

Instruction for Interviewer :
In order to situate the symptoms within the timeframe of the past two to four weeks please identify a significant event (for example, arrival in the country, in a residence, national holiday, political event, birthday, etc…) in the life of the asylum seeker and refer to it throughout the questionnaire whenever (Since X) appears.

21. Major Depressive Episode **CODE :_____**

21-1	Since X, have you felt sad, unhappy or depressed ? If yes, do you feel this way most of the time ?	NO	YES
21-2	Since X, have you been less interested in, or are you less able to enjoy, your daily activities ? (Ex : Listening to the radio, watching television, seeing friends, meeting new people, preparing meals, etc…) If yes, do you feel this way most of the time ? CARRY RESPONSE OVER TO QUESTION 22-3C OF THE PTSD SECTION	NO	YES
21-2	**ARE 21-1 OR 21-2 CODED YES?**	➔ NO	YES
21-3 a	Since X, have you had less of an appetite, or do you have a more of an appetite than usual (or do you feel like eating more or less than usual)? If yes, almost every day ?	NO	YES
b	Since X, have you had trouble (or difficulty) sleeping (either falling asleep or waking up in the middle of the night or too early in the morning)? Or do you sleep too much? Does this happen almost every night? DO NOT TAKE INTO ACCOUNT LIVING CONDITIONS OR THE USE OF SLEEPING PILLS WHEN ANSWERING THIS QUESTIION CARRY RESPONSE OVER TO QUESTION 22-4A OF THE PTSD SECTION	NO	YES
c	Since X, do you think or move more slowly than usual? (Ex: when answering someone who has asked you a question) If yes, is this most of the time? Or, on the contrary, are you more restless or do you have trouble sitting still? If yes, is this most of the time? CIRCLE YES IF, DURING THE INTERVIEW, YOU OBSERVE OBVIOUS SLOWNESS OR AGITATION	NO	YES
d	Since X, do you feel tired or without energy? If yes, almost every day?	NO	YES
e	Since X, do you feel bad about yourself or worthless or useless or guilty? Most of the time?	NO	YES
f	Since X, do you have trouble paying attention, thinking clearly or concentrating? (Ex: following conversations with, for example, your social worker or your nurse or doctor, when watching a television show or in your French or computer class?) Do you have trouble making decisions ? If so, most of the time ? CARRY RESPONSE OVER TO QUESTION 22-4C OF THE PTSD SECTION	NO	YES
g	Since X, have you thought about hurting yourself, wished you were dead, or wanted to kill yourself? If so, have you had these ideas often or repeatedly.	NO	YES
21-4	ARE **3** OR MORE ANSWERS IN 21-3 CODED **YES**? (or 4 if 21-1 OR 21-2 is coded NO)	**NO**	**YES** ***MAJOR DEPRESSIVE EPISODE, CURRENT***

Appendix 3F: MINI (revised MDE Module)

HUG/ programme santé migrants
Evaluation de l'état de santé des requérants d'asile lors de l'ESF ***étiquette patient***

Mini English

22. Posttraumatic Stress Disorder **CODE :** _____

22-1	Have you ever experienced or had to face a horrible, shocking event during which you thought you were going to die? Have you ever seen something like this happen to someone else? (Examples of traumatic events: serious accidents, sexual or physical assault, a terrorist attack, being held hostage, kidnapping, fire, discovery of a body, sudden death of someone close to you, war or natural disaster)	➔ NO	YES
22-2	**Since X**, have you felt as though you were reliving this event, while you are awake or in your dreams? Or do you think about it all the time, even though you don't want to?	➔ NO	YES
22-3 a	Since X, is it an effort not to think about the event? Do you stay away from things that remind you of it? Or Since X, have you avoided thinking about the event? Or do you avoid things that remind you of the event?	NO	YES
b	Since X, have you had trouble remembering some important part of what happened? (Ex: The exact date, place, number of aggressors, etc…)	NO	YES
c	**NOTE THE ANSWER TO QUESTION 21-2 OF THE EDM SECTION OR ASK THE FOLLOWING QUESTION:** Since X, have you been less interested in, or are you less able to enjoy, your daily activities ? (Ex : Listening to the radio, watching television, seeing friends, meeting new people, preparing meals, etc…) If yes, do you feel this way most of the time ?	NO	YES
d	Since X, do you feel as though you no longer care about the people or things around you? Compared to before this event, do you feel as though you've become a different person?	NO	YES
e	Have you noticed that your feelings became weaker or numbed after the event? (Ex of emotions : love, joy, anger, sadness, desire for vengeance, etc…)	NO	YES
	ARE **3** OR MORE **22-3** ANSWERS CODED **YES**?	➔ NO	YES
22-4 a	**NOTE THE ANSWER TO QUESTION 21-3B OF THE EDM SECTION OR ASK THE FOLLOWING QUESTION:** Since X, have you had difficulty sleeping (either falling asleep or waking up in the middle of the night or too early in the morning)? Or do you sleep too much? Does this happen almost every night?	NO	YES
b	Do you get angry or lose your patience more easily than before?	NO	YES
c	**NOTE THE ANSWER TO QUESTION 21-3F OF THE EDM SECTION OR ASK THE FOLLOWING QUESTION** : Since X, have you had trouble paying attention or concentrating? (Ex: following conversations with, for example, your social worker or your nurse or doctor, when watching a television show or in your French or computer class?) Do you have trouble making decisions ? If so, most of the time ?	NO	YES
d	Since X, have you felt more nervous or distrustful or suspicious than before? (Ex : As if something bad could happen to you at any moment)	NO	YES
e	Since X, are you easily startled (ex: Do you jump when you hear a door slam, or some other unexpected noise)?	NO	YES
	ARE **2** OR MORE **22-4** ANSWERS CODED **YES**?	➔ NO	YES
22-5	Since X, do these problems make you suffer? Or do they make relations with other people or your daily life more difficult?	NO	YES
22-6	**IS 22-5 CODED YES** ?	**NO**	**YES** ***POSTTRAUMATIC STRESS DISORDER***

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