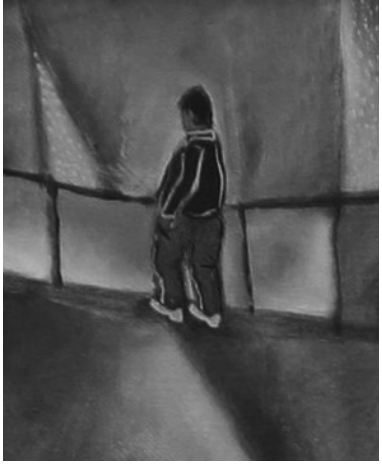


Chapter | 9

Concluding remarks, discussion and recommendations[1]

[1] In this chapter no referrals to literature are given, except in the paragraph ‘general discussion’. If studies are quoted without referral, we advice the reader to check the related chapter in this thesis.

Introduction

The Dutch Study Iraqi Asylum Seekers is an epidemiological study. Epidemiology is a branch of medical science that deals with the distribution of diseases in populations and with the distribution of factors that influence the occurrence of the disease. Epidemiological research attempts to determine who is prone to a particular disease, what exposure the affected individuals have in common and how much the risk is increased through exposure to a particular risk factor. By identifying personal characteristics and environmental exposures that increase the risk of disease, epidemiologists provide crucial input to risk assessments and contribute to the formulation of public health policies.

The father of epidemiological research is John Snow (1813-1858). This British doctor discovered through detailed and logical research that cholera was spread when people drank contaminated water (1849). His research results were eventually taken up by the government and led to the adaptation of the water supply systems, which decreased the spread of cholera significantly. Psychiatric epidemiology focuses on psychiatric problems and disorders and related risk factors. Rob Giel (1930-2009) has been called the father of Dutch psychiatric epidemiology. He was professor of psychiatry in Groningen from 1969 till 1995 and we were honoured by his presence at one of the first meetings on the present study.

This study emerged, like in Snow's case, from a clinical observation: there seemed to be a relation between 'source' (i.e. a long asylum procedure) and disease (i.e. disorder). This observation led to the main research question: *What is the impact of a long asylum-seeking procedure on mental and physical health, quality of life and disability of Iraqi asylum seekers in the Netherlands, in relation to pre- and post-migration risk factors ?*

The study estimates, in a cross-sectional design, the prevalence rates of mental health and health related dimensions ('distribution of diseases': descriptive epidemiology) and its relationships with a variety of risk factors ('factors that influence the occurrence of disease': analytic epidemiology). In order to estimate the relative impact of a long asylum procedure on health, the entire study group was pre-stratified, based on length of stay in the Netherlands. Group 1 arrived less than six months before the interview, and group 2 remained in the country for two years or more, without having a residence permit. The groups were compared on both risk factors and outcome measures and through several statistical procedures the relative contribution of each risk factor to the particular outcome measure was estimated.

In this final chapter the main findings and conclusions of the study are described, followed by some methodological considerations. After the general discussion, recommendations will be discussed, related to future research, the (public) health sector and the government, politicians and policy makers.

Main findings

Psychiatric disorders and a long asylum procedure

The results of the prevalence rates of psychiatric disorder showed that the Iraqi asylum seekers with a long asylum seeking procedure (group 2) had higher rates of psychiatric disorders compared to the asylum seekers that just arrived in the Netherlands (group 1). In group 2, 66.2% had 'one or more psychiatric disorder', versus 42.0% in group 1. Respondents in group 2 also had higher rates in anxiety disorders (30.5% versus 14.0%), depressive disorders (43.7% versus 25.2%), somatoform disorders (13.2% versus 4.9%) and alcohol dependency (6.6% versus 0%). The rates of post traumatic stress disorder (PTSD) were high (36.7%) but did not differ significantly between the groups. The two groups differed on a variety of risk-factors and we analysed the relative contribution of these risk-factors. It appeared that a long asylum procedure (i.e. 'membership of group 2') was the most important risk-factor, after 'female sex'. The risk to have 'one or more psychiatric disorder' in group 2 was more than twice as high (OR: 2.16) compared to group 1, independent from all the other included risk factors (e.g., adverse life events in Iraq).

In conclusion, asylum seekers who remain in the asylum procedure for more than two years have a significant higher risk for psychiatric disorders, compared to those who just arrive in the country. This risk is higher than the risk of adverse life events in the country of origin.

Post migration living problems (PMLP) and health

In order to study the post migration period in more details, a range of post migration living problems were assessed and evaluated in relationship with psychiatric disorders. Group 2 reported higher levels of PLMP, compared to group 1, e.g., worries about uncertainty about the future (86.8% versus 62.2%), missing the family (87.2% versus 71.3%) no permission to work (74.2% versus 31.5%). To reduce the number of variables, factor analysis was done on the 24 measured PMLP. Five clusters could be identified: 1) family related issues such as missing the family, worries about family in Iraq 2) discrimination, 3) issues directly related to the asylum procedure such as

fear of being sent home, 4) socio-economic living conditions, especially financial problems, housing problems and 5) socio-religious aspects such as lack of contact with people of the same religion. Some of the PMLP did not fit in any these clusters: language problems, no permission to work and work below level. All these clusters and items were significantly related to psychopathology, except 'socio-religious aspects'. The relative importance of these risk factors were estimated in a regression model, which showed that 'lack of work' and the clusters 'family related issues' and 'issues directly related to the asylum procedure' were the most important risk factors for psychopathology. These (clusters of) PMLP were especially present in group 2 and most respondents had all of these problems at the same time, which did increase their risks (accumulation of risk factors).

In conclusion, from the wide range of post migration living problems, worries about lack of work, family related issues and issues directly related to the asylum procedure are the most important risk factors for psychiatric disorders.

Functional disability, quality of life and physical health

The study on other indicators of health showed that group 2 had higher levels of disabilities and physical complaints, and lower levels of quality of life compared to group 1. Multivariate regression showed that length of stay was the strongest predictor for a low overall quality of life. In addition, lower quality of life was predicted by psychopathology, higher age, adverse life events in the Netherlands and the PMLP-clusters: family issues, socio-economic living conditions and socio-religious aspects. Disability was predicted by psychopathology, higher age and the PMLP clusters: family issues and socio-religious aspects. Physical complaints were predicted by length of asylum procedure, psychopathology, female sex, adverse life events in Iraq and PMLP-family issues.

In conclusion, asylum seekers who remain in the asylum procedure for more than two years have a significantly higher risk for lower quality of life and poorer physical health compared to those who just arrive in the country. Functional disability, quality of life and physical health problems are predicted by various types of post migration stressors, independently from psychopathology.

Use of health services

The reported use of regular services (in the last 2 months) were: preventive healthcare (nurse-doctor in the asylum seeker centre), general practitioner, medical specialist

(non-psychiatrist), social worker and mental health services. The preventive healthcare was the most frequently used service (55.4%), followed by the general practitioner (29.3%). Group 1 visited the preventive healthcare services more often than group 2 (72% versus 39.7%) and group 2 visited the mental health services more often than group 1 (9.3% versus 1.4%). The use of general practitioner, social worker and medical specialist (non-psychiatrist) was not higher in group 2. Drug consumption (hypnotics, anxiolytics and analgetics) was higher in group 2. Use of alternative services and treatments was very low in both groups. Respondents with psychopathology used significantly more services, but only 8.8% of them visited a mental health service. Further analyses showed that 'group 2 membership' and low perceived quality of general health predicted service use of a mental health worker. Psychopathology did not predict a visit to the mental health worker, but it did predict a visit to the medical specialist (non-psychiatrist) (OR: 1.34).

In conclusion, asylum seekers who remain in the asylum procedure for more than two years have a higher use of mental health services, but compared to the high prevalence of psychiatric disorder (66.2%), the use of this service is low (9.3%). Moreover, there is a mismatch between the type of health problem and the type of health service use.

Methodological considerations

In the interpretation of our study findings several strengths and weaknesses need to be acknowledged: these are related to design, sampling, response and representativity, translation and cultural validation of instruments. Each of these issues is discussed hereafter.

Design

The design of the study is observational in nature. Considering the main research question, a (prospective) longitudinal design with a cohort of asylum seekers would have been more appropriate. However this type of study was not feasible. The lives of asylum seekers are full of uncertainties: they frequently have to move to other centres, they are forced to leave the centres, they choose to leave to hide in illegality, they choose to go to another country etc. We would have been faced with a considerable bias resulting from a loss of baseline subjects at follow-up (drop-out). Therefore we designed a cross-sectional study. Initially we thought to compare refugees who received a resident permit immediately after entering the country (so-called 'invited refugees') with refugees who were living in the country for a long time (> two years)

who still did not get a resident permit (asylum seekers) . However, when we tried to contact the refugees with a resident permit, we failed to contact over 80% of the potential respondents, because the personal data (e.g., addresses) had been changed. Subsequently we designed a cross-sectional study in which we created a control group by pre-stratification of the entire study group of Iraqi asylum seekers, based on length of stay. We tried to reduce the differences between the 2 groups by studying only participants from the same country of origin and, in order to prevent missing important potential confounding risk factors, we gathered a wide range of potential risk factors for mental health problems. We used relevant literature and our own experience to choose which risk factors should be included and estimated the relative risk for each risk factor through statistical analysis. In our opinion the choice of a cross-sectional study of this type is the best possible design within the given circumstances.

Sampling, response and representativity

A strength of the study is the random sampling method. Everybody in the pre-selected groups had an equal chance to be included in the study. We were able to use this method because registration data were made available by the Central Agency for the Reception of Asylum Seekers (COA). By using random sampling we reduced selection bias. Moreover, to prevent another potential source of selection bias, we included registration data from all over the Netherlands.

A weakness of the study is the high number of non-contacts in both groups (group 1: 148 out of 582; group 2: 266 out of 474). In chapter 2 we described possible reasons. Fortunately we were able to differentiate the non-contacts in group 2: the percentage of non-contacts was especially high among asylum seekers that were registered with the COA, but were not actually living in a COA facility (centre). Consequently, the interviewed cases of group 2 mainly represent the population that was living in a regular centre (AZC). In order to calculate the response rate in our study, we defined the response rate as the proportion of completed interviews in the total number of eligible respondents as it is practiced in survey research. In this method non-contacts are considered as not-eligible, because it is not known if they are eligible. Following this method, we calculated the response rate in group 1 as 82% and in group 2 as 79%. Following another method in which the number of eligible respondents among the non-contacts is calculated with the help of the known eligibility among the contacted respondents and the inclusion of the partial interviews as respondents, we calculated the response rates in group 1 as 63% and in group 2 as 42%.

The high number of non-contacts is affecting the representativity of the final samples. It is important, though, to mention that representativity does not depend solely on the response rate. The sex ratio and mean age of respondents that participated in the study (i.e. interviewed respondents) could be calculated and did not differ from the original samples (all between sample comparisons $p<0.05$).

Instruments

A strength of the study is the use of well-studied and widely used instruments. The WHO-CIDI, version 2.1 was translated and tested in 58 languages, the WHOQoL-Bref in 23 and the reliability and validity of the BDQ has been evaluated in a 15-center, cross-national, multilingual study. Many studies among refugees use short instruments, that are particularly developed to detect the subjective psychological complaints among this group (HSCL-25 and HTQ). These instruments are dimensional and provide a score that does not result in a diagnosis according to one of the main classification systems (DSM, ICD). Moreover they only cover a limited range of symptoms (depressive, anxiety and PTSD symptoms). By using the WHO-CIDI, a categorical instrument, we were able to detect DSM-IV disorders and include a wide range of symptoms/disorders. The use of this instrument also creates the opportunity to compare the results with studies among general populations e.g., to compare with the results of the largest epidemiological study among the Dutch population. Finally, the WHO-CIDI and all the other used instruments are fully structured questionnaires which can be used by trained lay interviewers in face-to-face interviews.

Translation, cultural validation

We were fortunate that the majority of the included instruments were already culturally validated and translated in the Arabic language in the TPO-programme in Gaza. In this programme a translation process was used in which content, criterion, technical, conceptual and semantic (linguistic) equivalence were taken into consideration. However the Arabic language differs among populations in the Arabic world. We therefore worked with a focus group to adapt the list to the Iraqi study population. In this group each question was studied on comprehensibility, completeness, relevance and acceptability. Adaptations were made on the basis of consensus. The internal structure of instruments was left intact. These thorough procedures are a strength of the study because they improved the cultural reliability and validity of the original instruments. However, we can not exclude bias completely. E.g., the interpretation of the questions might have been different among the various ethnic groups (Kurdish, Arabic, Turkmenian, Armenian, Yezidi etc). Also some proposals of the focus

group had to be rejected because we could not allow additional questions in the instrumentsbecause of technical reasons. Consequently some concepts can be less valid than might have been possible. Finally, we could not avoid that some questions are phrased as statements, on which respondents were asked to respond if they agreed or not. Some studies have shown that these kind of questions have a lower degree of reliability.

General discussion

A long asylum procedure and mental health

To our knowledge the Dutch Iraqi Asylum Seekers Study is the first national community-based study among asylum seekers in a Western country. It is the first study that tries to assess the impact of a long asylum seekers procedure on mental health. However earlier studies did look at the effect of duration of stay in a host country on the level of psychological and psychiatric problems among refugees. As discussed in chapter 4, these studies show either a decrease or a stabilisation of such health problems over time. This contradicts the results of our study among asylum seekers, which suggest an increase of health problems over time. In a longitudinal study, Ryan et al. (2008) examined levels and predictors of distress among a community sample of persons who have sought asylum in Ireland. In this study they found that only those who attained a positive legal status outcome between T1 and T2 showed a decline in distress level. Hallas et al. (2007) studied a large, multiethnic group of asylum seekers (n=4516) in Denmark and found that referrals for psychiatric diagnosis as well as for somatic diagnosis increased significantly with length of stay in the asylum centre. These studies underline the stressfulness of being in an asylum procedure and/or living with the continuous threat of involuntary repatriation and confirm the findings of our study: a long asylum procedure is an important risk factor for mental health problems and other health related dimensions.

However, in a cross-sectional design, one can not automatically interpret causal relationships between a risk factor (i.e. a long asylum procedure) and the health outcome measures. Other explanations have to be considered and discussed. An alternative explanation is that the higher levels of psychopathology in group 2 compared to group 1 are caused by the selective attrition of Iraqi asylum seekers. The comparatively healthy individuals could have left the procedure, either due to a refusal of a residence permit or because they were fed up with their situation and applied for asylum in another country or went back to Iraq. In chapter 4, we argued

that this explanation is unlikely for the following reasons: 1) leaving the centre and the procedure before the final result of the procedure more likely depended on social networks, financial means and the asylum procedure in other countries, than on mental well-being; 2) in the years preceding the study, poor mental health per se seldom was a reason for the authorities to prolong the procedure, so the chances of being refused were likely to be equal between the mentally healthy and the unhealthy; and 3) the prevalence rates of PTSD in group 1 and 2 did not differ significantly.

Another explanation of the results of our study could be that the asylum seekers might have had the idea that they would have more chances for a resident permit if they presented a lot of mental complaints. Although this explanation can not be completely rejected, we do not think this has influenced our results considerably, because 1) the impact, if it exists, would have an effect on both groups, so for the comparison it would have little consequence; 2) in all written and oral information for the participants the non-existing relationship between the study and any legal procedure was strongly stated and the medical staff was used as a channel to contact the participants; 3) anonymity was guaranteed.

The high levels of health problems

The prevalence rates of mental health problems were strikingly high. A comparison of prevalence rates for psychiatric disorders between Iraqi asylum seekers (our study) and the general Dutch population (NEMESIS) shows that group 2 has much higher life-time prevalence rates than the Dutch population: 43.7% versus 19.0% for depressive disorders: and 30.5% versus 19.3% for anxiety disorders. Equally the 12-months prevalence rates differ significantly: 39.1% versus 7.6% for depressive disorders, 20.5% versus 12.4% for anxiety disorders and 23.5% versus 61.6% for 'one or more psychiatric disorder'. PTSD and somatoform disorders were not included in the NEMESIS. The National Comorbidity Survey as carried out in the USA, reported a life-time prevalence of the general population for PTSD of 7.8% (also measured with the CIDI). In a recent study De Vries and Olff (2009) found a similar prevalence rate (7.4%) among the Dutch population. In a study among USA veterans (Seal et al.,2009) from Afghanistan and Irak 12.8% were diagnosed with PTSD. Stellman et al. (2008) studied a large cohort of WTC rescue workers and found that 11.1% met probable PTSD criteria, 10 to 60 months after the WTC attack. In both groups of Iraqi asylum seekers the percentages are much higher (PTSD: gr 1: 31.5%; gr 2: 41.7%). This seems to be self-evident because a much higher percentage of asylum seekers is traumatised than the general population, but it is important to emphasise these findings because

there is a persistent belief nowadays that almost all asylum seekers are coming to the West for economAlso the prevalence rate of somatoform disorders and the levels of physical health complaints were especially high in group 2. The percentage of participants with a somatoform disorder was 4.9% in group 1 and 13.2% in group 2, while the prevalence rate in the general population was estimated at 1.0%. Within the cluster of somatoform disorders, group 2 had higher prevalence rates of conversion disorder (gr 1: 2.8%; gr 2 9.3%) and pain disorder (gr 1: 1.4%, gr 2: 11.3%). Moreover, group 2 reported a higher percentage of one or more physical complaint than group 1 (gr 1: 38.5%, gr 2: 66.2%). About 30% of group 2 had complaints of dizziness with falling, headache or back problems for over three months (gr 1: about 15%) Studies (e.g., McFarlane et al., 1994; Gureje et al.,2008), have shown that patients with a psychiatric disorder (especially depression and PTSD) have higher levels of physical complaints. Our study confirms these findings but also shows that other risk factors (e.g., a long asylum procedure and family related PMLP) were important as well. The results emphasize the entanglement of psychopathology and physical health problems and has, subsequently, important implications for health workers (see later).

Functional disability and quality of life

The Dutch Study Iraqi Asylum Seekers is the first study in which additional health outcome measures are assessed among asylum seekers. The WHO recommends to include disability and quality of life instruments in all epidemiological research because knowledge of the prevalence rates of psychiatric disorders alone do not give the full picture of the 'disease burden'. The results in this study confirm this statement and show that the suffering associated with a psychiatric disorder extends beyond the signs and symptoms of the disorder to broader areas of health (related) problems and impaired well-being.

As described above, quality of life and disability are both associated with psychopathology in our study. This is also found in other studies (e.g., Armenian et al., 1998). More important is the finding that other factors like length of the asylum procedure, various PMLP, and adverse life events in the Netherlands have a significant impact on these dimensions of health as well. E.g., the length of the asylum procedure (member Group 2) was the strongest predictor for 'overall quality of life' and the PMLP cluster 'socio-economic living conditions' (lack of privacy, housing problems, lack of safe environment for the children, financial problems) was a significant predictor of three (of the four) domains of quality of life. The finding that

psychopathology was not related to 'overall quality of life' shows that also asylum seekers without a psychiatric disorder experience a low quality of life.

Length of asylum procedure did not contribute significantly to functional disability. However, there was a strong relationship with the PMLP 'family related issues' and 'socio-religious aspects'. PMLP 'family related issues' were significantly more present in group 2, indicating that the length of asylum procedure (indirectly) does play an important role in relation to disability.

Health service use

The study results indicate a high unmet need for mental health care. Thirty per cent of the asylum seekers with a psychiatric disorder did not visit any service, and more than 90% did not visit a mental health service. However 60.6% visited a nurse/doctor in the centre and 33.8% the general practitioner. At the time of the study, both health services had the authority to refer a patient to the mental health service.

In exploring the mechanisms of the referral process an important finding was that the use of a general practitioner in group 2 (25.8%) was not higher compared to group 1 (32.9%), despite the higher levels of health problems in this group. The use of a general practitioner in group 2 is even lower compared to the general Dutch population, which is 42%, and even more so compared to immigrants: 51% (Westert et al., 2005). Van Oort et al. (2003) also found that asylum seekers visit the general practitioner less often than the general Dutch population: number of contacts per year 3.5 versus 4.5. The conclusion is that despite the higher prevalence of health problems, asylum seekers make less use of the general practitioner which is decreasing the chance of being referred to e.g., a mental health service. Moreover psychopathology appeared to be a predictor for higher use of a medical specialist (non-psychiatrist), but not for higher use of a mental health service.

Our findings lead to the following hypothesis 1) asylum seekers present themselves with physical rather than with mental problems (our study showed high levels of physical complaints), 2) the staff in the centre and the general practitioner do not recognize the mental health problems, and if they do 3) only a small percentage of patients is referred for adequate mental health care. In addition to this it is also possible that the mental health services were not (or were thought not to be) accessible for this group of patients, and that the staff in the centre and the general practitioner did not refer in anticipation of this fact/assumption.

In between the period of the data collection and 1-1-2009, special projects and programs were developed to improve both the services in the centre as well as the mental health services for asylum seekers. As far as we know the results of these projects and programs have not been evaluated. At 1-1-2009 COA contracted another insurance company and this company has changed the health services in the centres drastically. With the exception of the doctors for patients below 18 years, all doctors have been discharged and the nursing staff has been diminished. Only the general practitioner has been authorized to refer patients. These developments have not yet been finalized and their impact is unknown at this moment.

Recommendations

Recommendations for future research

Multi-national epidemiological research.

The study shows that Iraqi asylum seekers have high levels of mental and physical health problems. Risk factor analyses have shown the importance of stressors during the post-migration period. These post migration stressor differ between receiving countries (within the European Union and elsewhere), because there are substantial differences in reception, living conditions and rights of asylum seekers between these countries. Multi-national epidemiological research, with the use of the same instruments, will help to find differences in prevalence rates and risk factors in different countries. The results can contribute in formulating an asylum seekers policy which prevent harm to the (mental) health of asylum seekers as much as possible. Moreover, the study shows that, in epidemiological research among asylum seekers, it is very important not to focus solely on PTSD, but to include a wide range of psychiatric disorders. As epidemiological research is especially focused on finding high risk groups, comparison of the results with the general population should be possible.

> We recommend a epidemiological multi-national study among asylum seekers, with the inclusion of a wide range of potential risk factors and health outcome measures. The study should be done with recognized, frequently used instruments in order to be able to compare the results with the general, native, population.

Context-related trauma research

The participants in our study reported high levels of experienced adverse life events in the country of origin and we found high prevalence rates of psychiatric disorders. Risk factor analyses showed a significant relationship between these adverse life events

and psychiatric disorder. These relationship has often been found in other studies. Our study has shown, however, that the period between the adverse life events in the past and the mental health in the present (i.e. the time of the interview) is of great importance when we study the risk factors for mental health. E.g., we assessed the experience of torture and found that 24.5% in group 1 and 36.4% in group 2 were tortured. Nevertheless in the multivariate analyses, including adverse life events in the Netherlands and length of stay in the asylum procedure, torture was not a significant risk factor for 'one or more psychiatric disorder'. Our findings indicate that a research program among asylum seekers and refugees that focuses solely on the impact of trauma on mental health will never result in an appropriate picture of associated risk factors of mental health problems and the results of this type of research might even lead to misleading recommendations (e.g., that, in order to treat the patient, it is necessary in all cases to focus on the trauma's).

> We recommend that post migration stressors should always be included as determinants in trauma research among asylum seekers and refugees. More quantitative as well as qualitative research should be done on context-related risk factors and their relationship with (mental) health.

Recommendations for the (public) health sector

Application of integrated health policy

One of the responsibilities of the public health sector is to make authorities aware of the existence of a high-risk group. This study shows that asylum seekers are a particular group at risk for (mental) health problems and that the risks are not mainly related to experiences in the past but in the present. The consequence of this is, fortunately, that a lot can be done to lower these risks.

In the Netherlands the government promotes an 'Integrated approach in health policies'. This involves the recognition of the importance of other sectors in relation to health, e.g., housing, education and social affairs (so-called facet policy). To support local governments in these tasks, a national institute (TNO) has developed tools to do a screening of relevant determinants and to investigate possible relevant interventions.

> We recommend that the ideas of an integrated approach in health policies (facet policy) will be applied in the case of asylum seekers. Such an approach will put emphasize on improvements of living conditions, employment facilities, education, etc. which are very essential in relation to health. Local governments

and local public health services (GGD-en) should take the responsibility to develop such a policy.

Capacity building

Our study shows a high unmet need for healthcare among Iraqi asylum seekers. More than 90% of the persons with a psychiatric disorder did not visit a mental health worker. Moreover having a psychiatric disorder was a predictor for a referral to a medical specialist (non-psychiatrist) but not to a mental health worker (a mismatch between type of health problem and type of service). In the discussion of these findings the organization and the quality of the referral system has been questioned (see above). One of the characteristics of the complexity of the health problems of asylum seekers is the combination of mental and physical health problems.

We recommend that the relevant authorities (e.g., COA, insurance company) recognize the complexity of health problems of asylum seekers and the need for adequate mental health treatment. Based on this recognition a policy can be developed including e.g., an intensive training programme of medical staff (including general practitioners), personnel management which allows spending enough time to investigate the health problems, health care need and adequate preparation of referrals.

Resilience-oriented treatment

The complexity of the problems of asylum seekers that is described in the study reduces the applicability of routine treatment protocols and practices substantially. The use of these protocols requires a safe and stable environment, and besides, protocols usual deal with only one psychiatric diagnostic category or with one disorder, while co-morbidity is high in this target group. Moreover, the experience is that most asylum seekers are not ready and/or able to go through these procedures and that results are modest at best. In order to meet the specific needs of our target group, new strategies are necessary.

In a separate chapter (chapter 8) we described a resilience-oriented diagnostic and treatment model in which the concepts of stress, vulnerability and resilience (distinguished in personal strength and social support) are incorporated. Using this model the health worker and patient search for resources of resilience and work together to strengthen them. These resources can be classified according to the bio-psycho-social model: biological (e..g. physical exercise, understanding the body,

relaxation, treatment of medical illnesses), psychological (e.g., positive emotions and humour, acceptance, cognitive flexibility, empowering self-esteem, active coping), social (e.g., social relatedness, reconnecting the family, creating social support), cultural (e.g., cultural identity, acculturation, language skills), and religious/spiritual resources.

> We recommend the use of resilience-orientated therapies and strategies (ROTS) in the treatment of mental health problems among asylum seekers. The therapies and strategies do not primarily focus on adverse and/or traumatic experiences prior to arrival but pay serious attention to daily living problems and the enduring stress generated by the asylum procedure. The described ROTS model (with the concepts of stress, vulnerability and personal strength and social support) offers a theoretical and practical framework for both patients and health workers.

Recommendations for government, politicians and policy makers

Evaluation of policy on Iraqi asylum seekers

The data collection of our study was done at the time the government of Saddam Hussein was still in power. The respondents reported high levels of human right violations. The occurrence of many of these violations have been extensively reported by human right organizations e.g Amnesty International. In 2003 Saddam Hussein's government was overthrown by western allies, because of its supposed potential danger as a nuclear power. Later human rights issues were more prominently used to defend the military actions. After an intensive political debate, the political involvement of the Dutch government in overthrowing the Hussein government is presently under study. The policy on the handling of the applications of Iraqi asylum seekers in the years before the intervention was never evaluated, despite the fact that human rights breaches can be a reason to give refugees a resident permit according to international law.

> We recommend that the policy of the Dutch government on Iraqi asylum seekers that fled their country during the Saddam Hussein regime is as seriously evaluated as the Dutch policy on the political support of the military intervention.

Shortening of the asylum procedure

The main conclusion of the Dutch Study Iraqi Asylum seekers is that a long asylum procedure (> two years) is detrimental for the health situation of asylum seekers. It is paradoxical that such harm exists alongside the commitment of the Netherlands as

a signatory to the Refugee Convention of Geneva, to recognize the rights of people seeking protection. A policy that implements both the form and the spirit of the Refugee Convention should not result in harm to people who have sought protection.

The data for the Dutch Study Iraqi Asylum Seekers were collected in 2000/2001. In 2000, 34.0% of all registered asylum seekers stayed for over two years in a COA facility and in 2001, 47.8%.

According to the Dutch Alien Law 2000 *(Article 42 and 43)*, the official period in which the decision should be given is six months after the initial application for asylum. In individual cases this time limit can be extended by another six months, when advice from or research by a third party is necessary according to the Minister of Justice. However the percentage of persons that stayed for over two years in a procedure increased over the years with the highest percentage in 2004: 78.9% of the asylum seekers in a COA facility. In 2007 the percentage was still 57.5%. The conclusion is that the problem of long asylum procedures has not vanished under the Dutch Alien Law 2000. The present government (2009) is working on a new asylum procedure. The aim is to shorten the procedures. One of the tools to reach this goal is to recognize medical problems at an earlier moment in the procedure. We support this new policy. In the old regulations, only after rejection of the regular asylum application medical aspects could be brought forward in another procedure. Unfortunately, however, earlier efforts to shorten the asylum procedure failed and that too should be acknowledged. The overall poor health situation due to a long asylum procedure is harming the affected and their families and it is a threat to the (re)integration process, in the host country or elsewhere. Therefore and also from a human right perspective there should be a time limit to the asylum procedure.

> We recommend to put in all efforts to shorten the asylum procedure. Moreover we propose that the right to reside should be granted automatically when the procedure lasts longer than two years.
>
> We also recommend a thorough inventory by an experienced specialist of physical as well as mental complaints/disorders, in the beginning of the asylum procedure.

Improvement of living conditions

The respondents of the study (especially group 2) reported high levels of worries about their socio-economic living conditions. The quality of life domain ‘environmental

aspects' scored very low in group 2. Also in daily psychiatric practice patients report a lot of stress by poor housing conditions, lack of privacy, unsafe living environment, living together with all kinds of persons from different cultural background, poor transport facilities. In several qualitative studies these aspects are often mentioned as a source of complaints. Our study has shown that these stressors are significant risk factors for psychopathology and for low levels of quality of life.

> We recommend a reconsideration of the housing policy of asylum seekers with more attention to matters of privacy, possibilities for a normal family life and safety.

Work

A high percentage of asylum seekers reported worries about lack of work (group 2: 74%). Further analyses showed that 'worries about lack of work' was one of the most important risk factors for 'one or more psychiatric disorder'. Many asylum seekers come from countries where one has to work for a living and where social benefits are not known.

Other studies has shown that a sense of meaningfulness strongly contributes to a higher quality of life. Lack of work and/or other meaningful daily activities contribute to feelings of an 'empty existence' and are detrimental for the capacity of resilience.

Presently (September 2009) asylum seekers in the Netherlands are allowed to work for 24 weeks a year. However, due to the strict rules, only very few are able to find a job.

> We recommend an extension of the period in which asylum seekers are allowed to work. The rules on practical implementation of work should be simplified and an active approach is needed e.g., by COA workers in cooperation with local employers.

Recognition of the importance of family

Most Iraqi asylum seekers had strong and extended family ties before their flight. In our study, the cluster of family related issues consisted of the items: missing the family, worries about family in Iraq, inability to go home in case of emergency (e.g., sickness relatives in Iraq) and loneliness of the asylum seeker him/herself. Group 2 reported high levels of worries about these items. Further analyses showed that the cluster was related to higher levels of psychopathology, lower quality of life, more disability and

even higher levels of physical complaints. The items are not exclusively characteristic for asylum seekers. Refugees and migrants also have these problems. The reason it affects the asylum seekers so badly might be related to the uncertainty about the future, the fact that they can not easily build a new social network to compensate the lack of family relations due to frequents moves, the constraints in housing and financial facilities, the impaired Dutch language abilities by lack of schooling opportunities etc. Social support is known as a protective factor for health problems and an important source of resilience. When this support is lacking for a long period it affects health and functioning in a negative way.

> We recommend recognition by the government of the importance of family. Family reunification within the country (the Netherlands) should be based on a broad definition of 'family' (based on the extended family structure). Social support from other sources should be facilitated and encouraged (e.g., less moves, better access to social activities, more natural living environment, Dutch language lessons, more support by voluntary agencies).

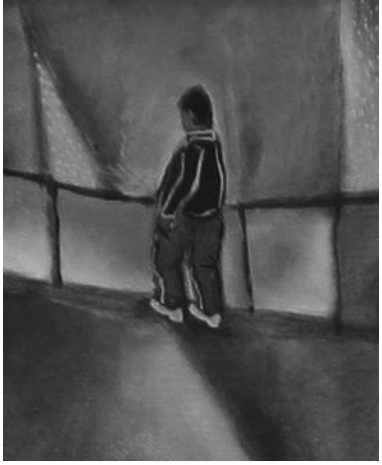
Finally

As described in the introduction, John Snow, the father of epidemiological research, discovered a relationship between contaminated water and a deadly disease in 1849. The cholera vibrio, that turned out to be the direct cause of this disease, was first discovered by Koch in 1883. Like in Snows' study, also in many modern epidemiological studies, the direct cause of a disease or disorder is not known. However such research highlights the importance of certain particular risk factors. Our study has shown that a long asylum seeking procedure and post migration living problems are important risk factors for mental health problems and other health related dimensions. Shortening of the asylum procedure and alleviation of the living problems that asylum seekers are faced with is therefore urgently needed.

As in the time of Snow, there will be arguments about these findings, as there will be discussion about the recommendations.

Snow took his research to the town officials of Soho and convinced them to take the handle off the pump, making it impossible to draw water and get contaminated. The officials were reluctant to believe him, but took the handle off as a trial, only to find out that the outbreak of cholera almost immediately trickled to a stop.

The recommendations in relation to our study, may not be as easy to implement as taking the handle off a water pump. However, we do hope that anyone who takes health seriously will try to implement the recommendations as best as possible, be it as researcher, health worker, politician or government official. The debate surrounding immigration is very complex and has many factors of influence. This study and its recommendations have tried to give this debate a new impulse from the perspective of (mental) health.



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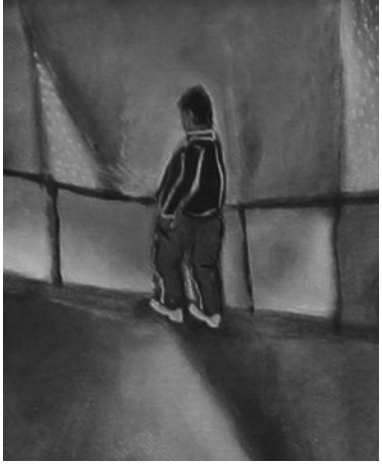


Summary

Dutch Study Iraqi Asylum Seekers

Impact of a long asylum seeking procedure on mental health and other indicators of health among Iraqi asylum seekers in the Netherlands: an epidemiological study.

This dissertation systematically assessed the prevalence of psychiatric disorders, quality of life, disability and physical health among one of the biggest group of asylum seekers in the Netherlands. These outcome measures were evaluated in relation with socio-demographics and pre- and post-migration adverse life events, with a special focus on the length of the asylum procedure. Post migration living problems were assessed and also related to the health outcome measures. Health service use was measured and evaluated in relation with potential predictors. The dissertation finishes with the clinical implications of the study and an elaboration of a resilience-oriented diagnostic and treatment model for asylum seekers.

The data collection, from at random selected respondents living in all provinces of the country, took place in the years 2000 and 2001.

Part I: Introduction, methodology and descriptive results

In the decade preceding this study over 3 million persons applied for asylum in Europe. In the same period over 300.000 applications for asylum were submitted in the Netherlands, putting an enormous pressure on the immigration system. About one fifth of all applications came from Iraqi refugees. Due to the higher influx of asylum seekers and to the restrictive immigration policies, the number of asylum seekers living in special housing facilities, awaiting the decision of their application increased from 30.000 to over 80.000 in 2001. Many of them had to wait very long for this decision, e.g., in 2000: 34.0% of the 78.200 waited more than two years.

Many asylum seekers experienced adverse life events and were in need of (mental) health care. The healthcare institutions (e.g. GGZDrenthe) were challenged to deliver care to a group they were not used to deal with. Besides the cultural and language aspects that complicated the treatment, the clinical observation was that the asylum procedure had a serious negative effect on the treatment results and that the health problems increased as the length of the asylum procedure became longer. The need arose to do adequate research on the mental health problems of asylum seekers and the idea of the Dutch Study Iraqi Asylum Seekers was born.

In chapter 1, the Dutch and international literature on mental health problems among asylum seekers and refugees is reviewed till the year of the study (2000). The literature showed extensive health problems among asylum seekers and refugees. Posttraumatic stress disorder (PTSD) appeared to be common but also other anxiety disorders, depressive disorders and dissociative disorders were frequently found. Often more than one disorder in the same person occurred. However, only a few studies dealt specifically with asylum seekers and there were several scientific limitations. Some of these limitations were: use of convenient and not at random samples, small size of the samples, focus on only one or two disorders, use of instruments only used in refugee population which limits the comparison with other groups, no attention for disability and quality of life, and many ethnic groups in one study.

Subsequently, the literature was searched for risk factors in relation with mental health problems. In describing these factors, we divided the risk factors in pre- and post-migration risk factors. Although the search gave information on a variety of risk factors, the importance of traumatic life events in relationship with other risk factors (e.g., a long asylum procedure, post migration living problems) in the pathway to psychopathology remained unclear.

Therefore we designed a study among asylum seekers with the main research question:
What is the impact of a long asylum procedure on mental and physical health, quality of life and disability of Iraqi asylum seekers in the Netherlands, in relation to pre- and post-migration risk factors?

Chapter 2 describes the methodology of the study. In relation to the main research question a longitudinal study would have been preferable but appeared to be impossible, due to many practical problems (such as frequent moves, hiding or expulsion after denial of residence permit, leaving the centres without further notice). Therefore we did a cross-sectional, community based study and prestratified the population in two groups, based on length of stay in the Netherlands (= being in an asylum procedure): respectively less than six months (group 1) and more than two years (group 2). The sampling was at random. Data could be analyzed from 294 respondents (group 1: 143, group 2: 151). Fully structured, culturally validated, Arabic questionnaires were used. The interviews were done by specially trained Iraqi volunteers. Psychiatric disorders were measured with the WHO Composite International Diagnostic Interview (CIDI, 2.1), quality of life with the WHOQOL-Bref, disability with the Brief Disability Questionnaire and physical health with a newly developed list, containing questions

about diseases and chronic physical complaints. The adverse life-events were gathered from four life periods: (1) 0-12 years, (2) 13 years – departure from Iraq, (3) departure from Iraq – arrival in the Netherlands and (4) after arrival in the Netherlands. They were measured with the Harvard Trauma Questionnaire. Experience of psychological and physical torture was asked for in detail with the Exposure to Torture Scale. In addition data about youth domestic events, death and separation in the family, and loss of material goods were gathered. The list of youth domestic events encompasses being raised by both biological parents, and 14 items related to an unsafe and abusing environment. Post Migration Living Problems (PMLP) where measured with an adapted list from Silove et al. (1997). The Iraqi-Arabic questionnaire was based on the Palestinian-Arabic version which had been translated from English and culturally validated and translated in a 7-step procedure. For use in the Iraqi population a focus group of 8 men and women from different ethnic and professional backgrounds modified the instruments. Frequencies and mean scores of outcome and risk factors were calculated and differences between the 2 groups were estimated with the help of chi-square and student t-tests. Univariate and multivariate regression analyses were used to study the predictive values of the pre-and post migration risk factors, with special focus on the impact of length of stay in the Netherlands.

The descriptive part of the results (chapter 3) showed significantly higher levels of psychiatric disorders in Iraqi asylum seekers staying in the Netherlands for more than two years (group 2) compared to those who just arrived (group 1). The prevalence rate of ‘one or more psychiatric disorders’ was 42% in group 1, versus 66.2% in group 2. Also the prevalence rates of anxiety, depressive and somatoform disorders were significantly higher in group 2. Posttraumatic stress disorder was high in both groups but did not differ ($p>0,05$). Alcohol dependency only occurred in group 2. Furthermore group 2 showed lower quality of life, higher disability and more physical health problems. Almost all (5 out of 6) chronic physical complaints were more prevalent in group 2. The frequencies of reported adverse life events were substantial, e.g., combat situations (41.8%), witness death family/friends (45.0%), imprisonment (32.3%), torture (29.3%). The most frequently mentioned post migration living problems (PMLP) were asylum procedure-related items and family-related items. Group 2 reported a high score (74.2%) on worries about ‘no permission to work’. Overall both adverse life events and PMLP were more prevalent in group 2. The descriptive results of health service use showed high overall service use: 71.4% made use of a service in the last two months. Although group 2 had much higher levels of health problems, there was no significant difference between the two groups in the

use of the general practitioner and the medical specialist. Group 2 visited a mental health practitioner more frequently, but the percentage (9.3%) was low compared to the (earlier mentioned) prevalence rates of psychopathology. Drug consumption was significantly higher in group 2. Finally, the opinion of the respondents about the interview is described. More than half of the participants reported that the interview was a positive experience.

Part II: Analyses of determinants and outcome measures.

In chapter 4 the prevalence rates of psychopathology are described and the results of the logistic regression analyses are shown and discussed. Through this type of analyses we estimated the relative contribution of socio-demographics and the pre- and post migration risk factors to psychopathology. In order to study the impact of a long asylum procedure we included 'group 2 membership' in the analyses. Because the two groups might differ on relevant risk factors we entered a detailed list of socio-demographic characteristics in the analyses, i.e.: age, sex, marital status, children, ethnicity, religion, literacy, geographic background, education and occupation in Iraq, language skills and psychiatric problems in the past. Mean scores were calculated from the list of youth domestic stress and the 4 lists of adverse life events. Because torture is a well known risk factor for a psychiatric disorder (especially PTSD) this item was entered as a separate item. The results from the analyses show that 'group 2 membership' was the most important risk factor (OR: 2.16) - , after 'female sex' (OR: 2.58). In other words, a long asylum procedure doubles the risk of getting a psychiatric disorder, no matter the experiences in the country of origin. Other independent risk factors for 'one or more psychiatric disorder' were: adverse life events in the youth (till 13th year) (OR: 1.28), between 13th year and departure Iraq (OR: 1.35), and after arrival (OR: 1.66). Adverse life events during the period between departure Iraq and arrival the Netherlands did not reveal significant risk. Torture did not show a significant relationship with 'one or more psychiatric disorder'. Similarly, in the analyses with depressive disorders, anxiety disorders and somatoform disorders, a long asylum procedure and adverse life events after arrival in the Netherlands produced had higher risks (higher OR's) than earlier experienced adverse life events.

In chapter 5, worries about post migration living problems (PMLP) and their relationships with psychopathology are reported and discussed. The aim of these analyses was to study the mechanisms of the impact of a long asylum procedure on psychopathology in more detail. Factor analyses showed that five clusters of PMLP

could be identified: family issues, discrimination, asylum procedure issues, socio-economic living conditions, and socio-religious aspects. Language problems and work-related items did not fit in one of the clusters and were analysed as separate items. We compared the scores of PMLP of participants with and without (different types of) psychopathology and found that almost all differences were significant. In the multivariate logistic regression analyses, worries related to the asylum procedure (i.e. uncertainty about residence permit, fear to be sent away, uncertainty about the future), worries about family related issues (i.e. missing the family, worries about family in Iraq, unable to go home in case of emergencies, loneliness) and worries about the absence of work appeared to have the strongest relationship with psychopathology. A higher score on 'no permission to work' increased the risk of 'one or more psychiatric disorder' with 44%. As mentioned earlier, this type of PLMP was especially reported in group 2.

Chapter 6 explores the outcome measures quality of life (Qol), functional disability and physical health and their relationships with psychopathology, and pre- and post migration variables. Group 2 had lower mean scores on the two overall measures of Qol and on three of the four domains of Qol (i.e. physical health, psychological health, and environment). Only the domain social relationships did not show a significant difference between the groups. Functional disability was worse in group 2 since there were higher mean scores on both 'physical and social role impairments' and on 'total number of days with serious impairment in the last month'. Physical diseases did not differ between the groups, but physical complaints were significantly more present in group 2. Overall 66.2% of the participants of this group reported one or more physical complaints, versus 38.5% in group 1. Results of the various regression analyses showed that Qol, disability and physical health were all related with psychopathology, but when we extended the model with pre-and post migration risk factors the analyses showed that length of stay, adverse life events and several post migration problems were significant predictive risk factors, independent from psychopathology. To be more precise: predictors of lower scores on Qol were: length of stay in the Netherlands, adverse life events after arrival in the Netherlands, days of dysfunction in the last months, and the PMLP cluster 'socio-economic living conditions'. Predictors of disability were psychopathology (i.e. 'one or more psychiatric disorder', depressive and somatoform disorders), higher age and the PMLP cluster 'family related issues'. Chronic physical complaints were predicted by psychopathology (i.e. depressive, anxiety and somatoform disorders), but also by length of stay in the Netherlands,

adverse life events between 13th year and departure, female sex, and the PMLP cluster 'family related issues'.

Chapter 7 describes the use of preventive and curative (physical and mental) health services of the study group and shows the relationships between health service use and predicting variables. In the literature three sets of variables are mentioned in relation to health service use: predisposing, enablement and need variables. Respondents' predisposition was measured by age, gender, religion, ethnicity and 'group 2 membership' (length of stay). Need factors included: psychiatric disorders, physical health, quality of life and disability, while PMLP were added as a special set of need variables. Enabling factors were not measured as regular health services for asylum seekers are available and accessible in the Netherlands without financial obstacles. In the first analyses the relation between psychopathology and health service use was studied. Results show that respondents with psychopathology used significantly more services (70% versus 54.5%), both curative and preventive services. Respondents with psychopathology visited a medical specialist (non-psychiatrist) much more often in group 1, but not in group 2. The use of drugs (analgetics, anxiolitics and hypnotics) in respondents with psychopathology was higher in both groups, compared to those without psychopathology. Subsequent analyses with all predicting variables showed different patterns of predictors for different types of health service. The conclusion of these analyses is that a long asylum procedure is not associated with higher levels of service use, except for mental health service use and drug use. Psychopathology is related to a higher level of service use, but when corrected for the influence of other predisposing and need factors, other factors such as high role and functional disability, and low perceived quality of general health, are more important predictors. Moreover having one or more psychiatric disorder(s) predicts the use of a medical specialist (non-psychiatrist), but does not predict mental health service use. The overall use of mental health service use is very low compared to the high prevalence of psychiatric disorders: over 80% of the asylum seekers with a psychiatric disorder used any health service, but only 8.8% visited a mental health service.

Part III Implications of study results into clinical practice

In chapter 8 the implications of the study results in relation to the clinical practice are discusses and a resilience-oriented diagnostic and treatment model is introduced. The most important implications are that there is a need for a thorough and broad diagnostic assessment procedure and that the treatment should not primarily focus on

adverse and/or traumatic experiences prior to arrival but pay serious attention to daily living problems and the enduring stress generated by the asylum procedure. Therefore it is recommended that the treatment should be resilience-orientated. In the chapter, biological, psychological, social, religious and cultural resources of resilience are discussed and translated to the mental health care of asylum seekers.

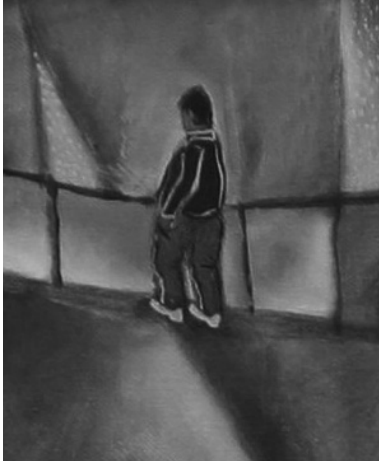
The 'resilience-oriented therapy and strategies'(ROTS) model brings together the concepts of vulnerability and stress and two aspects of resilience, i.e. personal strength (e.g., coping) and social support. Vulnerability and strength are considered personal characteristics (internal factors) and stress and social support are considered ecosocial characteristics (external factors). It is assumed that a dynamic equilibrium between these factors is required to remain or become a healthy person.

The ROTS model helps in the diagnostic process to gather information about relevant factors that are possibly related to the health complaints. When the model is adequately applied, the assessment leads to all kinds of ideas for interventions. In our opinion the ROTS model is very well applicable in all treatment modalities with asylum seekers. The conclusion of the chapter is that though treatment possibilities are limited due to, the ongoing stress and the existence of co-morbidity of stress-related psychiatric disorders, treatment is possible, even though it needs scientific corroboration.

Part IV Concluding remarks, discussion and recommendations

In the final chapter (9) the main findings and conclusions are described, followed by some methodological considerations on design; sampling, response and representativity; instruments; translation and cultural validation. After the general discussion, several recommendations are discussed. These recommendations relate to future research, the (public) health sector and government, politicians and policy makers.

The overall conclusion of the findings is that a long asylum procedure has a negative impact on the overall health situation of asylum seekers. The situation is not only harming the affected, but also interferes with the integration process in the Netherlands or elsewhere.



المختصر

دراسة هولندية حول طالبي اللجوء العراقيين

تأثيرطول مدة إجراءات اللجوء على مدى وقوع الأضطرابات النفسية والمؤشرات الصحية الأخرى لدى طالبي اللجوء العراقيين في هولندا: دراسة وبائية.

هذه الأطروحة تبحث وعلى طريقة منهجية، طبيعة ومدى الأضطرابات الطبية النفسية وجودة الحياة والعجز الوظيفي والصحة البدنية لدى احدى أكبر مجموعة من طالبي اللجوء السياسي في هولندا. ومن ثم تبحث الاطروحة الروابط بين هذه المؤشرات - الصحية وعوامل الأصابة المحتملة مثل الخصائص الأجتماعية والديموغرافية والأحداث الحياتية المرعة وظروف الحياة المقلقة قبل و بعد الخروج من العراق (عوامل الأصابة قبل وبعد الهجرة). وتعطى الأطروحة أهمية خاصة لعلاقة طول مدة إجراءات اللجوء بذلك. ومن ثم يتم النظر الى مرافق الرعاية الصحية التي استفاد منها اللاجئ العراقى وإلى أي مدى. وتنتهى الأطروحة بالأستنتاجات المترتبة على ما توصلت اليه الدراسة، لأجل تقديم المساعدة الصحية فى الواقع العملي وتقديم طرح تحليلي حول أنموذج موجه مرن للتشخيص والعلاج، وملائم بصفة خاصة لطالبي اللجوء.

طالبي اللجوء الذين شاركوا في البحث (العينة) كانوا من سكنة مناطق مختلفة، منتشرة في كافة أرجاء هولندا. وقد تم جمع البيانات المستخدمة في الدراسة في السنتين 2000 و 2001.

الجزء الأول : مقدمة، المنهجية والنتائج الوصفية

في السنوات العشر السابقة لهذه الدراسة كان قد طلب أكثر من 3 ملايين شخص اللجوء في أحدى الدول الأوربية. وكان فى الفترة نفسها عدد طالبي اللجوء في هولندا 300.000، مما أدى إلى وضع ضغوط هائلة على نظام الهجرة في هذا البلد. مايقرب من خمس عدد هذه الطلبات كان من قبل اللاجئين العراقيين. وبسبب الأعداد الهائلة لطالبي اللجوء من جهة والسياسات التقييدية لمنح القبول من جهة أخرى، تزايد العدد الأجمالي لطالبي اللجوء المنتظرين للبت في طلباتهم في واحد من مرافق الأستقبال في هولندا من 30.000 في عام 1994 إلى 80.000 في عام 2001. وكان على كثير من هولاء الأنتظار لمدة طويلة جدا على قرارالبت هذا، ففى عام 2000 إنتظر على سبيل المثال 34.0 ٪ من إجمال المتقدمين البالغ عددهم 78.200 لأكثر من سنتين.

كان عدد كبير من طالبي اللجوء قد تعرضوا لأحداث مروعة في بلدهم الأم وكانوا بحاجة لرعاية صحية (عقلية).
إن مؤسسات صحية مثل الرعاية الصحية العقلية في محافظة درينتا (GGZ Drenthe)، وجدت نفسها في موقع، مستعدة لتقديم الخدمات لجماعة من الناس لم يكونوا لغاية ذلك الوقت إلاعلى علم قليل بمثل هذه المؤسسات. وإن إختلاف الثقافة واللغة كان من شأنها أن تصعب عملية التواصل والعلاج. بالأضافة إلى ذلك كان من المتوقع أن يأثر طول مدة إجراءات اللجوء سلبيا على نتائج العلاج بل ويؤدى إلى زيادة المشاكل الصحية خلال فترة الأنتظار. ولأن الدراسات العلمية الموجودة لحد ذلك الوقت لم تستطع أن تقدم فهما لهذه الحالة، زادت الحاجة إلى دراسة مصممة بصورة جيدة حول هذا الموضوع وهذه أدت بدورها إلى ولادة فكرة هذا البحث (دراسة هولندية حول طالبي اللجوء العراقيين).

الفصل الأول يعطي لمحة عامة عن الدراسات الهولندية والدولية المتوفرة لغاية سنة 2000 (سنة إجراء الأطروحة)، حول المشاكل الصحية لطالبي اللجوء واللاجئين. وأظهرت الكتابات هذه الكثير من المشاكل الصحية بين هذه الشريحة. إن ما يسمى بأضطراب الشدة بعد الصدمة (PTSD) بدت كثيرة الحدوث، ولكن الأضطرابات الأخرى كأضطرابات الخوف وأضطرابات الكآبة والأضطرابات الأنفصالية كانت قد سجلت أيظا. وغالبا ما وجد أكثر من إضطراب نفسي واحد عند الشخص الواحد.
وكانت الدراسات الخاصة بطالبي اللجوء حصريا، نادرة جدا وكانت بالأضافة إلى ذلك تفتقر هذه الدراسات أيضا إلى مواصفات علمية هامة. ومن هذه النواقص: إستخدام عينات بحثية غير مختارة عشوائيا، قياس إحدى الأضطرابات النفسية او أثنين فقط (في العادة إضطراب الشدة بعد الصدمة والكآبة)، إستخدام الأدوات التي تستخدم حصريا في دراسات اللاجئين (والتي من شأنها أن تصعب عملية المقارنة مع الشرائح العامة للسكان)، عدم التركيز على عوامل مثل جودة الحياة والأعاقة الوظيفية والأعراض الصحية البدنية وكذلك وجود أكثر من مجموعة عرقية واحدة في البحث الواحد.

ومن ثم بحث في هذه الكتابات عن عوامل التعرض للمشاكل النفسية بين طالبي اللجوء واللاجئين. وعند تعريف هذه العوامل تم فرزها إلى العوامل قبل الهجرة والعوامل بعد الهجرة. على الرغم من أن الكتابات المتوفرة هذه قد أعطت الكثير من المعلومات حول أهمية عوامل الأصابة المختلفة، لاكنها لم توضح التأثير النسبي لعامل الصدمات الحياتية المروعة على

الصحة، مقابل تأثير عوامل التعرض الأخرى مثل (الفترة الطويلة لإجراءات اللجوء ومشاكل مابعد الهجرة). ولذلك قمنا نحن بأستحداث دراسة جديدة خاصة بطالبي اللجوء واللتي تعتمد السؤال البحثي الرئيسي التالي:

ماهو تأثير المدة الطويلة لإجراءات اللجوء على الصحة العقلية والبدنية وعلى جودة الحياة والأداء والنشاط اليومي لطالبي اللجوء العراقيين في هولندا وعلاقتها بعوامل الأصابة قبل وبعد الهجرة؟

الفصل الثاني يصف منهجية الدراسة. إذا أخذنا سؤال البحث المطروح أعلاه في نظرالأعتبار، كان من المفضل إجراء دراسة طولية، ولكن تحقيق مثل هذا البحث لم يكن ممكنا بسبب مشاكل عملية كثيرة مثل: التنقلات السكنية الكثيرة للاجئين، مغادرة اللاجئين إلى جهات مجهولة، الترحيل أو الأختفاء بعد رفض طلب الجوء. ولهذا السبب تم إجراء دراسة سكانية عرضية مقطعية وأخذ فيها عينات عشوائية من مجموعتين مختلفتين من حيث طول فترة البقاء (= فترة إجراءات اللجوء) في هولندا: وهما المجموعة الأولى (أقل من 6 أشهر) والمجموعة الثانية (أكثر من سنتين). وقد إستطعنا جمع وتحليل المعلومات من 294 مستطلعا (المجموعة الأولى: 143 والمجموعة الثانية: 151. وقد تم إستعمال قوائم إستبيانية باللغة العربية، متكاملة الهيكل ومتجددة ثقافيا. وأجريت المقابلات من قبل متطوعين عراقيين مدربين تدريبا خاصا لهذا الغرض. وقيست الأضطرابات النفسية بمقياس الأستطلاع التشخيصي الدولي المركب لمنظمة الصحة العالمية (CIDI, 2.1)، وقيست جودة الحياة بمقياس (WHOQoL, Bref)، والعجز الوظيفي بمقياس إستبيان مختصرللإعاقة (BDQ) وقيست أخيرا الصحة البدنية بواسطة لائحة متطورة حديثا تحتوي على أسئلة حول أعراض جسدية وأمراض بدنية.

وقد تم الأستفسارعن الأحداث الحياتية المروعة على أربعة فترات حياتية مختلفة للاجئ:
(1) 0-12 سنة، (2) 13 سنة - مغادرة العراق، (3) مغادرة العراق - الوصول إلى هولندا (4) بعد الوصول إلى هولندا. وإستخدم لهذا الغرض إستمارة إستبيان هارفارد للصدمة (HTQ). وتم الأستفسار بصورة مفصلة عن سابقة التعذيب النفسي والجسدي بحسب مقياس التعرض للتعذيب (ETS). بالأضافة إلى ذلك تم جمع المعلومات حول حالات الوفاة والأنفصال عن الأسرة وفقدان أفراد العائلة وفقدان الممتلكات. كما وتضمنت قائمة الظروف العائلية في مرحلة النشوء، أسئلة حول ما إذا كان اللاجئ نشأ في معية أحد أوكلا الوالدين. وأحتوت القائمة كذلك على 14 بندا حول ما إذا كان هناك إهمال للاجئ أوعدم وجود الأمان في مرحلة النشوء. وتم قياس المشاكل في فترة مابعد الهجرة، ما يسمى بالمشاكل الحياتية مابعد الهجرة (PMLP)، بإستخدام نسخة مرهمة من قائمة سيلوف (Silove .ea 1997).

وقد أعتمدت قائمة الإستبيان العربية- العراقية المستحدثة في هذا البحث، لحد كبيرعلى النسخة العربية- الفلسطينية. وقد ترجمت هذه النسخة الأخيرة من الإنجليزية وتمت الترجمة وعملية التجديد الثقافي حسب (طريقة الخطوات السبعة). وقد قامت مجموعة متخصصة متكونة من 8 رجل وإمرأة، ذوي خلفيات عرقية ومهنية مختلفة، بترهيم القوائم الأستطلاعية المذكورة بحيث يمكن إستخدامها لشريحة اللاجئين العراقيين. وقد تم حساب التردد ومعدلات النتائج وحساب عوامل الأصابة وتقدير الفروقات بين المجموعتين، بواسطة إختبار كوادرات الشي (Chi-Quadrate test) واختبارات ستودينت الثائية (Student t-tests). وأستخدمت طريقتي تحليل الأنحدارالخطي البسيط والأنحدار الخطي المتعدد لدراسة الأرقام المتوقعة لعوامل الأصابة قبل وبعد الهجرة، مع تركيز خاص على تأثير مدة البقاء في هولندا على ذلك.

ويبين الفصل الثالث (الجزء الوصفي للنتائج) بأن الأضطرابات النفسية لدى طالبي اللجوء العراقيين الساكنين لمدة أطول من سنتين في هولندا (المجموعة 2) أكثر بوضوح مما عليه أولئك الذين قد وصلوا لتوهم إلى هولندا (المجموعة 1). فقد كان معدل إنتشار ' إضطراب نفسي واحد أو أكثر' 42.0٪ في المجموعة 1 و 66.2٪ في المجموعة 2. كذلك كانت معدلات إنتشار إضطرابات الخوف والكآبة والهجاس (وهم المرض) أعلى بشكل ملموس في المجموعة 2 مقارنة مع المجموعة 1. وكانت نسبة إضطراب الشدة بعد الصدمة مرتفعة في كلا المجموعتين، ولم يكن الإختلاف بين المجموتين ملموسا (ع < 0.05). وكان الإدمان على الكحول موجودا فقط في المجموعة 2. علاوة على ذلك أظهرت المجموعة 2 درجات منخفضة لجودة الحياة وأخرى عالية للعجز الوظيفي والأعراض الجسدية. وتبين بأن تقريبا كل (5 من 6) من الأعراض الجسدية المزمنة كانت قد سجلت أكثر لدى المجموعة 2 مقارنة مع المجموعة 1. كانت النسبة المئوية للأحداث الحياتة المروعة كبيرة، على سبيل المثال : أوضاع قتالية (41.8 ٪)، مشاهدة وفاة أفراد العائلة أو الأصدقاء (45.0 ٪)، السجن (32.3 ٪)، التعذيب (29.3 ٪). كانت أكثرية مشاكل مابعد الهجرة المذكورة مرتبطة بإجراءات اللجوء والقضايا المتعلقة بالعائلة. هذا وقد أدلى عدد كبير(74.2 ٪) من المستطلعين في المجموعة 2 بأنهم يتعرضون للقلق بسبب عدم السماح لهم بالعمل. وبصورة عامة أضهرت المجموعة 2 نسبة أعلى من كل من الأحداث الحياتية المروعة ومشاكل مابعد الهجرة. وأظهرت النتائج الوصفية للأستفادة من الرعاية الصحية بأن (71.4 ٪) من المستطلعين قد أستخدم في الشهرين الأخيرين قبل المقابلة، بصورة ما إحدى أشكال الرعاية. وعلى الرغم من أن الفريق 2 أظهرت النسبة الأكبر من المشاكل الصحية، إلا أنهم لم يستخدموا خدمات طبيب العائلة أو الأخصائي (غير النفسي) أكثر من قرائنهم في الفريق 1. صحيح بأن المجموعة 2 قد إستخدموا خدمات الصحة العقلية بنسبة (9.3 ٪)، ولكن هذه النسبة تعتبر منخفضة بالمقارنة مع أرقام

شيوع الأضطرابات النفسية المشار إليها سابقا. كانت نسبة إستخدام العقاقير الطبية في المجموعة 2 أعلى بنسبة ملموسة. وفي نهاية هذا الفصل سأل عن رأي المستطلعين حول المقابلة بصورة عامة، وما هو جدير بالذكر كان رأي أكثر من نصف المشاركين حول المقابلة إيجابيا.

الجزء الثاني : تحليل المحددات والنتائج

في الفصل الرابع تتم دراسة ووصف أرقام معدل إنتشار الأضطرابات النفسية (السايكوباثولوجي) ونتائج التحليل الأنحداري اللوجستي. وبإستخدام هذا النوع من التحاليل، حسبنا التأثير النسبي للعوامل الأجتماعية – الديموغرافية وعوامل الأصابة قبل وبعد الهجرة بالنسبة للسيكوباثولوجي. ولكي نتمكن من دراسة تأثير الإجراءات الطويلة لمدة للجوء، أدخلنا عضوية المجموعة 2 في التحاليل. ولأنه كان من الممكن أن يختلف المجموعتين بالنسبة لعوامل إصابة مهمة، تم الأعتماد في التحاليل على قائمة تفصيلية للبيانات الأجتماعية - الديموغرافية، مثل: العمر والجنس والحالة الزوجية والأطفال والعرق والدين وقابلية الكتابة والقراءة والخلفية الجغرافية والمستوى التعليمي والمهنة في العراق والمهارات اللغوية والمشاكل النفسية في الماضي. وقد تم حساب متوسط الأرقام المسجلة بالنسبة لقائمة ظروف الأسرة في فترة النشوء والقوائم الأربعة للأحداث الحياتية المروعة وأدرجت هذه الأرقام في التحاليل. ولأنه كان من خلال الدراسات السابقة معروفا بأن التعذيب عامل مهم للأصابة بالأضطرابات النفسية (خاصة إضطراب الشدة بعد الصدمة) أدرج هذا البند بشكل منفصل في التحاليل. ولقد أظهرت نتيجة التحليل بالنسبة "لواحدة من الأضطرابات النفسية أو أكثر" بأن عضوية المجموعة 2" هو أهم عامل من عوامل الأصابة (OR: 2· 16)، النتيجة لا تنطبق على جنس الأنثى (OR: 2· 58). بعبارة أخرى: تؤدي إجراءات اللجوء الطويلة المدة إلى مضاعفة التعرض لإضطراب نفسي بضعفين، بغض النظرعن الأحداث في البلد الأم. عوامل الإ صابة الأخرى هي: الأحداث الحياتية المروعة في مرحلة النشوء (لغاية السنة 13 من العمر) (OR.1· 28)، في الفترة بين 13سنة ومغادرة العراق (OR.1· 35) وبعد الوصول الى هولندا (OR.1· 66). هذا ولم تظهر الأحداث الحياتية المروعة في الفترة ما بين مغادرة العراق والوصول الى هولندا أية زيادة للإصابة. كذلك بالنسبة لعامل 'التعذيب' لم يظهر أية زيادة للأصابة بإ ضطراب نفسي في هذا التحليل. كما أظهرتحليل حالات إضطرابات الكآبة و إضطرابات الخوف وإضطراب الهجاس (وهم المرض) بأن إجراءات اللجوء الطويلة والأحداث الحياتية المروعة بعد الوصول إلى هولندا أدت الى نسبة أعلى للأصابة (OR أكبر)، إذا ما قورنت بالأحداث الحياتية المروعة في الفترات السابقة.

في الفصل الخامس تم وصف ونقاش مدى الأهتمام بكيفية العلاقة بين مشاكل ما بعد الهجرة والسايكوباثولوجي. وكان الهدف من هذه التحاليل بصفة أكبر، لأجل فهم الطريقة التي أثرت بها إجراءات اللجوء الطويلة على ظهور المرض النفسي (السايكوباثولوجي). ومن خلال عملية تحليل العوامل ظهرت الإمكانية بتقسيم مشاكل مابعد الهجرة إلى 5 حزم: العوامل المتعلقة بالعائلة، التمييز، العوامل المتعلقة بإجراءات اللجوء، الظروف المعيشية الأجتماعية والأقتصادية وأخيرا العوامل الأجتماعية - الدينية. أما مشاكل اللغة والعوامل المتعلقة بالعمل فلم يكن من الممكن إدراجهما في أية من هذه الحزم الخمسة، لذلك تم إدراجهما في حزم خاصة لتحاليل أخرى لاحقة. هذا وقد قارننا الأرقام المسجلة لمشاكل مابعد الهجرة للمستطلعين المصابين وغيرالمصابين (بأنواع مختلفة) من السايكوباثولوجي، فوجدنا بأن كافة الفروق بين الفريقين كانت معتبرة وملموسة. وقد بينت التحاليل من نوع الأنحدارالخطي المتعدد بأن الحزم الآتية تظهر أقوى إرتباط مع ظهور السايكوباثولوجي: القلق بسبب العوامل المتعلقة بإجراءات اللجوء مثل (عدم وضوح إمكانية الحصول على تصريح الأقامة، التخوف من الأرجاع إلى البلد الأم وعدم وضوح آفاق المستقبل)، القلق بسبب العوامل المتعلقة بالعائلة مثل (فقدان العائلة، القلق حول العائلة في العراق، عدم إمكانية الرجوع إلى البلد في حالة حدوث مكروه للعائلة والوحدة) والقلق بسبب عدم السماح بالعمل. رقم أعلى لعامل عدم جواز العمل أدى إلى زيادة التعرض "لواحدة أو أكثر من الأضطرابات النفسية" بنسبة 44 ٪. وكما سبق الذكر في الفصل الثالث كان هذا النوع من "مشاكل حياتية مابعد الهجرة" أكثر ذكرامن قبل المستطلعين في المجموعة 2.

الفصل السادس يبحث مقاييس النتائج، جودة الحياة والعوق الوظيفي والصحة البدنية وعلاقتها بالسيكوباثولوجي وبمشاكل ماقبل ومابعد الهجرة. المجموعة 2 أظهرت معدلا أكثر إنخفاظا بالنسبة للسؤالين العامين حول جودة الحياة وبالنسبة لثلاثة من المجالات الأربعة (الصحة البدنية والصحة النفسية والبيئة الحياتية). فقط بالنسبة للمجال الرابع (العلاقات الأجتماعية) لم يكن الفرق بين المجموعتين فرقا ملموسا أو ذو دلالة. وتبين بأن العوق الوظيفي لدى المجموعة 2 كان أشد: معدلات أعلى بالنسبة لكل من (العوق البدني والعوق الأجتماعي) وكذلك (المجموع الكلي لأيام الشهرالأخيرالمتصفة بمعوقات كبيرة). الأمراض البدنية عند المجموعة 2 لم تكن تحدث بنسبة ملموسة أكبر، مقارنة بالمجموعة 1، كما هو الحال مع الأعراض البدنية. ففي المجموعة 2 أدلى 66.2 ٪ من المشاركين بوجود عرض بدني واحد أو أكثرمقابل 38.5 ٪ في المجموعة 1. وأظهرت التحاليل الأنحدارية المختلفة بأن كلا من العوق الوظيفي والصحة البدنية كانت ذات علاقة بحدوث المرض النفسي (السيكوباثولوجي). وبعدما أضيفت عوامل ماقبل ومابعد الهجرة إلى التحاليل، بدت بوضوح بأن 'طول فترةالبقاء في هولندا' وأحداث الحياة المروعة ومشاكل الحياة مابعد الهجرة المختلفة، كانت متنبئات لمقاييس النتائج، وبغض النظرعن

السيكوباثولوجي. وبصياغة أدق: كل من طول فترة البقاء في هولندا، أحداث الحياة المروعة في هولندا، المجموع الكلي لأيام الشهرالأخيرالمتصفة بمعوقات كبيرة والحزمة "ظروف الحياة الأجتماعية - الأقتصادية" من المشاكل الحياتية مابعد الهجرة، تنبأت بمعدلات منخفضة لجودة الحياة. والسايكوباثولوجي (أي ' إضطراب نفسي واحد أو أكثر'، إضطرابات إكتئابية وإضطرابات وهامية)، السن الكبير وحزمة 'البنود المتعلقة بالعائلة' من المشاكل الحياتية مابعد الهجرة تنبأت بدورها بعجز وضيفي أكبر. وتم التنبؤ بحدوث أعراض جسدية مزمنة بسبب السيكوباثولوجي (بعبارة أخرى، إضطرابات إكتئابية وإضطرابات الخوف وإضطرابات وهامية)، ولكن كذلك بسبب طول فترة البقاء في هولندا وأحداث الحياة المروعة في الفترة بين سن 13 ومغادرة العراق وعامل الجنس الأنثوى وحزمة 'البنود المتعلقة بالعائلة' من المشاكل الحياتية مابعد الهجرة.

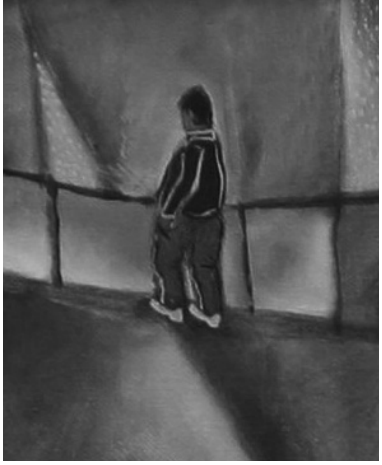
الفصل السابع يصف إستخدام المرافق الصحية الوقائية والعلاجية (البدنية والعقلية) ويبين أوجه الأرتباط بين هذا الأستخدام والمتغيرات المبحوثة المتنبئة. بالنسبة لأستخدام مرافق الرعاية الصحية تفرزالدراسات ثلاثة مجموعات متميزة من المتغيرات: قابلية الأصابة وتحسين الأستخدام والحاجة للرعاية. القابلية وإستعداد الأصابة تقاس بالعوامل: العمر والجنس والدين والعرق و'عضوية المجموعة 2' (أي مدة الأقامة). متغيرات الحاجة للرعاية التي أدرجت في البحث كانت: الأضطرابات النفسية، الصحة البدنية، جودة الحياة والعجزالوضيفي. وبالأضافة إلى ذلك تم إضافة المشاكل الحياتية مابعد الهجرة كمجموعة مستقلة ضمن متغيرات الحاجة للرعاية. ولم يتم قياس متغيرات تحسين الأستخدام لأن الخدمات الصحية العادية في هولندا متوفره ومسموحة من دون عقبة مالية لطالبي اللجوء. وقد تم في التحاليل الأولى دراسة العلاقة بين السايكوباثولوجي وإستخدام الرعاية. أظهرت نتائج هذه التحاليل أن إستخدام المصابين بالأمراض النفسية لمرافق الرعاية أعلى بنسبة ملحوظة مقارنة بغيرالمصابين ممن شملهم الأستطلاع (70 ٪ مقابل 54.5 ٪). وكانت هذه النتيجة تنطبق على كل من إستخدام الرعاية الوقائية وإستخدام الرعاية العلاجية. المستطلعين المصابين بالأمراض النفسية في المجموعة 1 ترددوا على الأطباء الأخصائين (غير النفسين) أكثر بكثير مما هو عليه الحال بالنسبة للمستطلعين المصابين بالأمراض النفسية في المجموعة 2. إستخدام الأدوية (المسكنات والدواء المقلل للخوف والمنومات) كان في كلا المجموعتين أعلى لدى المستطلعين المصابين بالأمراض النفسية. التحاليل الأخرى التي أدرجت فيها كل المتغيرات، أظهرت أنماطا مختلفة من المؤشرات لأستخدام مرافق الرعاية المختلفة. يستنتج من هذه التحاليل بأن إجراءات اللجوء الطويلة ليست مؤشرا لزيادة الأستفادة من الرعاية الصحية، بأستثناء إستخدام الرعاية الصحة النفسية (GGZ) وتعاطي الأدوية. إن السايكوباثولوجي يؤدي الى إستخدام أكبر للرعاية، ولكن عند تصحيح هذه العلاقة بالنسبة لتأثيرالعوامل الأخرى كقابلية الأصابة والحاجة للرعاية، يتبين لنا بأن تأثير العوامل الأخرى مثل العجز الوضيفي والمعدل المنخفض لجودة الحياة أكبر من ذلك. الأستنتاج الآخر للتحاليل هو أن وجود ' إضطراب نفسي واحد أو أكثر' مؤشر إلى إستشارة طبيب أخصائي (غير طبيب نفساني)، وليس مؤشرا لأستخدام مرفق صحي عقلي (GGZ). بصورة عامة إستخدام المرافق الصحية العقلية منخفضة جدا، إذا ما قورنت بنسبة إنتشار الأمراض النفسية (السايكوباثولوجي): أكثر من 80 ٪ من طالبي اللجوء المصابين بإضطراب نفسي يستفيد من خدمات المرافق الصحية، ولكن 8.8 ٪ فقط منهم يتردد على مصحة للأمراض العقلية.

الجزء الثالث : إستعمالات الأطروحة في واقع تقديم الخدمات

الفصل الثامن يعالج الآثارالتطبيقية لنتائج الدراسة لصالح واقع تقديم الخدمات ويقدم الفصل أنموذجا تشخيصيا وعلاجيا مرن التوجه. وأهم فوائد هذه النتائج: هناك حاجة ماسة إلى مرحلة تشخيصية شاسعة ومنظبطة وأن العلاج لاينبغي أن يركز في المقام الأول على الصدمات الحياتية وأحداث الحياة في الماضي ولكن يجب أن يهتم بجدية بمشاكل الحياة اليومية (الظروف) والقلق المستمر من جراء إجراءات اللجوء. ولهذا يتم التوصية بتقديم علاج مرن التوجه. في هذا الفصل يتم الحديث عن عدد من المصادر البيولوجية والنفسية والأجتماعية والدينية والثقافية للمرونة ويتم ترجمتها إلى علاج طالبي اللجوء.
ما يسمى بأنموذج "العلاج المرن الموجه والأستراتيجيات ROTS" يتضمن مفهومي القلق والضعف وجانبين من المرونة: القوة الشخصية (مثل التعامل مع المشاكل) والدعم الأجتماعي. ويعتبر الضعف والقوة في الأنموذج خصائص شخصية (عوامل داخلية) ويعتبرالقلق والدعم خصائص بيئية (عوامل خارجية). ويسمى هذا الأنموذج في الهولندية (SSKK). ولكي يصبح الشخص سليما ويبقى سليما يرى النموذج وجود الحاجة الى توازن حركي (دينامي) بين هذه العوامل المختلفة. هذا الأنموذج (ROTS) يساعد على فهم العوامل المهمة في مرحلة التشخيص والتي قد تؤثرعلى الأعراض الصحية. واذا أحسن تطبيق هذا النموذج بصورة جيدة، فإنه يوفر العديد من الأفكار والخيارات اللازمة للمرحلة العلاجية. في رأينا ومن خلال تجاربنا نقول بأن نموذج (ROTS) يمكن تطبيقه بصورة جيدة في جميع أنواع العلاجات لطالبي اللجوء.
إستنتاج هذا الفصل هوأن الخيارات العلاجية تصبح على كل حال محدودة بسبب وجود الضغط والقلق المستمر وبسبب وجود مركب الأضطرابات النفسية المتعلقة بالقلق، ولكن العلاج لطالبي اللجوء هو ممكن. و يبقى هذا الأستنتاج بحاجة إلى أدلةعلمية بعد.

في الفصل التاسع يتم وصف النتائج والأستنتاجات الأكثرأهمية للأطروحة، ويليها بعض التخمينات المنهجية بشأن تصميم البحث وطريقة أخذ العينات والأستجابة والخصوصية والوسائل المستخدمة والترجمة وتجديد الأستبيانات ثقافيا لجعلها قابلة للأستعمال. بعد المناقشة العامة يتم صياغة بعض التوصيات. هذه التوصيات تخص البحوث المستقبلية والصحة العامة والدولة والساسة وصناع القرار.

النتيجة النهائية لهذه الدراسة هي أن إجراءات اللجوء الطويلة تؤثر سلبيا على الحالة الصحية العامة لطالبي اللجوء. وهذه الحالة الصحية السيئة لاتعني فقط معاناة اللاجئين المعنيين، ولكن تأثركذلك سلبيا على عملية الأندماج في هولندا أو في البلد الذي يعيش فيه اللاجئ.



Samenvatting

Nederlandse Studie Irakese Asielzoekers

Invloed van de duur van de asielprocedure op de prevalentie van psychiatrische stoornissen en andere indicatoren van gezondheid bij Irakese asielzoekers in Nederland: een epidemiologische studie.

Deze dissertatie heeft op systematische wijze aard en omvang van psychiatrische stoornissen, kwaliteit van leven, functiebeperkingen en lichamelijke gezondheid onderzocht onder één van de grootste groepen asielzoekers in Nederland. Vervolgens werden de verbanden onderzocht tussen deze gezondheids-indicatoren en de potentiële risico factoren, zoals socio-demografische eigenschappen en schokkende levensgebeurtenissen en stresserende levensomstandigheden voor en na de vlucht uit Irak (de zogenaamde pre- en post migratie risicofactoren). Speciale aandacht werd gegeven aan het verband met de duur van de asielprocedure. Verder werd onderzocht in welke mate de asielzoekers gebruik maakte van welke gezondheidszorg voorziening. De dissertatie besluit met de consequenties van de bevindingen van de studie voor de hulpverleningspraktijk en een uiteenzetting over een veerkracht gericht model voor diagnostiek en behandeling, met name toegespitst op asielzoekers

De asielzoekers die deelgenomen hebben aan het onderzoek (de zogenaamde respondenten), woonden verspreid over heel Nederland. Alle gegevens voor de studie werden verzameld in de jaren 2000 en 2001.

Deel I: Inleiding, methodologie en beschrijvende resultaten
In de tien jaar voorafgaande aan de studie vroegen meer dan drie miljoen mensen asiel aan in één van de Europese landen. In dezelfde periode bedroeg dit aantal in Nederland 300.000, wat een enorme druk legde op het immigratiesysteem. Ongeveer één vijfde van de aanvragen kwam van Irakese vluchtelingen. Vanwege de grote aantallen asielzoekers en het restrictieve toelatingsbeleid groeide het aantal asielzoekers dat in één van de opvangfaciliteiten wachtte op de beslissing over hun aanvraag van 30.000 in 1994 tot 80.000 in 2001. Veel van hen moesten lang wachten op deze beslissing, in 2000 wachtte bijvoorbeeld 34.0% van de 78.200 asielzoekers al meer dan twee jaar.

Veel asielzoekers hadden schokkende gebeurtenissen meegemaakt in hun land van herkomst en hadden (geestelijke) gezondheidszorg nodig. Gezondheidsinstellingen (bijvoorbeeld GGZDrenthe) zagen zich geplaatst voor een taak om zorg te bieden aan een groep waar zij tot dan toe grotendeels onbekend mee waren. Cultuur en

taalverschillen bemoeilijkte het contact en dus de behandeling. Daarnaast was er de indruk dat de lange asielprocedure de behandelresultaten negatief beïnvloedde en dat de gezondheidsproblemen zelfs toenamen gedurende de wachttijd. Omdat de wetenschappelijke literatuur hier geen inzicht in gaf, groeide de behoefte aan een goed opgezet onderzoek en het idee van de Nederlandse Studie Irakese asielzoekers was geboren.

In hoofdstuk 1 wordt een overzicht gegeven van de Nederlandse en de internationale literatuur over gezondheidsproblemen van asielzoekers en vluchtelingen tot aan het jaar van de studie (2000). Deze literatuur toonde aanzienlijke gezondheidsproblemen aan onder asielzoekers en vluchtelingen. Posttraumatische stress-stoornis (PTSS) bleek vaak voor te komen, maar ook andere angststoornissen, depressieve stoornissen en dissociatieve stoornissen werden gerapporteerd. Vaak werden er meerdere stoornissen bij dezelfde respondent gevonden. De studies die specifiek over asielzoekers gingen, waren echter zeer schaars en bovendien hadden deze studies belangrijke wetenschappelijke beperkingen. Een aantal van deze beperkingen waren: het gebruik van niet willekeurig (at random) geselecteerde onderzoeksgroepen, het meten van slechts één of twee stoornissen (meestal PTSS en depressie), het gebruik van instrumenten die alleen in vluchtelingen studie gebruikt worden (wat vergelijking met de algemene populatie bemoeilijkte), geen aandacht voor kwaliteit van leven, functionele beperkingen en lichamelijke gezondheidsklachten en meerdere etnische groepen in één studie.

Vervolgens werd in de literatuur gezocht naar de risicofactoren voor psychiatrische problematiek onder asielzoekers/vluchtelingen. Bij de beschrijving van deze factoren werden pre- en post migratie risicofactoren onderscheiden. Alhoewel de literatuur veel informatie gaf over het belang van de verschillende risicofactoren, bleef de relatieve invloed van schokkende levensgebeurtenissen op (on)gezondheid ten opzichte van de invloed van andere risicofactoren (bijvoorbeeld een lange asielprocedure en post migratie problemen) onduidelijk.

Daarom ontwierpen we een studie onder asielzoekers met als belangrijkste onderzoeksvraag:

Wat is de invloed van een lange asiel procedure op de geestelijke en lichamelijke gezondheid, kwaliteit van leven en dagelijks functioneren van Irakese asielzoekers in Nederland, in relatie tot de pre- en post migratie risicofactoren?

Hoofdstuk 2 beschrijft de methodologie van de studie. In relatie tot de genoemde onderzoeksvraag zou een longitudinaal onderzoek de voorkeur hebben gehad, maar zo een onderzoek bleek niet mogelijk vanwege vele praktische problemen, zoals: frequente verhuizingen, vertrek met onbekende bestemming (MOB) en uitwijzing of onderduiking na een afwijzing van een verblijfsvergunning. Daarom werd een cross-sectioneel bevolkingsonderzoek uitgevoerd waarbij willekeurige steekproeven getrokken werden uit twee groepen die onderling verschilde in duur van verblijf in Nederland (= duur van de asielprocedure): minder dan zes maanden (groep 1) en meer dan twee jaar (groep 2). Van 294 respondenten (groep 1: 143, groep 2: 151) konden de gegevens verzameld en geanalyseerd worden. Er werden volledig gestructureerde, cultureel gevalideerde, Arabischtalige vragenlijsten gebruikt en de interviews werden afgenomen door speciaal getrainde Irakese vrijwilligers. Psychiatrische stoornissen werden gemeten met de WHO-Composite International Diagnostic Interview (CIDI, 2.1), kwaliteit van leven met de WHOQoL-Bref, functiebeperkingen met de Brief Disability Questionnaire en lichamelijke gezondheid met een nieuw ontwikkelde lijst die zowel vragen over lichamelijke klachten als over lichamelijke ziektes bevatte.

Meegemaakte schokkende levensgebeurtenissen werden uitgevraagd over vier levensperiodes: (1) 0-12 jaar, (2) 13 jaar – vertrek uit Irak, (3) vertrek uit Irak – aankomst in Nederland en (4) na aankomst in Nederland. Er werd hierbij gebruik gemaakt van de Harvard Trauma Questionnaire. Ervaringen van psychologische of lichamelijke martelingen werden gedetailleerd uitgevraagd met de Exposure to Torture Scale. Daarnaast werden gegevens verzameld over dood en separatie of verlies van familie en verlies van materiële zaken. De lijst over gezinsomstandigheden in de jeugd bevatte verder vragen over het wel of niet opgroeien met (beide) ouders en 14 items over een eventuele onveiligheid en verwaarlozing in de jeugd. De problemen in de post migratie periode (de zogenaamde Post Migration Living Problems. PMLP) werden gemeten met een aangepaste lijst van Silove ea. (1997).

De voor dit onderzoek ontwikkelde Irakees-Arabische vragenlijst was voor een groot deel gebaseerd op een Palestijns-Arabische versie. Deze versie was vertaald uit het Engels en cultureel gevalideerd en vertaald volgens een 7-staps procedure. Met behulp van een focus groep, bestaande van 8 mannen en vrouwen met verschillende etnische en professionele achtergrond, werd de vragenlijst aangepast voor gebruik onder de Irakese populatie.

Frequenties en gemiddelde scores van de uitkomstmaten en van de risicofactoren werden berekend en de verschillen tussen de twee groepen werden geschat met

behulp van Chi-kwadraat en student t-testen. Univariate en multivariate regressie analyses werden gebruikt om de voorspellende waardes van de pre- en post migratie risicofactoren te bestuderen, met daarbij een speciale focus op de invloed van de duur van verblijf in Nederland.

Het beschrijvende deel van de resultaten (hoofdstuk 3) toonde aan dat Irakese asielzoekers die al meer dan twee jaar in Nederland zijn (groep 2) significant meer psychiatrische stoornissen hadden dan degene die net in Nederland aangekomen waren (groep 1). Het prevalentie cijfer voor 'één of meer psychiatrische stoornis' was 42.0% in groep 1 en 66.2% in groep 2. Ook de prevalentie cijfers voor angst, depressieve en somatoforme stoornissen waren significant hoger in groep 2 vergeleken met groep 1. Posttraumatische stress-stoornis was hoog in beide groepen, maar verschilde onderling niet significant ($p>0.05$). Alcoholafhankelijkheid kwam alleen voor in groep 2. Verder liet groep 2 lagere scores zien voor kwaliteit van leven en hogere scores voor functiebeperkingen en lichamelijke klachten. Bijna alle (vijf van de zes) chronische lichamelijke klachten kwamen meer voor in groep 2 vergeleken met groep 1. Het percentage van genoemde schokkende levensgebeurtenissen was aanzienlijk, bijvoorbeeld: gevechtssituaties (41.8%), getuige zijn van de dood van familie/vrienden (45.0%), gevangenschap (32.3%), marteling (29.3%). De meest frequent genoemde PMLP waren items die samenhingen met de asielprocedure en familie gerelateerde items. Verder gaven bij groep 2 veel mensen (74.2%) aan dat zij zich veel zorgen maakte over het feit dat zij niet mochten werken. Over het algemeen had groep 2 hogere scores voor zowel schokkende levensgebeurtenissen als PMLP. De beschrijvende resultaten over het gebruik van zorg toonde aan dat 71.4% in de laatste twee maanden vóór het interview gebruik had gemaakt van een bepaald type zorg. Alhoewel groep 2 veel meer gezondheidsproblemen meldde, maakte zij niet vaker gebruik van de huisarts en de medische specialist (niet-psychiater). Groep 2 bezocht vaker een ggz-hulpverlener, maar het percentage (9.3%) was laag vergeleken met de eerder genoemde prevalentiecijfers voor psychiatrische stoornissen. Medicatie gebruik was significant hoger in groep 2. Aan het einde van het hoofdstuk wordt de mening van de respondent over het hele interview beschreven. Meer dan de helft (55.5%) van de deelnemers gaf aan het eens te zijn met de stelling 'Het interview was een positieve ervaring', slechts 2.7% was het niet eens met deze stelling.

Deel II: Analyses van de determinanten en uitkomstmaten.

In hoofdstuk 4 worden de prevalentie cijfers voor psychiatrische stoornissen (psychopathologie) en de resultaten van de logistische regressie analyses beschreven

en bediscussieerd. Met behulp van dit type analyses berekenden we de relatieve invloed van de socio-demografische en de pre- en postmigratie risicofactoren op psychopathologie. Om de invloed van een lange asielprocedure te bestuderen namen we "lidmaatschap van groep 2" op in de analyses. Omdat de twee groepen mogelijk op belangrijke risico factoren zouden kunnen verschillen werd een gedetailleerde lijst van socio-demografische gegevens opgenomen in de analyses, zoals: leeftijd, sexe, burgerlijke stand, kinderen, etniciteit, religie, alfabetisme, geografische achtergrond, genoten onderwijs en beroep in Irak, taalvaardigheden en psychiatrische problemen in het verleden. Gemiddelde scores van de lijst over gezinsomstandigheden in de jeugd en van de vier lijsten voor schokkende levensgebeurtenissen werden berekend en opgenomen in de analyses. Omdat uit de literatuur bekend is dat martelingen een belangrijke risico factor is voor het krijgen van een psychiatrische stoornis (vooral PTSS) werd dit item apart in de analyses opgenomen.

Het resultaat van de analyse voor 'één of meer psychiatrische stoornissen' laat zien dat "lidmaatschap van groep 2" de meest belangrijke risicofactor is (OR: 2.16), op 'vrouwelijk geslacht" na (OR: 2.58). Met andere woorden: een lange asielprocedure verdubbelt het risico op een psychiatrische stoornis, onafhankelijk van de gebeurtenissen in het land van herkomst.

Andere risicofactoren waren: schokkende levensgebeurtenissen in de jeugd (tot het 13e jaar) (OR 1.28), in de periode tussen het 13e jaar en vertrek uit Irak (OR:1.35) en na aankomst (OR: 1.66) Schokkende levensgebeurtenissen in de periode tussen vertrek uit Irak en aankomst in Nederland gaven geen vergroot risico. Ook 'martelingen' liet geen verhoogd risico zien voor het hebben van een psychiatrische stoornis in deze analyse.

De analyses met depressieve stoornissen, angst stoornissen en somatoforme stoornissen, lieten eveneens zien dat een lange asielprocedure en schokkende levensgebeurtenissen na aankomst in Nederland hogere risico's geven (hogere OR's), vergeleken met schokkende levensgebeurtenissen in eerdere periodes.

In hoofdstuk 5 zijn de mate van bezorgdheid over 'post migration living problems' (PMLP) en het verband met psychopathologie beschreven en bediscussieerd. Het doel van deze analyses was meer te weten te komen over de wijze waarop een lange asielprocedure invloed had op psychopathologie. Uit de factor analyses bleek dat het mogelijk was om de PMLP in vijf clusters te verdelen: familie gerelateerde items, discriminatie, asielprocedure gerelateerde items, socio-economische leefomstandig-

heden en sociaal-religieuze items. Taal problemen en werk gerelateerd items paste niet goed in één van deze clusters en werden als aparte items opgenomen in de verdere analyses. We vergeleken de scores van PMLP van de respondenten met en zonder (verschillende types van) psychopathologie en vonden dat vrijwel alle verschillen significant waren. In de multivariate logistische regressie analyses bleken de volgende clusters het sterkste verband met psychopathologie te vertonen: zorgen over asielprocedure gerelateerde items (onzekerheid over verblijfsvergunning, angst om terug gestuurd te worden en onzekerheid over de toekomst), zorgen over familie gerelateerde items (gemis van de familie, zorgen over familie in Irak, het niet naar Irak kunnen als er iets naars gebeurd met de familie, eenzaamheid) en zorgen over de het niet mogen werken. Een hogere score op 'niet mogen werken' verhoogde het risico op 'één of meer psychiatrische stoornissen' met 44%. Zoals eerder (hoofdstuk 3) vermeld werd dit type PMLP het meest genoemd door groep 2.

Hoofdstuk 6 onderzoekt de uitkomstmaten kwaliteit van leven, functiebeperkingen en lichamelijke gezondheid en hun verband met psychopathologie en met pre- en post migratie problemen. Groep 2 had lagere gemiddelde scores op de twee algemene vragen over kwaliteit van leven en op drie van de vier domeinen. (lichamelijke gezondheid, psychologische gezondheid en leefomgeving) Alleen bij het domein 'sociale relaties' was er geen significant verschil tussen de groepen. De functiebeperkingen bleken erger te zijn in groep 2: hoger gemiddelde scores op zowel 'lichamelijke en sociale beperkingen' als op 'totaal aantal dagen van aanzienlijke beperkingen in de laatste maand'. Lichamelijke ziektes kwamen niet significant vaker voor in groep 2 vergeleken met groep 1, maar lichamelijke klachten wel. Van de respondenten in groep 2 gaf 66.2% aan één of meer lichamelijke klachten te hebben tegenover 38.5% in groep 1. De diverse regressie analyses lieten zien dat zowel kwaliteit van leven als functiebeperkingen en lichamelijke gezondheid gerelateerd waren aan psychopathologie. Toen de pre- en post migratie factoren aan de analyses werden toegevoegd, bleek echter dat 'lengte van verblijf in Nederland', schokkende levensgebeurtenissen en diverse PMLP voorspellers waren van deze uitkomstmaten, onafhankelijk van psychopathologie. Meer precies geformuleerd: lengte van verblijf in Nederland, schokkende levensgebeurtenissen in Nederland, totaal aantal dagen van aanzienlijke beperkingen in de laatste maand en het PMLP cluster 'socio-economische leefomstandigheden' voorspelden lagere scores op kwaliteit van leven. Psychopathologie (dat wil zeggen 'één of meer psychiatrische stoornissen', depressieve stoornissen en somatoforme stoornissen), hogere leeftijd en het PMLP cluster 'familie gerelateerde items' voorspelden meer functiebeperkingen.

Chronische lichamelijke klachten werden voorspeld door psychopathologie (dat wil zeggen depressieve stoornissen, angst stoornissen en somatoforme stoornissen), maar ook door lengte van verblijf in Nederland, schokkende levensgebeurtenissen tussen het 13e jaar en vertrek uit Irak, vrouwelijk geslacht en het PMLP cluster 'familie gerelateerde items'.

Hoofdstuk 7 beschrijft het gebruik van preventieve en curatieve (lichamelijke en geestelijke) gezondheidsvoorzieningen en laat de verbanden zien tussen dit gebruik en de onderzochte voorspellende variabelen. In de literatuur worden met betrekking tot zorggebruik drie groepen van variabelen onderscheiden: predisposerende, gebruik-bevorderende en zorgbehoefte variabelen. De predispositie van de respondenten werd gemeten met: leeftijd, geslacht, religie, etniciteit en 'lidmaatschap van groep 2' (lengte van verblijf). De geincludeerde zorgbehoefte variabelen waren: psychiatrische stoornissen, lichamelijke gezondheid, kwaliteit van leven en functiebeperkingen. Daarnaast werden de PMLP toegevoegd als een aparte groep zorgbehoefte variabelen. Gebruik-bevorderende variabelen werden niet gemeten omdat de reguliere gezondheidsvoorzieningen in Nederland voor asielzoekers zonder financiële belemmeringen beschikbaar en toegankelijk zijn. In de eerste analyses werd het verband tussen psychopathologie en zorggebruik bestudeerd. De resultaten hiervan toonde aan dat respondenten met psychopathologie significant een hoger zorggebruik hadden dan de respondenten die dat niet hadden (70% tegenover 54.5%). Dit hogere gebruik gold zowel voor de curatieve als voor de preventieve zorg. Respondenten met psychopathologie in groep 1 bezochten de medische specialist (niet-psychiater) veel vaker, maar dit was niet het geval in groep 2. Het gebruik van medicijnen (pijnstillers, angstreducerende medicijnen en slaapmedicijnen) was in beide groepen hoger in respondenten met psychopathologie. Verdere analyses, waarin alle variabelen geincludeerd werden, lieten verschillende patronen van voorspellers van gebruik van diverse zorgvoorzieningen zien. De conclusie van deze analyses is dat een lange asielprocedure geen voorspeller is van meer zorggebruik, met uitzondering van het gebruik van de GGZ en medicijngebruik. Psychopathologie is gerelateerd aan een hoger zorggebruik, maar wanneer dit verband gecorrigeerd wordt voor de invloed van andere predisposerende en zorgbehoefte factoren dan blijkt dat andere factoren zoals functiebeperkingen en een lagere score van kwaliteit van leven een grotere invloed hebben. Een andere conclusie is dat het hebben van 'één of meer psychiatrische stoornis' het gebruik van een medische specialist (niet-psychiater) voorspelt, maar niet het gebruik van een GGZ voorziening. Over het algemeen is het gebruik van een GGZ voorziening erg laag, indien dit vergeleken wordt met de prevalentie van

psychopathologie: meer dan 80% van de asielzoekers met een psychiatrische stoornis maakt gebruik van een gezondheidsvoorziening, maar slechts 8.8% bezoekt een GGZ voorziening.

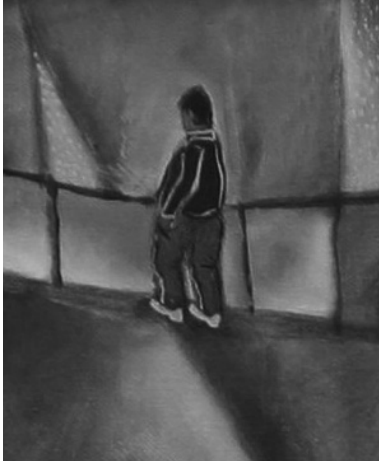
Part III Implicaties van de studie voor de hulpverleningspraktijk
In hoofdstuk 8 worden de implicaties van de studieresultaten voor de hulpverleningspraktijk besproken en wordt een veerkracht (resilience) gericht diagnostiek en behandelmodel geïntroduceerd. De meest belangrijke implicaties zijn dat er een zorgvuldige en brede diagnostische fase nodig is en dat de behandeling zich niet primair moet richten op de schokkende en traumatische levensgebeurtenissen uit het verleden maar dat er serieuze aandacht besteed moet worden aan de dagelijkse leef problemen (de context) en aan de voortdurende stress die de asielprocedure genereert. Daarom wordt aanbevolen een veerkracht gericht behandeling aan te bieden. In het hoofdstuk worden een aantal biologische, psychologische, sociale, religieuze en culturele bronnen van veerkracht besproken en vertaald naar de behandeling van asielzoekers.

Het zogenaamde 'resilience-oriented therapy and strategies'(ROTS) model omvat de concepten van stress en kwetsbaarheid en twee aspecten van veerkracht: persoonlijke kracht (bijvoorbeeld coping) en sociale steun. Kwetsbaarheid en kracht worden daarbij beschouwd als persoonlijke eigenschappen (interne factoren) en stress en steun als omgevings eigenschappen (externe factoren). In het Nederlands spreken we van het SSKK-model. Het model gaat er vanuit dat er een dynamische evenwicht tussen de verschillende factoren nodig is om een gezond persoon te worden en/of te blijven. Het ROTS model helpt om in de diagnostische fase zicht te krijgen op relevante factoren die mogelijk invloed hebben op de gezondheidsklachten. Wanneer het model goed toegepast wordt, levert het allerlei ideeën en mogelijkheden op voor de behandelfase. Naar onze mening en ervaring is het ROTS model goed toepasbaar in alle soorten van behandeling van asielzoekers. De conclusie van het hoofdstuk is dat de behandelmogelijkheden weliswaar beperkt worden door de voortdurend aanwezige stress en het bestaan van co-morbiditeit van stress-gerelateerde psychiatrische stoornissen, maar dat behandeling van asielzoekers mogelijk is. Deze conclusie behoeft nog wel wetenschappelijke onderbouwing.

Part IV Concluderende opmerkingen, discussie en aanbevelingen.
In het slothoofdstuk (9) worden de belangrijkste bevindingen en conclusies van de studie beschreven, gevolgd door enkele methodologische overwegingen betreffende

onderzoeksontwerp, manier van sampling, respons en representativiteit, gebruikte instrumenten, vertaling en culturele validatie. Na de algemene discussie worden er enkele aanbevelingen geformuleerd. Deze aanbevelingen betreffen toekomstig onderzoek, de (openbare) gezondheidszorg en de overheid, politici en beleidsmakers.

De eindconclusie van het onderzoek is dat een lange asielprocedure een negatieve invloed heeft op de algehele gezondheidssituatie van asielzoekers. Deze slechte gezondheidssituatie betekent niet alleen veel leed voor de betrokken asielzoekers, maar heeft ook een negatieve impact op het integratieproces in Nederland of in een ander land.



Dankwoord

Zonder de hulp, adviezen en morele steun van vele mensen was dit proefschrift nooit tot stand gekomen. Dit zeg ik niet omdat je dat nu eenmaal hoort te zeggen bij deze gelegenheid maar omdat ik het echt meen. Het Afrikaanse filosofische gezegde ‘ik ben omdat wij zijn’, is bewaarheid geworden in het hele traject naar deze promotie.

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Indrukwekkend en verrijkend heb ik de ontmoeting met jou ervaren, Satar Kawoosh. Ik had je naam gekregen van iemand die jou ooit geholpen had met Nederlandse taal en heb je opgezocht in je huis. Een rijtjes huis in een gewone Hoogeveense straat,

dat jij hebt omgetoverd tot één groot kunsthuis. Overal je prachtige schilderijen en je atelier op zolder. Zeer bijzonder dat ik een schilderij van jou, gemaakt destijds toen je nog asielzoeker was, mocht gebruiken op de voorkant van dit proefschrift.

De hoogleraren prof.dr. W.L.J.M. Deville, prof.dr. D. Wiersma, prof.dr. T.P. Spijkerboer, prof.dr. F.A.M. Kortmann en prof. R.M. Wintrob MD wil ik hartelijk bedanken voor het lezen en beoordelen van mijn proefschrift als leden van de leescommissie en hun deelname aan de promotiecommissie.

Mijn werkgever, GGZDrenthe, wil ik bedanken voor het in mij gestelde vertrouwen en voor de financiële ondersteuning. Ook de betrokkenheid van de huidige divisie directie in de afrondingsfase van mijn promotie stel ik zeer op prijs. Dank voor financiële ondersteuning betreft ook Stichting OpenAnkh, die destijds medefinancier was van het project "Zorgvernieuwing Asielzoekers Drenthe".

Dan komen we nu bij de kring rond het onderzoek heen.

Allereerst wil ik mijn collega's uit de Nederlandse en internationale cirkels van de transculturele en epidemiologische psychiatrie bedanken. De mogelijkheden om mijn studie bevindingen op allerlei congressen en bijeenkomsten te presenteren heb ik zeer gewaardeerd. Het gezegde 'onderzoek is communicatie' is absoluut waar. Je kunt iets zelf gevonden hebben in de analyses, maar pas in discussie, reflectie met anderen krijgt het zijn waarde. Vragen, aanvullingen en tegenwerpingen hebben mijn denken gescherpt en mij verder geholpen in het vervolg van de studie. De (inter)nationale uitwisseling van bevindingen en ideeën ervaar ik als zeer verrijkend en plezierig. De persoonlijke belangstelling van velen voor de emotionele kant van het promotietraject hebben mij goed gedaan.

Ook in de collegiale sfeer valt de steun die ik heb ondervonden in 'mijn' intervisie groep. Kamini Ho Pian, Caroline ten Brink, Robert Jan Hanhart en Bas Groot, dank voor jullie enthousiasme.

De dagelijkse contacten met de patiënten en de prima samenwerking met de collega's van De Evenaar, hebben mij geïnspireerd gehouden om mensen van ver te 'verstaan' en met hen op te zoek te gaan naar bronnen van veerkracht. Het werk op De Evenaar geeft veel voldoening, maar soms kruipt het leed en de onmacht van de ander onder je huid. Om dit werk te doen heb je zelf ook veerkracht nodig. Evenaren, dank voor de hulp daarbij !

En vervolgens de kring van mensen uit de persoonlijke sfeer

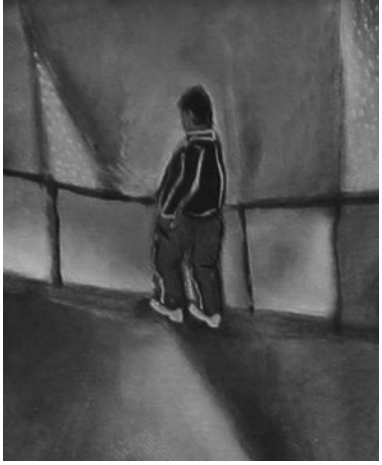
Heel, heel veel dank aan alle vrienden en familieleden die met belangstelling het hele onderzoekstraject hebben gevolgd. Het overlijden van neef Nico en schoonzus Greet in de afgelopen periode hebben verdriet gebracht. De dood, waar zoveel van de respondenten ook mee te maken hebben gehad, kwam zo heel dicht bij en relativeerde veel. Tegelijkertijd nodigde het mij uit om te leven en door in mijn werk anderen te helpen een vrijer leven te leven.

Van de vrienden wil ik met name noemen de 'Utrechtse vriendenclub': Bas, Greetje, Matti, Jaap, Hans, Mieke, Aldert, Marion, het eetclubje van de GGDRotterdam, Wilma, Fauzia, Jan en Gijs-Willem en verder Peter, Aafke, Lex, Mariet, Piet, Martha, Alie, Ruud, Theo, Fennie, Antoinette, Henk, Hans, Lou, Wim, Greta, Kees, Andre, Joke, Regi, Ellen, John en, o je wat is dit gevaarlijk, ik ben vast mensen vergeten, allen dank.

En dan de meest nabije kring.

Wie had ooit kunnen denken dat mijn twee kinderen mijn paranimfen zouden worden. Jullie zijn volwassen geworden met een vader die, soms gedreven, soms gefrustreerd (ja, die box-bal staat nog op mijn bureau), werkte aan iets wat wel heel veel tijd nam, maar waarvan hij toch vond dat het de moeite waard was. Sander, dank voor het screenen van de diverse teksten, je adviezen op taalkundig en 'logisch denken' gebied. Hester, dank voor je lieve woorden en je vele lieve kaartjes. Ik voel me zeer gezegend met jullie.

Emmy, er zijn geen woorden voor om jou te bedanken. Je hebt met mij vele diepte en hoogte punten beleefd. Je hebt met mij mee gescholden op mensen of zaken die de voortgang van het hele traject in de weg stonden. Je hebt me gemist als ik weer eens een praatje ergens moest houden. Je hebt steeds in mij geloofd. Niet in de zin dat ik hier nu zou staan als doctor, maar gewoon in mij, wat de uitslag van dit hele traject ook zou zijn geweest. Je bent fantastisch.



About the author

In 2006 I was invited to write a bio-sketch for the Newsletter of the section Transcultural Psychiatry of the World Psychiatric Association (WPA-TPS). An adapted and updated version of this bio-sketch can be found below.

When I was asked to contribute a bio-sketch for the Newsletter, my memories went back to the last evening of the cultural psychiatry conference in Rhode Island in Oct, 2004. At the farewell diner the atmosphere was very pleasant. Probably inspired by this atmosphere and by the afternoon symposium, in which four participants told their life story, a group of residents invited several guests to sit at their table and tell their life story connected to transcultural psychiatry. I was one of those invited.

To my own surprise, I started my story by telling my audience that I was born thanks to Hitler. That attracted their attention and I started to explain: a year before World War II, young men in Holland were recruited into the army. My father volunteered. He was assigned a managerial job and was sent to another part of the country. Because there were not enough barracks, he was housed with civilians. And, as you may have guessed, my mother was part of the family that my father was sent to live with. They married in 1944 and I was always told that when my oldest brother was one month old, he saw the "tommies" (Canadians, Americans) parachuting food packages above Rotterdam: the hunger was over!

I was born in 1953 in Rotterdam, the fourth of five children. In addition to the war, different types of Christian faith have influenced my life. My father was raised in a very liberal family, while my mother was from a very conservative Calvinistic family. My father adopted the lifestyle of my mother after their marriage, which had serious implications for us as children: on Sundays no outdoor activities, no sports or bike riding, and no dancing, no going to cinemas or street fairs. Notwithstanding all these constraints, I received a lot of love; although I didn't always realize that at the time. There was one interest that my mother and I had in common: Africa. She was active in the Christian mission movement and my interest in this faraway, strange world grew through her influence.

During my puberty, I rebelled a lot against all the limitations and rules my parents imposed on us children, and I think from that time on opposition became my second nature. Later on I saw the parallel between my life experience and the context of the times in the western world. There was a lot of opposition around me: student revolt in Paris, marches against Vietnam, freedom fighters against their colonial masters. My interest in politics grew and I defended the left wings ideas; even in the church group.

In school and university we discussed the future of the world, how to limit the power of capitalism and how to make things better and wealth be more equally shared.

During my medical training at the University of Utrecht from 1974 until 1981, psychiatry attracted my main interest - especially the so-called anti-psychiatry movement ,of course - but I was determined to become a tropical doctor. A year-long program in Cultural Antropology and Medical Sociology at the University of Leiden made me even more motivated.

During that time, I found the love of my life and told her that if she wanted to share her life with me, she should accept going to Africa with me. Fortunately, she shared this interest with me and became active in the 'third world movement'. We demonstrated together in Amsterdam against nuclear missiles, and were proud that the opposition against these missiles was called "the Dutch Disease".

To prepare myself for working in the tropics, I worked (1982-83) as a resident in gynecology, surgery and internal medicine, and participated in a 3-month course at the Royal Tropical Institute in Amsterdam. In September 1983, we -my wife, our son and me- went to Nigeria: to Cross River State, an Ibibio area that included a large number of tribes and languages.

We went to the tropics accompanied by the shame of colonial times and its past history of white superiority. In the area we came to, however, the people who lived there had only very good experiences with whites, and we were well accepted from the beginning. Also all our political concepts and ideas became completely irrelevant in this environment and nobody was interested in hearing about them - nuclear missiles were no issue in that part of Nigeria. Next to my culture shock in adapting to living in Nigeria, this was my main shock: a complete identity switch, or is it better to see this as part of the overall culture shock?

My own faith had moved in a more ecumenical direction in the several years before going to Nigeria, but this also became irrelevant, at least in the world outside our doors. Because the hospital was attached to the Lutheran church, we became familiar with the Lutheran faith. The local interpretation of this faith was: everything that happens is the will of God, so if your child dies, or if your village is infected Guinea worm, there is nothing you can do about it.

Fortunately, the urge to live and to protect your children is universal and strong, and in daily life a lot of people worked to make things better. Most health workers had

an attitude of helping and cooperating. In addition to the work in the hospital work, I was the head of the primary health care program, and the tuberculosis program. These responsibilities brought me to a wide variety of villages and tribes. I sat down with village heads and women's groups, talking about clinics, mother and child care programs and water wells. I did hernia surgery on a kitchen table, to compete with private practitioners who were surgically incompetent, cried about lives lost, wrote many proposals and reports, organized training programs, celebrated weddings and funerals (big ones), survived a major allergic reaction to an ant bite, had another child (a daughter), was in the news because of a yellow fever outbreak, worked collaboratively with local healers (to the dismay of the Nigerian director) and spent holidays in Kenya and Togo. I had no time for research, which was another thing that seemed completely irrelevant in this environment.

After five years in Nigeria, we went back to the Netherlands in 1988. I worked for a while with an association against leprosy and tuberculosis and spent some time in Kenya and Tanzania with that organization, to evaluate several clinical programs. They had offered me a job in Nairobi, but this did not work out. My wife and children were getting settled in Holland and I had to accept that my career in tropical medicine had to come to an end.

Professionally, I was confused about what to do next. I had developed some interest in public health matters and there was a movement started by the WHO called 'healthy cities', which was directed to limit health differences related to 'socio-economic status'. Rotterdam, my birthplace, had joined this movement, and I got a job in the youth department. I did some research, attended courses in epidemiology, set up a network between school doctors, counselors and social workers, and served as a part-time school doctor in districts with large populations of immigrants. This job offered me several opportunities: to adjust to a Dutch working environment, to develop more skills in immigrant health issues and to do some scientific work.

I re-evaluated my professional life and more and more I came to the conclusion that my real satisfaction was working with patients. My interest in psychiatry was revitalized by the contacts with adolescents and their parents, and I decided to apply for a job in this field.

My first weeks in the psychiatric intensive care unit in Deventer (1992) are still very fresh in my memory; what a change! Another type of 'culture shock' experience. A year later, I was able to enter the official training program, just by luck, I think. The

hospital had applied for years to be recognized as a training hospital and suddenly they succeeded. I got the chance to enter the training program in psychiatry. By that time I knew that psychiatry was my field of medical work. I eagerly started to read psychiatry books and articles and worked to improve my skills in making contact with all kinds of patients. During my training, I spent my 'elective period' in a service treating asylum seekers and refugees (Phoenix). Transcultural psychiatry had entered my life, as a very natural development to the next phase.

My work with my present employer, GGZDrenthe, a community mental health institute in the northern part of Holland, started in 1999. My assignments were to set up a mental health program for asylum seekers, and to organize a transcultural psychiatry training program. I wrote a plan and proposed that I would not see patients myself, because I wanted to set up a system in which a large number of people were challenged and trained to work with asylum seekers. They agreed, and so for my own clinical work, I worked with an organization for refugees in Amsterdam (Pharos).

After three years the management asked me to set up a day clinic for asylum seekers and refugees. We put together a treatment team, and after a while De Evenaar (2002) was inaugurated (easily written, but everyone knows the process is more complicated). I became the psychiatrist in charge, ended my job in Amsterdam and my family and I moved up north. Patients come from all over the three northern provinces of the Netherlands and in 2006 we got permission to expand to a 'Centre for Transcultural Psychiatry' and open an out-patient clinic. The Centre is also involved in training of psychiatrists and I am a teacher of transcultural psychiatry in the general psychiatry training program for residents. Fortunately we have a wonderful and well motivated team.

The job also gave me the opportunity to set up the epidemiological study among asylum seekers, that is described in this dissertation.

Since September 2008 I am the chair of the Platform of Transcultural Psychiatry of the Netherlands Associations of Psychiatry (NVvP). Shortly before my appointment the Platform was asked by the WPA-TPS to organize an international conference and I became the chair of this conference as well. The conference will be held in Amsterdam, June, 13th -16th , 2010.

The work with asylum seekers and refugees is challenging and rewarding. They learn from me (I hope), but in many cases I learn from them. They are enriching my life.

Many times their capacity to cope and to overcome past losses and trauma's surprises me. Many times their trust in me and my co-workers touches me. But sometimes the work is not easy, as you all know. The confrontation with such an incredible amount of suffering creates feelings of sadness and anger. My study gave me the opportunity to analyse the backgrounds of the problems I noticed in my patients in every day practice. It also gave me the chance to draw the attention of a wide audience to the problems of this marginalized group.

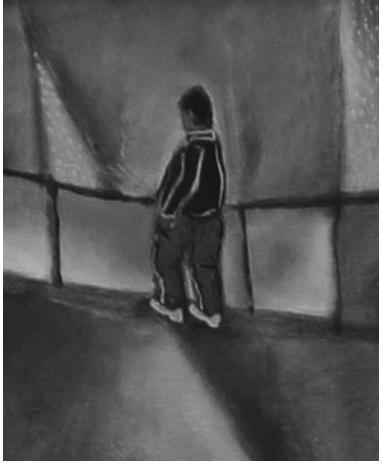
To do this study and work several things were and are important to me: my tendency to oppose and not to sit back when injustice is done, my loving wife and children, my friends, my colleagues and my faith in a loving God who connects people from all over the world.

In addition to all these supportive resources, there is one more I would like to mention; the feeling of being connected to a wider network of people who share the same interest and (com)passion throughout the world. This is a very important source of inspiration for me to continue both my clinical and research work.

Therefore I feel honored that Professor Ron Wintrob, chair of the World Psychiatric Association – Transcultural Psychiatric Section (WPA-TPS) agreed to join the reading and promotion committee, as a representative of this world wide network.

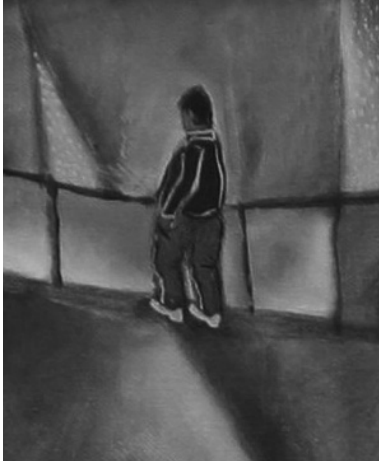
Nobody knows what the future brings. The Dutch word for future is 'toekomst', that means, the future is coming towards you. I am curious about the challenges ahead of me and eager to make the most of the opportunities that will arise.

Kees Laban, April 2010



Curriculum Vitae

Cornelis Laban (roepnaam Kees) werd geboren op 17 september 1953 te Rotterdam. Na het voltooien van het Atheneum-B aan het Christelijk Lyceum Delft heeft hij zijn dienstplicht vervuld als verpleeghulp bij de geneeskundige troepen. In 1974 startte hij met de studie geneeskunde aan de Universiteit van Utrecht. In het studiejaar 1976-1977 volgde hij als bijvak de cursus Medische Sociologie voor Ontwikkelingslanden, aan het instituut voor Culturele Antropologie aan de Universiteit van Leiden. Hij studeerde af in 1982 en werkte vervolgens als arts-assistent chirurgie, gynaecologie/obstetrie en interne geneeskunde in het MCLeeuwarden. Na het volgen van de tropencursus aan het KIT te Amsterdam werkte hij van 1983 tot 1988 als algemeen tropenarts in Yahe, Nigeria, via Dienst Over Grenzen. Aldaar was hij o.a. hoofd van het primary health and tuberculosis programme. Van 1989-1992 werkte hij als beleidsmedewerker/adolescentenarts bij de GGD Rotterdam e.o., afdeling Jeugdzorg, waar hij o.a. onderzoek deed naar zorgverschillen tussen allochtone en autochtone jongeren. In 1992 kwam hij als 'assistent-niet-in-opleiding' in dienst van de GGz-instelling Brinkgreven te Deventer. Vanaf 1993 volgde hij aldaar de opleiding tot psychiater, die hij voltooide in 1998. Tijdens deze opleiding deed hij keuzestages beleidspsychiatrie en transculturele psychiatrie (bij Phoenix, Gelderse Roos). Zijn eerste positie als psychiater was in Almelo bij het team geïntegreerde indicatie en kortdurende behandeling, gecombineerd met het werk als adolescentenpsychiater bij dezelfde instelling (Adhesie). In 1999 startte hij bij de GGZDrenthe als coördinator van het 3-jarig project "Zorgvernieuwing Asielzoekers'. Van 1999 tot 2002 werkte hij eveneens bij Pharos, kenniscentrum voor vluchtelingen, op de vestiging in Amsterdam. Sinds 2003 is hij als psychiater en hoofd behandelbeleid verbonden aan De Evenaar, Centrum voor Transculturele Psychiatrie Noord Nederland. Van 2003 tot 2007 combineerde hij deze functie met het werk als Beleidscoördinator Interculturalisatie bij de GGZDrenthe en zette hij diverse projecten op. Hij was lid van de Commissie Interculturalisatie bij GGZNederland en verschillende andere landelijke commissies en werkgroepen. Momenteel is hij coördinator van het Platform voor Transculturele Psychiatrie van de Nederlandse Vereniging voor Psychiatrie.



Publications related to this thesis

Laban CJ, Gernaat HBPE, Komproe IH, Schreuders GA, De Jong JTVM (2004) Impact of a long asylum procedure on the prevalence of psychiatric disorders in Iraqi asylum seekers in the Netherlands. J Nerv Ment Dis, 192:843-852.

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Laban CJ, Hurulean E, Attia A (in print) Resilience as starting point in diagnostics and treatment of asylum seekers and refugees [Veerkracht als uitgangspunt bij diagnostiek en behandeling bij asielzoekers en vluchtelingen] In: J de Jong, S Colijn (red.) *Handboek Culturele Psychiatrie en Psychotherapie.* Utrecht: De Tijdstroom