

Chapter | 1

Background of the study and research questions

Introduction

Numbers of asylum seekers and refugees and length of asylum procedure

The Dutch Study Iraqi Asylum Seekers started in 1999 and the data collection took place in 2000 and 2001. In these years the top ten of countries of origin of the asylum seekers coming to the Netherlands was: Iraq, Afghanistan, former Yugoslavia, Iran, Somalia, Bosnia-Herzegovina, Sudan, Sri Lanka, Turkey and Azerbaijan (COA, 2000, 2001).

The United Nations High Commissioner for Refugees (UNHCR) estimated the total number of persons applying for asylum in Europe in the years 1992 to 2000 at 3,267,524 (UNHCR, 2001). In the same period, 322,814 applications for asylum were submitted in the Netherlands, according to the Immigration and Naturalisation Service (Immigratie- en Naturalisatiedienst, IND) (IND, 2001). The annual number of asylum seekers registered with the Central Agency for the Reception of Asylum Seekers (Centrale Opvang Asielzoekers, COA) increased from about 32,809 in 1994 to over 83,801 in 2001 (Table 1, COA, IND). The COA, an independent administrative body funded by the Ministry of Justice, provides accommodation for asylum seekers during the asylum procedure and prepares them for staying in the Netherlands, returning to their country of origin, or transmigration.

For many years the influx and outflux of asylum seekers in the COA facilities was high. Worldwide and in the Netherlands Iraqis have been one of the biggest groups of refugees. UNHCR estimated in 2000 that around 1.5 million Iraqis were living outside their country. In the years prior to the present study, Iraqis accounted for about one fifth of the total number of applications in the Netherlands (Table 1).

Table 1. Asylum seekers in the Netherlands in the years 1994-2001.

Year	Occupancy COA on 31 December	Influx COA facilities	Outflux COA facilities	Applications by Iraqis
1994	32,809	45,212	39,772	6,075
1995	30,166	25,762	29,166	2,698
1996	29,800	19,870	20,162	4,378
1997	37,720	31,331	23,206	9,641
1998	54,070	42,019	24,631	8,300
1999	64,771	38,227	27,340	3,703
2000	78,200	33,602	19,147	2,773
2001	83,754	25,223	19,638	1,329

Source: COA, IND

The high influx of asylum seekers put a tremendous pressure on the administrative system of the Immigration and Naturalisation Service. Moreover, the increasingly complex asylum determination process resulted in long delays and backlogs in the process and in long ‘waiting’ periods in the asylum seekers centres. In May 1999, 2,352 (23.2%) of the 10,139 Iraqi asylum seekers were staying two years or longer in the procedure. In this month a sample was drawn for the present study.

Although the influx of asylum seekers decreased in the years after the study, the percentage of asylum seekers that were waiting in the centres for more than two years increased up to 78.9% in the year 2004 (Table 2, COA). Only a small percentage of them had received a residence permit and were waiting for a house, but the far majority were still in the asylum procedure. By the year 2007 the occupancy of the centres had decreased to 21,294 people, while the number that had stayed in a COA facility for over two years was still high: 12,235 (57.5%).

Table 2. Asylum seekers in the Netherlands in the years 1999-2007.

Year	Asylum influx total	Occupancy COA on 31 December	> two years in COA facilities	Influx Iraqis	Iraqis in COA facilities
1999	42,729	64,771	13,257 (20.5%)	3,703	10,139 (15.7%)
2000	43,895	78,200	26,580 (34.0%)	2,773	11,294 (14.4%)
2001	32,579	83,754	40,018 (47.8%)	1,329	10,144 (12.1%)
2002	18,667	69,752	44,888 (64.4%)	1,022	7,703 (11.0%)
2003	13,402	52,780	39,269 (74.4%)	3,472	6,611 (12.5%)
2004	9,782	40,761	32,150 (78.9%)	1,043	4,597 (11.3%)
2005	12,347	28,732	22,613 (78.7%)	1,620	2,890 (10.1%)
2006	14,465	23,460	16,306 (70.0%)	2,766	2,763 (11.8%)
2007	9,731	21,294	12,235 (57.5%)	2,004	3,710 (17.4%)

Source: COA

Due to this continuing increase of asylum seekers, living in centres spread all over the country, regional mental health institutions in the Netherlands were confronted with an increase of patients from a wide variety of national and cultural backgrounds, who differed in many ways from regular patient populations. Since many asylum seekers centres were located in the northern part of the country, this increase of asylum seekers was especially felt in this region (in 2001, 35% of the 83,754 asylum seekers lived in the four northern provinces – Groningen, Friesland, Drenthe, Overijssel – while only 17% of the Dutch population lived in these provinces; COA, 2001; CBS, 2001).

GGZDrenthe, being one of the community mental health providers in the northern region, took the initiative to start a special project for asylum seekers. The project

goals were: (1) to improve psychiatric services for asylum seekers by training mental health workers in transcultural psychiatry and trauma-related psychopathology and by creating an adequate mental healthcare structure, and (2) to collect epidemiological data on the physical and mental health situation of asylum seekers. The Dutch Study Iraqi Asylum Seekers as well as the Centre for Transcultural Psychiatry, which is discussed in chapter 9, resulted from this project.

Mental health of asylum seekers and refugees

The literature mentioned below was investigated at the start of the study in 1999. The short review illustrates the scientific background of the study. More recent relevant literature is reviewed in subsequent chapters.

Research in the Netherlands

At the time of the study, the largest study on the health of asylum seekers and refugees in the Netherlands had been done by Van Willigen and Hondius (1992). In this study, 156 participants from Iran and Turkey were interviewed. They found that 78% had one or more physical complaints and 90% had psychological problems. There were high scores on the Hopkins Symptom Checklist (HSCL-25) on sleeping, anxiety and depressive complaints, but only 4% of respondents fulfilled the criteria of a depressive disorder (non-validated cut-off score > 1.75) and 11% had a post-traumatic stress disorder (PTSD) (measured with a self-made list for violence-related experiences). The study population was a convenience sample of asylum seekers and refugees attending a non-psychiatric, medical centre. The participants were either attending the centre for a medical screening or to find help for a somatic or psychological problem. The majority of them (70%) had stayed in the Netherlands for less than a year. The study also showed a positive relationship between the amount of adverse life experiences and physical and psychological complaints. No relationship was found between years of education, age, presence of a family and the level of complaints. Asylum seekers had significantly more complaints, compared to refugees (those who had a permanent residence permit).

Meis (1995) studied 149 recently arrived refugees from Iraq. They were invited by the Dutch government and received a permanent permit on arrival. Using the General Health Questionnaire (GHQ-12), he found that 32% had a 'low perceived mental health'. Men scored higher than females. No association was found between this score

and traumatic experiences in the past. In this study no psychiatric disorders were measured.

Another study was done by Roodenrijs et al. (1998) among 47 Somali asylum seekers (76%) and refugees (non-patients). Using the Harvard Trauma Questionnaire they found that 35% fulfilled the DSM-IV criteria for a PTSD. Moreover, a high percentage had depressive complaints (63%) and anxiety complaints (36%), with the use of a non-validated cut-off score of 1.75 (HSCL-25). The co-morbidity was substantial: 43.3% had more than one syndrome. On average the Somalis experienced 15.9 traumatic life events. No relation was found between these events and PTSD, anxiety and depression scores.

The above studies show extensive health problems among asylum seekers and refugees. However, a lot of questions remain unanswered. The study population of Van Willigen and Hondius (1992) was a convenience sample of a heterogeneous group and most of them were help-seekers. Therefore this select sample did not give information about the health problems of asylum seekers in the community. The study population of Roodenrijs et al. (1998) also used a convenience sample and was small, which made it difficult to find relationships between risk factors and health problems. Moreover, all above studies used a limited amount of instruments, which all had dimensional scales and cut-off points that were not validated for the study populations. This limits the possibility to compare the results with other studies.

Research outside the Netherlands

At the time of the study, most studies had been done among South Asian refugees in the USA (Westermeyer, 1988; Carlson & Rosser-Hogan, 1991; Moore & Boehnlein, 1991; Mollica et al., 1997, 1998). More recently, Bosnian/Yugoslavian populations were studied (Weine et al., 1998; Thulesius & Hakansson, 1998; Favore et al., 1999). In addition, there are studies from New Zealand (Pernice & Brook, 1994; Chueng, 1994), Australia (Silove et al., 1997; Steel et al., 1999) and the Scandinavian countries (Sundquist, 1993; Hauff & Vaghum, 1995; Lavik et al., 1996).

Overall, these studies showed high levels of psychopathology, although the range of prevalence rates was substantial. Silove et al. (1997) summarized the findings as follows: community-based studies: prevalence rates of depressive disorder vary between 15 to 80% and PTSD (post-traumatic stress disorder) between 3.5 to 86%; patient-based studies: depressive disorders vary between 42 to 89% and PTSD is higher

than 50%. Silove et al. mentioned that, because of the use of different instruments, it is hard to compare these studies.

Carlson & Rosser-Hogan (1991) studied 50 Cambodian refugees and found a prevalence rate of 80% for depression (measured with the HSCL-25) and 86% for PTSD (measured with a PTSD-checklist based on DSM-III-R). In comparison, in a community-based study in the USA, Kessler et al., (1995) found a lifetime prevalence of 7.8% for PTSD. Surprisingly, the high levels of psychopathology found by Carlson & Rosser-Hogan (1991) were present in a (small) group of refugees that had already been in the USA for three to six years.

Also other studies showed the persistence of PTSD. For instance, in a follow-up study among 34 Bosnian refugees (Weine et al., 1998) the percentage of participants with a PTSD only dropped from 74 to 44%. In a cohort study among 145 Vietnamese refugees, Hauff & Valgum (1995) found no improvement of psychological stress (measured with the SCL-90) and depression (17.7%, measured with the Present State Examination – PSE) after three years of resettlement.

The only study specifically among Iraqi refugees was done by Gorst-Unsworth & Goldenberg (1998). They studied 84 Iraqi men, who were referred for medical, psychological or social help and found 10.7% PTSD and 44% depression (measured with the PSE). In their comments, the authors stated that the low percentage of PTSD is hard to explain. They re-analysed their data and included two instead of three items of ‘avoidance’, which resulted in a raise to 18% PTSD. They also measured experienced torture and found that 65% was tortured.

Next to depression and PTSD other psychiatric disorders have been studied among refugees in Western countries. Westermeyer (1988) found (using the DIS – Diagnostic Interview Schedule) that 54% of the study population of 97 Hmong refugees had a DSM-III-R diagnosis, e.g., dysthymia and generalized anxiety disorder. Carlson & Rosser-Hogan (1991) found high scores of dissociation (98%), measured with the Dissociative Experience Scale. Also Weine et al. (1998) measured dissociation (using the SCID-Disorders of Extreme Stress). None of the 24 studied Bosnian refugees fulfilled the criteria of a dissociative disorder. Michultka et al. (1998) showed that 38% of 50 refugees from Central America had another anxiety disorder besides PTSD. In the study of Gorst-Unsworth & Goldenberg (1998) a surprisingly high percentage of patients had compulsive complaints (20%).

The only study solely focusing on asylum seekers was from Silove et al. (1997). They studied a convenience sample of 40 asylum seekers from diverse backgrounds living in Australia and found that 37% had a PTSD (measured with the CIDI: Composite International Diagnostic Interview – PTSD section).

It is important to note that all studies that included more than one diagnosis mentioned the high rate of co-morbidity. Moore & Boehnlein (1991) e.g., found that 74 of the 75 patients with a depression also had PTSD. Complaints about chronic pain were strongly correlated to these disorders. Ramsay et al. (1993) found that 20% of 100 survivors of organized state violence (mixed group of refugees) had both PTSD and depression. In the study of Michultka et al. (1998) 46% of the participants with a PTSD, also had a depression. High levels of co-morbidity in PTSD patients are also found in non-refugee populations, especially depression, dysthymia, other anxiety disorders (Helzer et al., 1987; Solomon et al., 1991) and dependencies (Bremner et al., 1996).

The above mentioned studies show that refugee populations have high prevalence rates of psychological and psychiatric problems. PTSD and depression are most commonly present, but other disorders are prevalent as well. Moreover, not all refugees who experienced traumatic life events develop a PTSD. The importance of traumatic life events in relationship with other risk factors (before, during and after the flight) in the pathway to psychopathology remains unclear.

An important disadvantage of the studies mentioned above was the small size of the samples. Another disadvantage is that, with a few exemptions (e.g., Silove et al., 1997), no categorical instruments like the CIDI were used. Most studies used dimensional instruments with non-validated cut-off scores.

Risk factors of stress response syndromes

Hereafter, the risk factors are discussed, studied in trauma-related research programmes among refugee and non-refugee populations. The overview is not meant to cover all the literature on this issue. We restricted ourselves to studies among refugees in Western countries. Moreover, it contains only studies done before the year 2000. The overview serves to inform readers about the background of the Dutch Study Iraqi Asylum Seekers.

In several studies (Silove et al., 1997; Steel et al., 1999) two types of risk factors in refugee populations are distinguished: pre-migration and post-migration factors. We use the same distinction in our study, but added a period within the pre-migration period: i.e., the youth period ‘under 12 years’ to assess childhood vulnerability factors and another period between the moment of migration and the arrival in the Netherlands, because several persons in the focus group (see later) advised us to do so. It is important to assess adverse life events in different life periods because of the cumulative risk. Breslau et al. (1999) for instance found that previous exposure to trauma signals a greater risk of PTSD from subsequent trauma. Moreover, distinguishing between these periods creates the possibility to assess the relative risks from various periods.

Pre-migration risk factors

Many studies (Mollica et al., 1987; Ramsay et al., 1993; Hauff & Valgum, 1995; Silove et al., 1997; Steel et al., 1999) show that the severity and duration of traumatic events play an important role in occurrence and persistence of psychopathology in refugees (among others PTSD). Basoglu et al. (1997) found that torture survivors who were committed to a political cause or had expectations of arrest and torture (i.e., political activists) had lower levels of psychopathology compared to non-political activists (thus showing the importance of psychological preparedness). The nature of emotional reactions directly after a traumatic event has been shown to be important for later occurrence of symptoms: having many dissociative symptoms shortly after a traumatic event (peritraumatic dissociation) increases the risk for PTSD substantially (Shalev et al., 1996). Several studies (Hauff & Valgum, 1995; Breslau et al., 1999) found a higher risk for PTSD in women, compared to men. A national community-based study (Bromet et al., 1998) showed that a psychiatric disorder in the past or having a parent with a psychiatric disorder increases the risk for PTSD significantly. If a person has experienced a trauma before, the risk for PTSD after a next trauma is increased. The more traumatic events in the past, the higher the risk (Breslau et al., 1999). Maltreatment in childhood showed to be an important risk factor. In the study of Bromet et al. (1998) the impact of traumatic events in childhood is related to PTSD later in life. Especially in women, this impact appears to be substantial.

Loss of beloved ones is also a risk factor: Mollica et al. (1987) found that widows among Cambodian refugees in the USA had a much higher risk for psychiatric problems. Caspi et al. (1998) showed that the loss of one or more children had a strong relationship with health problems (physical and psychological) and functional

disability. This finding was confirmed by Breslau et al. (1998) who found that “although recent research has focused on combat, rape, and other assaultive violence, as causes of PTSD, sudden unexpected death of a loved one is a far more important cause of PTSD, accounting for nearly one third of PTSD cases.”

Post-migration risk factors

‘Social loss’, missing friends and family, showed to be an important risk factor for psychological stress and depression among refugees from Turkey and the Middle East (Van Velsen et al., 1996). This risk was independent from the risk of traumatic events. Gorst-Unsworth & Goldenberg (1998) found in a patient group that lack of affective ‘social support’ was a more important predictor for psychopathology than traumatic events in Iraq.

In the study of Silove et al. (1997) among asylum seekers, the following post-migration risk factors were found related to PTSD: delays in processing refugee applications, difficulties in dealing with immigrant officials, obstacles to employment, racial discrimination, and loneliness and boredom.

Steel et al. (1999) compared Tamil asylum seekers with refugees and migrants in Australia (in total 196). Path analyses showed that the difference in post-traumatic stress symptoms was explained for 20% by pre-migration factors and for 14% by post-migration factors. Of the post-migration factors three components contributed equally: health, wellness and problems in the asylum-seeking procedure, problems with adaptation and loss of cultural context and lack of support. The mere fact of having a residence permit did not have a significant relationship with post-traumatic stress symptoms.

The long-term subjective appraisal of traumatic events has its influence: Henning (1997) showed for example that subjects with ‘combat-related guilt’ had higher levels of complaints. Many studies have shown that ‘social support’ can moderate psychopathology (Russell & Cutrona, 1991) and a variety of aspects has been described and studied (Komproe & Rijken, 1995). In a study among Namibian refugees, Shisana & Celentano (1987) found that the length of exile among those who had been in exile longer than one year and perceived low esteem and emotional social support from significant others was positively and strongly related to a general anxiety disorder, while among those with high esteem and emotional social support no relationship was observed. Also the way people cope with their post-migration stress has its impact on the levels of psychopathology. Problem-focused coping is thought to be a protective

factor in circumstances where the stressors are changeable, while in case they are not, emotion-focused coping is thought to be more adequate (Lazarus, 1984).

In many studies (e.g., Kessler National Comorbidity Survey' (NCS), 1994; Bijl et al., 1997) social-economical status (SES) is a significant risk factor: people with lower income and less education have more overall morbidity and more co-morbidity. There are no data available from refugee populations and the relation between SES and psychopathology.

The general conclusion from abovementioned scientific research (a short overview from the literature before 2000) is that traumatic experiences in the country of origin are a risk factor for psychopathology in refugees and asylum seekers, and that besides these experiences many other factors are important, like post-migration stressors. Some of these factors are present in both refugees and asylum seekers (e.g., uprooting, acculturation problems, missing the family), other factors are more prevalent in asylum seekers (delays in processing refugee applications, difficulties in dealing with immigrant officials, limitation in the fields of work, money, housing, etc.), still other factors are more individual-related factors (trauma's, appraisal of events and reaction on trauma's, social support, way of coping, etc.). Many studies are directed to some of the risk factors. Only a few authors (e.g., Steel et al., 1999) studied the interrelationship between a range of risk factors and the impact of (clusters of) risk factors on psychopathology and physical health. The Dutch Study Iraqi Asylum Seekers follows this line of research.

Moreover, the study was largely influenced by the line of research of the Transcultural Psychosocial Organization (TPO), a WHO Collaborating Centre (De Jong, 1998, 2001). In 2006, TPO merged with HealthNet into HealthNet TPO.

In conclusion: none of the mentioned studies gives information about the impact of a long asylum procedure on mental and physical health and wellbeing. The clinical impression, however, is that this long waiting period in uncertainty and deprived circumstances are especially stressful and enhance the risks for a psychiatric disorder. The Dutch Study Iraqi Asylum Seekers was invented to make a start to fill this gap in scientific knowledge.

Background of Iraqi asylum seekers and refugees

Since independence in 1932 there has been a lot of political and societal unrest in Iraq. The Ba'ath party of Saddam Hussein, which was dominated by Sunni Muslim Arabic families and tribes from north-west Iraq (Tripp, 2000) had been the leading power since 1968. In various periods, two groups of the population, the Shia Muslims in the South and the Kurds in the North, violently opposed the government, but their attacks were in vain and the oppression became even harder. Iraqi refugees started to come to Western countries in the eighties, during the war with Iran (1980-1988). After this war, the Kurds were heavily attacked by Saddam, whose army used chemical weapons. The invasion in Kuwait by Saddam in 1990 brought more turmoil. The government tried to regain its power in the North and only after UN intervention Saddam was forced to withdraw his troops and the area got a de facto autonomous status. Rival groups (PUK and KDP) however were still causing a life-threatening situation for many. The Shia Muslims thought to make use of the weakened position of Saddam's government after the Kuwait invasion and rose in revolt. They were beaten however and many fled the country. The oppression of many groups continued and many people left the country, both Kurds and non-Kurds. The economic sanctions since 1990, which included a trade embargo, have decreased the standard of living tremendously and have caused a lot of suffering to Iraqi citizens (Global Policy Forum, 2002).

The majority of Iraqi refugees are Shia Muslims and Kurds. Smaller groups are the non-Kurd Sunni Muslims, Assyrians, Armenians and Turkmen (Soeterik, 1993). From 1997, many Kurds, but also Turkmen and Assyrians, left their homes during the forced expulsions of non-Arabs from the Kirkuk region. They had the choice to go to southern Iraq or to the Kurdish provinces in the North. If Kurds chose to go north, all their properties were confiscated by the authorities and one member of their left-behind family was detained. As of May 1999 at least 91,000 people were deported to the northern provinces. Some lived with relatives, the majority however lived in camps or fled the country (Amnesty International, 1999).

The human rights violations in the years preceding the study are and were well known throughout the world. In its annual report over the year 2000, Amnesty International reported for instance as follows. "Suspected government opponents and occasionally others are systematically and routinely tortured in Iraq. Some of the victims have died and many have been left with permanent physical and psychological damage. Others have been left with mutilated bodies resulting from the application of certain judicial punishments introduced by the government in the 1990s." Amnesty International's

concerns about the systematic use of torture and about other gross human rights violations in the country were shared by the UN Commission on Human Rights which, in its 2001 session, condemned the “widespread, systematic torture and the maintaining of decrees prescribing cruel and inhuman punishment as a penalty for offences.” The Commission called on the government to “abrogate all decrees that prescribe cruel and inhuman punishment or treatment, including mutilation, and to ensure that torture and cruel punishment and treatment no longer occur.”

Asylum procedure in the Netherlands

We will shortly explain the major aspects of the asylum procedure at the time of the study. Every asylum seeker whose application was not given an ‘inadmissible’ decision in the Registration Centre (about 90% of the cases) was referred to a Relief and Investigation Centre (Opvang Centrum, OC). There were about 17 of such centres, spread over the country. Here, further interviewing took place and a medical screening was done. When the influx of asylum seekers exceeded the capacity of the OC’s, different kinds of temporary housing facilities were provided (e.g., tents). This was also the case during the period this study took place. These facilities were called pre-OC’s. In most cases the procedure could not be concluded within three months and the asylum seekers were referred to one of the many Asylum Seekers Centres (Asielzoekerscentrum, AZC), also spread over the country. These AZCs varied in size, but until today most of them have 350-400 places. Moreover, there was a variety of smaller settings from 20-100 places (parts of hotels, holiday homes, etc.), the Additional Asylum Seekers Centres (Aanvullende Opvang, AVO). They had the same objectives as the AZCs. People who could find a place to stay by themselves (e.g., with family) were allowed to live outside the centre (self-care arrangement, zelfzorgarrangement, ZZA). At the time of the study an increasing number of asylum seekers made use of this arrangement: for instance 6,410 (11.6%) in March 1999 against 10,061 (14.5%) in April 2000 (COA, 1999, 2000).

In the years prior to the study and during the study period the basic objective of the centres was to provide each asylum seeker a ‘sober but humane’ reception. This meant that the centres provided only lodging and limited educational and recreational facilities. During the asylum procedure the asylum seekers had no permission to work (only some seasonal work during a few weeks was allowed) or to rent a house. Some sports facilities were offered. A small weekly allowance was provided (about 40 euro) in addition to some reimbursement of travel costs to a lawyer, the hospital, etc.

At the time of the study the ‘old’ Aliens Act (1965) was still valid. Over the past 40 years several amendments have been made on this Act. These amendments resulted in a variety of temporary residence permits and were geared at trying to diminish the influx of people. In relation with this study the provisional residence permit (voorlopige vergunning tot verblijf, VVTV) is relevant (amended in 1994). The VVTV could be awarded in cases where “forced expulsion to the country of origin would result in exceptional hardship for the alien, given the overall situation there.” As soon as the situation in the country of origin improved, the recipient of the VVTV status was expected to return. The VVTV had very limited rights attached to it, but after three years the status could be transformed to a permanent status. Between 1994 and 1998 many Iraqis were given this provisional status, however in November 1998 the Dutch government declared the northern part of Iraq a safe area and all VVTV’s for Iraqis were withdrawn. The arguments for this change in policy were that the government in Baghdad did no longer control the North and the North itself was divided into two areas: one controlled by the Patriotic Union of Kurdistan (PUK), the other by the Kurdistan Democratic Party (KDP). At the time these parties ceased fighting each other. Also the Iraqis who came from other regions (like Central Iraq) were affected by this change in policy. The northern part of Iraq was considered to be a ‘internal flight alternative’ for all Iraqis. It is beyond the scope of this study to go into detail about the public debate, the numerous court cases and the reports of national and international councils (e.g., UNHCR) that followed this decision (Zuidema, 2001). In the new Alien Act (valid from April 1st 2001) the VVTV permit disappeared entirely.

The consequence for Iraqi asylum seekers (including all participants in the present study) was that they had to fear expulsion unless they could convince the court and the IND that they could not return to Iraq.

The healthcare facilities for asylum seekers

At the time of the study, medical services were present in each centre. The Community health services for Asylum Seekers (Medische Opvang Asielzoekers, MOA) was staffed by doctors and nurses, who performed health assessments of recently arrived asylum seekers and coordinated referrals to primary care provided by general practitioners (GP’s) and mental healthcare facilities. The MOA services were available on weekdays between 8.30 and 17.00 h. Outside these hours asylum seekers had to report any health problems to a central office by phone. If they were not able to speak Dutch and did not have somebody to translate for them, the security officers

on the centres could help them. Depending on the assessment by the central office, a general practitioner on call was asked to visit the patient or receive him/her in his/her local office.

If an asylum seeker was transferred to another AZC or left the centre after receiving a residence permit, all data transfer was arranged by the MOA. Also group health education on topics such as healthcare in the Netherlands, sexually transmitted infections, hygiene and nutrition was given and if necessary, individual sessions were arranged. Moreover the MOA was responsible for infectious disease control and regular hygiene and safety inspections of all communal areas at the reception centres. In the Netherlands, Dutch citizens have direct access to a general practitioner, while asylum seekers could only enter the curative healthcare system after a screening by a nurse or doctor in the asylum seekers centre. This system has been criticized (Netherlands Health Care Inspectorate, 2003), but others claim that these professionals may prevent inadequate referrals. Since January 2009 the system has been changed and asylum seekers have direct access to the general practitioner. All asylum seekers are, as long as they are in the procedure, covered for their healthcare costs by an assurance system, paid (indirectly) by the Ministry of Justice.

Motivation of the study

Based on the above description of the situation of Iraqi asylum seekers in the Netherlands, the epidemiological data in the literature and the clinical experience in the treatment of asylum seekers, the reasons to perform our study were as follows:

1. There is little scientific knowledge about the psychiatric, physical and health-related problems of asylum seekers in the Netherlands and elsewhere in the world.
2. The available studies as well as clinical experiences indicate that these problems are substantial and are not always recognized sufficiently by health workers. There might be a large amount of unmet needs and a large treatment gap.
3. The available studies as well as clinical experiences suggest that the range of psychiatric problems is much wider than only PTSD. Other anxiety disorders, depressive disorders, etc. occur and co-occur (high co-morbidity). Also a high prevalence of physical complaints is to be expected.
4. There are no research data available on the various aspects of disability and quality of life among asylum seekers.

5. Little is known about the pre- and post-migration risk which play a role in the occurrence and persistence of health problems.
6. The clinical impression is that a long asylum procedure and the related restricted possibilities in the areas of housing, work, finances, schooling, etc. are very important stress factors associated with higher levels of health problems.
7. The development of an adequate (mental) healthcare programme is hampered by the lack of epidemiological data. Cues to improve preventive as well as curative healthcare strategies are highly needed.

Research questions

All research questions deal with the same randomly sampled population of two groups of adult Iraqi asylum seekers (>18 years). The questions focus on both groups (total score), on each group separate (group 1: < six months in the Netherlands and group 2: > two years in the Netherlands) and on the comparison of the two groups (see chapter 2: Methodology).

The main research question is:

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?

Descriptive part (chapter 3):

1. What are the socio-demographics of the study group?
2. What traumatic life events are experienced in life periods before, during and after the flight?
3. What are the perceived problems after arrival in the Netherlands, the so-called post-migration living problems (PMLP)?
4. What is the prevalence of psychiatric disorders (anxiety disorders, depressive disorders, post-traumatic stress disorder, somatoform disorders, alcohol-related disorders and 'one or more' psychiatric disorder)?
5. What is the prevalence of co-morbidity of psychiatric disorders?
6. What is the prevalence of perceived physical health problems?

7. What is the perceived health in terms of quality of life and functional disabilities?
8. What are the levels of health service use and what services are attended?
9. How do the participants perceive their participation in the interview?

Analytical part (chapter 4, 5, 6 and 7):

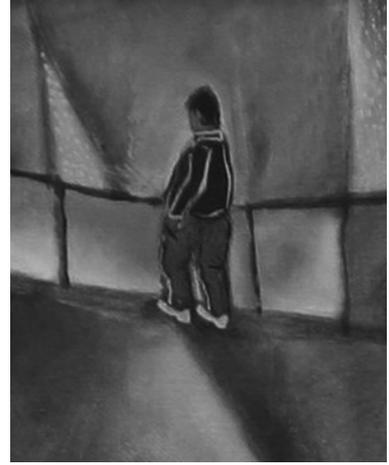
10. What is the relation between traumatic life events and psychiatric disorders?
11. What is the relation between the length of stay in the Netherlands and psychiatric disorders?
12. What is the relation between the PMLP and psychiatric disorders?
13. Which pre- and post-migration risk factors predict psychiatric disorders, in relationship with each another?
14. What is the relation between length of stay and quality of life, functional disability, and somatic complaints and diseases?
15. What are the relations between psychiatric disorders and quality of life, functional disability, and somatic complaints and diseases?
16. What is the impact of length of stay, adverse life events and post-migration living problems, on the relation between psychiatric disorders and the three other indicators of health (mentioned in question 15)?
17. What is the relation between length of stay and health service use?
18. Which other predisposing and need variables predict health service use?

Finally (chapter 8 and 9):

19. What are the consequences for the clinical practice?
20. What conclusions and recommendations can be derived from the study?

Chapter | 2

Methodology



Study design

The Dutch Study Iraqi Asylum Seekers is a cross-sectional national epidemiological study. A longitudinal design would have been more appropriate to answer the major research question, but right from the start of the study we considered this impossible. At the time of the study the tracking system of the IND and the COA did not allow a follow-up study since asylum seekers were often moved, disappeared when they were undocumented or were deported from the centre after denial of a residence permit. Therefore we feared that due to the high mobility of the group we would have lost track of too many respondents if we would perform a longitudinal study.

Population/sample selection

Because of the special interest of the study in the relationship between a long asylum-seeking procedure and health, a pre-stratification was done of the entire adult (> 18 years) population of Iraqi asylum seekers in the Netherlands, based on the length of stay.

Personal information (name, birth date, sex, address of the centre) of the Iraqi asylum seekers was retrieved from the Central Agency for the Reception of Asylum Seekers (COA).

The general exclusion criteria were: having a permanent residence permit, being too sick to be interviewed (physically and/or mentally), being institutionalized in or admitted to a hospital, not fluently speaking Arabic or Kurdish, living in a temporary improvised housing facility of the COA, being a family member in the first line of another participant in the study, and being in the Netherlands longer than six months but shorter than two years.

Group 1 was selected on the criterion that persons had stayed less than six months in the Netherlands. The group was sampled from the monthly lists of newly arrived Iraqi asylum seekers between September 2000 and November 2001. The total number of recently arrived (first applicants) Iraqi asylum seekers that were admitted in a COA facility during this 15-month period was 825 (see Figure 1 and Table 1). This group had passed the first screening after entering the country in a registration centre. The number of persons that do not pass this first screening is not published by the Immigration and Naturalisation Service (IND). Because of lack of housing facilities 243 persons (20.9%) were temporary housed by the COA in all kind of improvised

settings (shelters, holiday bungalows, etc.). These persons were moved too frequently to be selected for an interview and were excluded from the sampling procedure. There were no special criteria used by the COA to select the type of housing for the newly arrived asylum seekers (personal communication). The remaining group of 582 persons – 317 males (54.4%) and 265 females (45.6%) – was accommodated in regular reception centres (OC's). From this group we randomly selected 362, with the help of at random tables. These 362 selected persons received letters of invitation to participate in the study. Concerning 51 persons we received information from the OC's staff that they had left with unknown destination. We did not get any information about 97 persons. So in total 148 persons could not be contacted. From these persons we could only register age and sex. From the 214 contacted individuals we excluded 39 persons because they had relatives in the first line (17), had stayed more than six months in the country (19), or had language problems (3). Finally, 175 individuals could be contacted and were eligible for the interview. Of these, twenty-four permitted only a short interview and eight refused any cooperation.

Therefore, from group 1, data could be used for full analysis from 143 persons: 71 males (49.7%) and 72 females (50.3%).

Group 2 was selected on the criterion that they had been living in the Netherlands for at least two years. On the chosen date of May 31st, 1999, the COA defined 2,352 Iraqi asylum seekers that fulfilled this criterion, 1,844 males (78.4%) and 508 females (21.6%). We randomly selected two times 250 persons, with the help of SPSS analytic computer programme. After removal of doubles, 474 persons remained. These 474 selected persons received letters of invitation to participate in the study. Concerning 41 persons we received information that they had left with unknown destination. We were not able to get any information about 225 persons. So in total 266 persons could not be contacted. From these persons we could only register age and sex. From the 208 contacted individuals we excluded 18 persons for the following reasons: relatives in the first line (5), having a residence permit (6), language problems (4), too sick to be interviewed (3). From the 190 persons we were finally able to contact and whom were eligible for an interview, nine-teen permitted only a short interview and twenty refused any cooperation.

Therefore, from group 2 data could be used for full analysis from 151 persons: 119 males (78.8%) and 32 females (21.2%).

Selected potential respondents were contacted by means of the available address lists. Most of the asylum seekers registered with the COA live in various types of asylum seekers centres spread all over the Netherlands. However, the lists were not up to date (due to moves, removals, wrong addresses, registration problems, etc.), thus a considerable number of potential participants could not be contacted. Especially the potential participants living outside the centres were very hard to contact: only 19.4% of the selected asylum seekers that were living outside a centre could be contacted.

Table 1. Response and retrieval of at random samples of Iraqi asylum seekers < six months (group 1) and > two years (group 2) ago in the Netherlands, 2000-2001.

	Group 1	Group 2
Total Iraqi asylum seekers > 18 years	582*	2.352**
Sample	362	474
Exclusion criteria		
Relatives first line	17-	5-
> Six months in the country	19-	
Received residence permit		6-
Language problems	3-	4-
Too sick to be interviewed		3-
Left the centre without notice	51-	41-
Non-contacts	97-	225-
Persons eligible for interview	175	190
Refused interview	8-	20-
Permitted only short interview	24-	19-
Analysed	143	151

* all newly arrived and admissible Iraqi asylum seekers (> 18 yrs) in the period between September 2000 and November 2001

** all Iraqi asylum seekers (> 18 yrs), two years or longer in procedure on 31 May 1999

Response and representatives

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. So, in our study, only the persons that could be contacted and were not excluded according to the exclusion criteria (more than six months and less than two years in the country, relatives first line, having a residence permit, language problems, too sick to be interviewed), were considered to be eligible for the interview. Following this method, we calculated the response rate in group 1 as 82% (143/175) and in group 2 as 79% (151/190).

In another method of estimating response ratio's (ISER) (Lynn et al., 2001) the number of eligible respondents among the non-contacts is calculated with the help of the known eligibility among the contacted respondents. Moreover partial interviews are included as respondents. Following this method the response rates are: group 1: 63.0% and group 2: 41.5%.

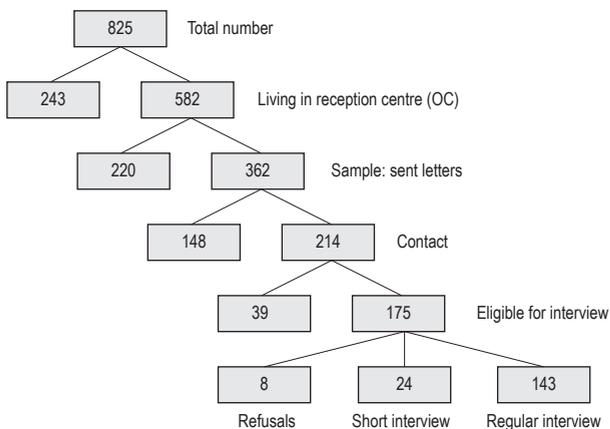
The number of non-contacts is high in both groups, although the efforts to get in contact with the selected cases were intensive (see data collection). We were able to differentiate several groups among the non-contacts in group 2, related to their living situation. According to the lists of the COA: 290 (61.2%) of the 474 sampled asylum seekers were living in a regular centre (AZC), 24 (5.1%) in a small 'additional' centre (AVO) and 160 (33.8%) were living outside a centre (e.g., with family, a self-care arrangement – ZZA). The percentage of non-contacts were: living in a regular centre: 42.4%; living in a small centre: 75.0% and living outside a centre: 80.6%. Moreover, 15 persons (8.9%) living in a regular centre and 4 persons (12.9%) living outside a centre (partly) refused to participate. There were no refusals among the (small number of) persons living in small centres. So the interviewed cases mainly represent the population which was living in a regular centre (AZC).

The high number of non-contacts (which is known from other studies among refugees and immigrants) can effect 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 $p < 0.05$). No other socio-demographic information was available about the non-contacts. Moreover, nothing can be said about their health problems. However, in our view, there are no reasons why these non-contacts would have other levels of psychopathology.

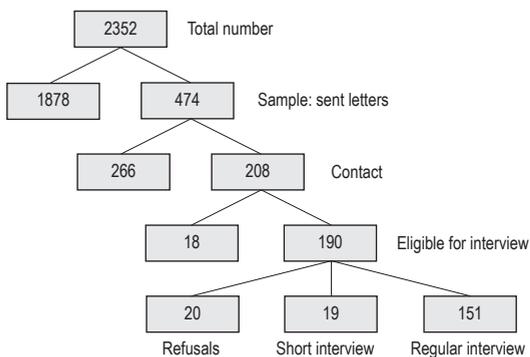
Data collection

Invitation letters were sent to all potential participants, using the address of the centre they were registered according to the given information (COA). Before sending the invitation letters, all regional managers of the different departments of the centres were informed about the study and information was placed on their internal websites. Several Iraqi organizations in the Netherlands were informed and some published the information (in Arabic and Dutch) in their periodicals. In the invitation letter (in

Group 1: Iraqi asylum seekers arrived between September 2000 and November 2001



Group 2: Iraqi asylum seekers > two years in asylum procedure at 31-5-1999

**Figure 1.** Flowchart

Arabic and Dutch), information about the purpose and the content of the study were given. At the same time, letters in Dutch were sent to the medical staff in the centres. They received information about the study and the name and birth date of the potential participants. Moreover we asked them to help to contact the participant, explain once again the aim and content of the study and make an appointment for the interviewer. In the invitation letter to the potential participant we asked the person to contact the interviewer by phone or contact the medical staff. The possibility to contact the

interviewer directly was included because of possible language problems and in case the medical staff was not or not often available (persons living in small centres or outside a centre). If the asylum seeker was not living in the centre, his/her home address was asked from the administrative staff in the centre. In case of refusal or no response we asked the medical staff to try to get in contact with the participants on the day they were coming to the centre for their identification to the IND (all asylum seekers have to present themselves once a week to an officer of the IND or his/her representative in the centre. This requirement was introduced to check if an asylum seeker is actually still there and available for further investigations). Sometimes the interviewers tried to find the asylum seeker by just going to the centre and asking and looking around. Some participants were found through the help of other participants. When the sought-after participants appeared to have moved (which was quite often the case), we asked the service-desk of the COA to find the most recent place of stay and the abovementioned procedure was followed in the new centre. At least two invitation letters were sent in case of no response.

We discussed using an incentive (e.g., some money) to encourage participation. Because of the chance of bias we decided not to give any incentive, besides a “thank you for your cooperation”. In many cases the asylum seekers thanked the interviewers for the time spent.

All interviewers (14) were Iraqi and fluent in Dutch and Arabic. Several (5) were fluent in the Kurdish languages (Soorani, Bahdini) as well. They were selected and trained with the help of a staff member of the Transcultural Psychosocial Organization (TPO), who got her training from an official WHO-CIDI training centre. The four-day training sessions were followed up by two refresher training courses. In the training, attention was paid to the potential stress that might occur in the interviewers when asking participants about traumatic events. All interviewers had a refugee background and although their own possible reactions during interviewing and scoring the traumatic events was also touched on in the screening process before they were accepted as interviewers, this issue was discussed again in the training sessions. They were invited to discuss possible stress with the researcher. The very frequent contacts with all the interviewers gave enough room to do so. However, in only a few occasions the interviewers reported that they experienced stress during or after the interviews. We were fortunate to work with a very stable and highly motivated group of interviewers. This despite the fact that the financial resources of the study were

limited and we could only afford to give them travel costs and a small allowance per interview and training session.

Before starting the interview with the respondent, the purpose of the study was explained again and the issues of anonymity and privacy were emphasized. Moreover, participants were once more told that the interview had nothing to do with their procedure and that the Immigration and Naturalisation Service had nothing to do with the interview. The participants were asked for an oral consent (see later). They were given the possibility to ask for a break and, if necessary, to stop the interview and continue another time, within two weeks.

All completed questionnaires were thoroughly screened and if necessary sent back to the interviewer for correction or completion. In several cases it was necessary to call or to go back to the participant to complete the interview. One of the interviewers was trained to do the data entry. Frequently, at random quality checks were done on his work (about 20%).

Instruments

The composite questionnaire of this study contains adapted versions of instruments previously used in Algeria, Cambodia, Ethiopia and Gaza (De Jong et al., 2001, 2003).

The socio-demographic section was adjusted to suit the situation of the asylum seekers in the Netherlands. It contained questions about age, sex, children, ethnicity, religion, literacy, language skills, education, profession, social status in Iraq, area of origin and length of stay in the Netherlands. Because of their potential associations with one or more of the outcome measures, issues concerning someone's marital status, children and family members in the Netherlands and number of places someone lived in in the Netherlands, were asked for in detail. Furthermore information was collected on psychiatric problems in the past and in the family, including alcohol misuse/addiction.

Problems in early life (youth domestic stress) was assessed with a 23-item list: the first set of questions is about the people the respondent was living with: "Where you living with both your biological parents until the age of thirteen?" If the answer was 'no', questions were asked about the actual situation during this period (death parent(s), living with relatives, adopted, etc.). To estimate youth domestic stress, thirteen questions were asked about difficult experiences within the family (e.g., domestic violence, neglect, teasing, periods of silent denial).

Traumatic experiences and other adverse life events were gathered with the first section of the Harvard Trauma Questionnaire (HTQ), an instrument widely used in research among refugees (Mollica et al., 1987). This questionnaire contains the following experiences: lack of food/water; sick without medical care; lack of shelter; imprisonment; serious injury; combat situations; sexual abuse/rape; social isolation; close to death; separated from family; witness death family/friend; lost or kidnapped; witness murder family/friends; torture; solitary confinement; witness torture family/friend; and witness torture stranger. After discussion in the focus group (see later), a few items were added. In the period 0-12 years: quarrels between parents, tense family relationships; in all other periods: continuous fear about fate spouse, raising kids alone. We did not specify any questions for men or women. If the questions were not applicable to one or the other for obvious reasons, the interviewer was trained to skip the question. Data were collected over 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.

Exposure to torture was explored in more detail and measured with the Exposure to Torture Scale, which is part of the Semi-structured Interview for Survivors of Torture (SIST) (Basuglo, 1996). Twenty-three methods of physical torture were investigated (e.g., beating, falaqa, food deprivation, rope bandage – falaqa, or falanga, is an extremely painful method of torture whereby the soles of the feet are beaten with an object such as a cane or rod, a club, a piece of wood, or a whip –). Twenty-two methods of psychological torture were investigated (e.g., mockery/humiliation, threats against the family, threats of further torture). Three items of the SIST were removed by the focus group because the methods were thought not to be practised in Iraq: Palestinian hanging, fondling of genitals, and stripping naked. Five items were added by the focus group to adapt the list to the Iraqi situation: rape of family members, threat of rape of family members, continuous threat of death, forced intake of poisonous drugs (e.g., Lithium) before release, forced to torture others.

Post-migration stress factors were gathered with a Post Migration Living Problems (PMLP) checklist which was adapted from Silove et al. (1997). The following items were copied from the list Silove et al. used: fears of being sent home, unable to return home in case of emergency, worries about family back home, separation from family/missing the family, no permission to work, loneliness. The item on discrimination was divided in three aspects: discrimination in general, in words and in deeds. To make the list more applicable to the situation in the Netherlands and more in line with the

experiences of the members of the focus group and our own clinical experience, the following items were added: uncertainty about residence permit, uncertainty about the future, housing problems, financial problems-self, financial problems-family, lack of privacy, lack of social contacts, lack of contacts with people of the same religion, language problems, work below level, lack of safe environment for children, worries about political friends in Iraq, delay in marriage. In total the list in the present study contained 24 items. The participants were asked whether or not the problem was applicable to them and if so, how much they worried about it on a five-point scale of worries (between 1 = 'not worried' and 5 = 'very much worried').

Psychiatric disorders were measured with the World Health Organization Composite International Diagnostic Interview (CIDI), version 2.1 (1997), sections: C (somatoform disorders), D (anxiety disorders), E (depressive disorders), J (alcohol dependency and misuse) and K (obsessive compulsive disorder and post-traumatic stress disorder). The section about psychotic disorder was excluded because it is very long and often results in false negative and false positive outcomes (Kessler et al., 1994). The CIDI is designed for use in large-scale community epidemiological surveys and other settings where it is not feasible to have clinicians make a diagnosis. The CIDI is highly structured and can be administered by lay interviewers. It was also designed to foster cross-cultural comparative research. To this end, the CIDI was translated and field-tested in many different countries, where it was found to be a generally acceptable, appropriate and reliable diagnostic tool (Witchen et al., 1991; Kessler, 1999).

The Symptom Checklist-90-R (Derogatis, 1977, 1994) was used to study the mental health problems on symptom level. The instrument measures psychological problems and symptoms of psychopathology, generally summarized as 'emotional stress'. Each of the 90 items is rated on a five-point scale of distress (between 1 = 'not at all' and 5 = 'extremely'). Subsequently, the answers are clustered into nine domains: somatization, obsessive-compulsive problems, interpersonal sensitivity, depressive complaints, psychoticism, phobic anxiety, paranoid ideation, anxiety problems and hostility. The results are reported in a score which is defined by the mean score divided by the number of items in the domain. The cut-off score for a symptomatic case is usually taken at 1.75.

Quality of life (QoL) was assessed with the WHOQOL-BREF (WHO, 1998). This is a 26-item version of the WHOQOL-100 assessment. The concept of Quality of Life of the WHOQOL-BREF is based on the same definition as the WHOQOL-100 and defined as an individual's perception of their position in life in the context of the

culture and value systems in which they live and in relation to their goals, expectations, standards and concerns (WHOQOL Group, 1995). Domain scores produced by the WHOQOL-BREF correlate highly (0.89 or above) with WHOQOL-100 domain scores (calculated on a four-domain structure). The psychometric properties were evaluated using cross-sectional data from 23 countries (n=11,830). Analyses of internal consistency, item-total correlations, discriminant validity and construct validity through confirmatory factor analysis, indicate that the WHOQOL-BREF has good to excellent psychometric properties and performs well in preliminary tests of validity. For the total sample, values for Cronbach's α were acceptable (>0.7) for three domains and marginal for one domain (social relationships: 0.68). The discriminant validity was significant for each domain and the construct validity was good: only seven items had strong correlations (>0.50) with domains other than their intended domain. These results suggest that overall, the WHOQOL-BREF is a sound, cross-culturally valid assessment of QoL. The first two single questions, i.e.: "How would you rate your quality of life?" and "How satisfied are you with your health?" refer to 'overall quality of life' and 'general health'. The other questions belong to four different domains of quality of life (Skevington et al., 2004):

- *Physical health* (seven items): activities in daily life, dependence on medical substances and medical aids, energy and fatigue, mobility, pain and discomfort, sleep and rest, work capacity.
- *Psychological health* (six items): bodily image and appearance, negative feelings, positive feelings, self-esteem, spirituality/religion/personal beliefs, thinking/learning/memory and concentration.
- *Social relationships* (three items): personal relationships, social support, sexual activity.
- *Environment* (eight items): financial resources, freedom/physical safety and security, health and social care: accessibility and quality, home environment, opportunities for acquiring new information and skills, participation in and opportunities for recreation/leisure activities, physical environment (pollution/noise/traffic/climate, transport).

Disability was measured with the Brief Disability Questionnaire (BDQ). This instrument (Von Korff et al., 1996) is derived from the Medical Outcome Survey Short Form (SF-36) and rates impairment in daily activities. The instrument has been evaluated in a 15-centre, cross-national, multilingual study (Von Korff et al, 1996).

The reliability coefficients estimated by the Mokken scaling programme were high (0.84 to 0.95) and individual items were responsive at similar levels of disability. The BDQ has a good internal consistency (Cronbach's α ranging from 0.83 to 0.94) and is associated with varying disability across anxiety, affective and somatization disorders (Ormel et al., 1994). The BDQ asks respondents whether they were limited in physical and social activities because of health problems during the last month before the interview. Each of the 11 items is rated as not at all (1), sometimes or a little (2), or moderately/definitely (3). Two additional questions ask about days of serious impairment due to ill health and the total number of days spent in bed due to ill health. In this study we used the total score (BDQ-tot; range between 11 and 33) for physical and social role impairments and the score BDQ-days (range between 0 and 31) which refers to the total number of days with serious impairment. The questionnaire is developed as a self-rating scale, but in our study it was part of the interview.

Physical health was assessed with a self-developed list of 22 items, dealing with perceived physical health ("In general, how do you consider your physical health?") and chronic physical health problems and physical handicaps. The physical health problems were divided in two categories: physical complaints (stomach problems, intestinal problems, back problems more than three months, joint problems more than three months, headache more than three months) and physical diseases (lung disease, heart disease, high blood pressure, liver disease, kidney disease, diabetes, epilepsy, eye problems, ear problems, wounds by accidents, hereditary disease, other illness).

Health service use was measured with a self-developed questionnaire of nine items, dealing with regular services as well as alternative services in the two months prior to the interview. The following regular services were included:

- *Out-patient services*: preventive healthcare (nurse/doctor in centre), primary healthcare (general practitioner), generic healthcare (medical specialist, non-psychiatric), social care (social worker), psychiatric services (mental health professional).
- *In-patient services*: hospital admission-physical health, hospital admission-mental health; use of drugs (any drugs, hypnotics, anxiolytics and analgetics). Examples of drug names were given to be sure the drugs were put in the right category.

The following complementary and alternative medicine (CAM) services were included: contact religious helper, use of religious rituals and treatment, contact herbal doctor, use of herbal treatment.

Translation and cultural validation

The Iraqi-Arabic questionnaire was based on the Palestinian-Arabic version used in the TPO programme in Gaza (De Jong et al., 2001), which had been translated from English and culturally validated according to the recommendations of Flaherty et al. (1988) and the rules of the World Health Organization (Sartorius & Janca, 1996). Content, criteria, technical, conceptual and semantic equivalence were taken into consideration in the translation process, which consisted of the following steps: (1) examination of the instruments by two to four bilingual experts on content and concept equivalence, (2) translation of the instruments, (3) literal back-translation of the instruments by other translators, (4) examination of the translation by monolingual experts not familiar with the local language, (5) back-translation of all those items amended by the monolingual group, (6) examination of the back-translation by a bilingual group informed by the discussion in the monolingual group, and (7) testing in a pilot study.

Because the Palestinian-Arabic version of the questionnaire was made with the help of several focus groups we only used one focus group to adapt the list to the Iraqi study population. The focus group consisted of eight Iraqi men and women from different ethnic and professional backgrounds (among others medical doctors). They studied each question on comprehensibility, completeness, relevancy and acceptability, according to the guidelines described by Van Ommeren et al. (1999). Adaptations were made on the basis of consensus. The internal structure of instruments was left intact. It appeared to be necessary to change a substantial number of words and sentences to adapt the questions for the Iraqi study group. The questions added about the Dutch situation were translated by a professional translator and then commented on for content and phrasing by the members of the focus group. Because they were all bilingual, translation and back-translation was a routine part of the process. A few last changes were made after the pilot study, in which the translation was tested, as well as the feasibility of conducting a rather lengthy interview.

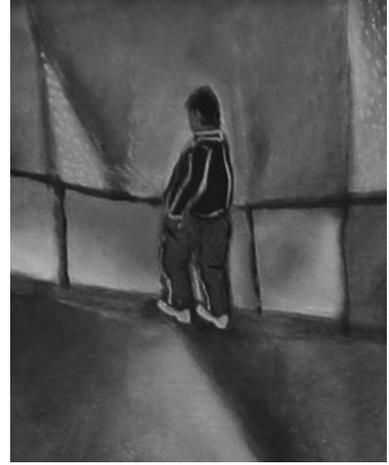
Medical ethical evaluation

The research protocol was approved by the national Central Committee on Research Involving Human Subjects (Centrale Commissie Mensgebonden Onderzoek, CCMO) and by the local ethics committee of GGZDrenthe. In correspondence with the rules of the Law on Medical Scientific Research involving Human Beings (Wet Medisch-Wetenschappelijk Onderzoek met Mensen, WMO) an independent physician was appointed to be available for the respondents for questions and complaints. His name and telephone number were mentioned in the letters of invitation. The independent physician was a member of the medical staff of one of the AZC's and therefore well aware of the situation and problems of asylum seekers. For the purpose of his duty related to the study, he was thoroughly informed about the purpose, the design and the methods of the study. The CCMO stated that there was a (slight) risk that some respondents would have an adverse emotional reaction on the interview which might lead to dangerous behaviour. We challenged this opinion. According to the law there is such a risk when persons are "submitted to physical or mental proceedings" or are "asked to perform certain risky tasks". We stated that neither of this was the case in this study. Moreover in an, at that time, recent article, Ploem (1999), being a member of two ethics committees stressed that research that was fully based on structured interviews was not the type of research meant by the WMO. Subsequently we quoted an article from Newman (1999) about the ethical aspects in trauma research. Newman found that in fully structured trauma-focused interviews the psychological adverse reactions were minor and even if they do occur, the final opinion about the interview was positive. Many respondents (86%) indicated after the interview that their participation in the interview was a positive experience. We stated that this corresponded with our own experience in the pilot interviews. The Iraqi asylum seekers were happy with the interview, they had the feeling that they were taken seriously and were willing to spend two to three hours for the interview. No matter our opposing argument the CCMO did not change its opinion. Therefore we had to inform all the respondents about the possible risk prior to the interview. We decided to instruct the interviewers to inform the respondents on this matter when they were face to face with the respondent. We thought that writing this in the invitation letter would frighten some people off. At the same time, because of this decision, we had to take an insurance to cover costs of claims of 'dead or harm' caused by the interviews. We instructed the interviewers to tell the respondents of the possibility to contact the independent physician and also to tell them that the medical staff in the asylum seeker centre could be contacted if necessary (the staff was always kept abreast of the time

of the interview). Moreover, we instructed the interviewers to observe stress reactions during the interviews and advised them to have a short break if necessary. Finally, we added several questions to assess the experience of the participants. As expected, the result was that only very few (2.7%) disagreed with the statement “the interview was a positive experience” (see chapter 3, Table 11 for the results).

References

All references can be found at the end of the book.



Chapter | 3

Descriptive characteristics of the study population

Introduction

This chapter gives an overview from the results of the descriptive part of the study (see research questions, chapter 1). Data are given on socio-demographics, traumatic experiences in the various pre-migration life periods, physical and psychological torture experiences, post-migration living problems, psychiatric disorders, quality of life, functional disability, physical complaints and diseases, and health service use. In the description of the comparison between group 1 and group 2 only significant differences are mentioned. The applied instruments have been explained in chapter 2. In this chapter, no explanations or interpretations of the results are given, these will follow in the chapters 4 to 8.

Socio-demographics

Table 1 shows a wide variety of socio-demographic characteristics, including data on the psychiatric history. Except for the length of stay in the Netherlands the two groups revealed to be very much alike. However, group 1 contained more females and subjects younger than 24 years of age. The majority were, as expected, Muslims. The difference in ethnicity was mainly due to the fact that there were more Armenians in group 1. This finding corresponds with the difference in religion because most Armenians are Christians. Group 1 had more family members living in the Netherlands on arrival (group 1: 57.3% versus group 2: 31.1%), also at the time of the interview (group 1: 59.9% versus group 2: 41.7%).

Group 1 reported more often that the Netherlands was the country of preference for asylum (group 1: 76.9% versus group 2: 56.3%).

Traumatic experiences and other adverse life events

Table 2 shows the adverse life events in various pre-migration periods (measured with the HTQ, Mollica et al., 1978). In the first period (till the 13th year), witnessing the death of a family member or a friend (15.6%) and experiencing combat situations (10.9%) were the most frequently reported events. Witnessing torture and murder in this period was especially reported by group 2: resp. 8.6% and 6.6%. In both groups, most events took place in the second period (between the 13th year and departure/flight from Iraq). The most prevalent life events in this period were: combat situations (41.8%), witness death family/friends (45.0%), imprisonment (32.3%), witness torture stranger (41.1%), witness murder family/friends (34.4%) and torture (29.3%). All these events were more prevalent in group 2. In the third period (between departure from Iraq and arrival in the Netherlands) the most prevalent life events were being sick

Table 1. Socio-demographic characteristics of at random samples of Iraqi asylum seekers < six months (group 1, n=143) versus > two years (group 2, n=151) in the Netherlands, 2000-2001.

Variables	Group 1 (n=143)	Group 2 (n=151)	Total (n=294)	
Sex (%)				s
Male	49.7	78.8	64.6	
Female	50.3	21.2	35.4	
Age (%)				s
18-24 years	21.7	9.3	15.3	
25-34 years	42.0	49.0	45.6	
35-44 years	14.7	25.8	20.4	
45-64 years	14.0	13.2	13.6	
> 64 years	7.7	2.6	5.1	
Ethnicity (%)				s
Arabic	30.8	32.5	31.6	
Kurdish	48.3	53.0	50.7	
Armenian	11.9	2.0	6.8	
Other	9.1	12.6	10.9	
Religion (%)				s
Shi'ite Muslim	18.6	17.6	18.1	
Sunni Muslim	50.0	49.3	49.7	
Christian	24.3	13.5	18.8	
Other	7.1	19.6	13.3	
Marital status (%)				
Married	60.8	70.2	65.6	
Widow/widower	7.7	5.3	6.5	
Divorced	1.4	3.3	2.4	
Never been married	30.1	21.2	25.5	
Children				
Having children (%)	52.4	59.6	56.1	
Number of children (mean, SD)	3.15 (2.46)	3.03 (1.82)	3.08 (2.13)	
Literacy (%)				
Reading	83.9	89.4	86.7	
Writing	81.1	87.7	85.0	
Highest education (%)				
University	21.8	25.7	20.7	
College	12.6	13.2	11.2	
High school	19.3	19.1	16.7	
Middle school	17.6	16.2	14.6	
Primary school	19.3	18.4	16.3	
No school or only Quran school	9.2	7.4	7.1	
Years of education (mean, SD)	9.28 (2.51)	9.31 (2.58)	9.30 (2.54)	
Social position in Iraq—self rating (%)				
Low	16.9	14.6	15.7	
Average	68.3	62.9	65.5	
High	14.8	22.5	18.8	
Psychiatric problems in history (%)				
Psychiatric history family	7.0	13.2	10.2	
Alcoholic parent	7.0	10.6	8.8	
Psychiatric problems self	0	0	0	
Stay in months (mean, SD)	2.51 (1.16)	36.77 (6.3)	20.12 (17.76)	s

s. = significant $p < 0.05$ (statistics: chi-square tests)

without medical care (21.1%), continuous fear about spouse (19.7%), lack of food/water (18.7%) and lack of shelter (15.6%). Also these events were more prevalent in group 2.

Table 2. Traumatic experiences and other adverse life events in Iraqi asylum seekers < six months (group 1) versus > two years (group 2) in the Netherlands, 2000-2001.

	Youth till 13 th year in Iraq			Between 13 th year and departure Iraq			Between departure and arrival in the Netherlands		
	Group 1 n=143 %	Group 2 n=151 %	Total n=294 %	Group 1 n=143 %	Group 2 n=151 %	Total n=294 %	Group 1 n=143 %	Group 2 n=151 %	Total n=294 %
One or more life event	22.4	37.1	29.9*	61.5	73.5	67.7*	23.1	51.0	37.4*
Combat situations	7.0	14.6	10.9*	32.2	51.0	41.8*	0.7	0.7	0.7
Witness death family/friend	11.9	19.2	15.6	30.1	45.0	37.8*	0.7	2.6	1.7
Imprisonment	0.0	0.0	0.0	26.6	37.7	32.3*	1.4	4.0	2.7
Witness torture stranger	2.8	8.6	5.8*	19.6	41.1	30.6*	0.7	1.3	1.0
Witness murder family/friends	1.4	6.6	4.1*	23.8	34.4	29.3*	0.7	1.3	1.0
Torture	0.0	0.7	0.3	23.1	35.1	29.3	0.7	0.7	0.7
Continuous fear for spouse ¹				18.2	33.1	25.9*	8.4	30.5	19.7*
Close to death	1.4	2.6	2.0	16.8	29.1	23.1*	1.4	5.3	3.4
Sick without medical care	4.9	4.0	4.4	20.3	25.2	22.8	13.3	28.5	21.1*
Solitary confinement	0.0	0.0	0.0	18.9	25.8	22.4	0.7	0.7	0.7
Lack of food/water	4.9	4.6	4.8	16.8	25.8	21.4	10.5	26.5	18.7*
Lack of shelter	2.1	4.6	3.4	14.0	21.2	17.7	8.4	22.5	15.6*
Separated from family	1.4	2.6	2.0	12.6	22.5	17.7*	2.1	9.3	5.8*

¹ added by Iraqi focus group to Harvard Trauma Questionnaire (HTQ, Mollica)

* = significant: $p < 0.05$ (statistics: chi-square tests)

Types of psychological and physical torture

Table 3 shows the physical and psychological types of torture (measured with the Exposure to Torture Scale of the SIST, Basoglu et al., 1996) throughout all life periods and reported in more than 10% of the respondents of both groups. The figures mainly reflect torture in the period between the 13th year and departure. Only one respondent reported to be tortured in the youth and two reported torture in the period between the departure from Iraq and the arrival in the Netherlands. Overall, group 2 reported more torture than group 1. The most prevalent types of physical torture were beating, food deprivation, rope bandage, falaqa (beating on the sole of the foot) and water deprivation. Moreover, in group 2 more than 15% reported forced standing, beating on the ears with cupped hands, sleep deprivation and restriction of movement. The most prevalent types of psychological torture were threats to death, verbal abuse,

isolation, blindfolding and mockery/humiliation. Moreover, in group 2 more than 15% reported threats against the family, continuous danger of being killed, denial of privacy, threats of further torture and witnessing torture.

Table 3. Type of physical and psychological torture in any period of life in Iraqi asylum seekers < six months (group 1) versus > two years (group 2) in the Netherlands, 2000-2001.

	Group 1 n=142 %	Group 2 n=151 %	Total n=294 %
Torture all types	24.5	36.4	30.6*
Physical torture			
Beating	22.4	34.4	28.6*
Food deprivation	11.2	21.2	16.3*
Rope bondage	13.3	19.2	16.3
Falaqa (beating soles of the feet)	10.5	17.2	13.9
Water deprivation	9.8	17.2	13.6
Forced standing	7.3	17.9	12.9*
Beating on the ears with cupped hands	9.8	15.9	12.9
Sleep deprivation	7.7	17.9	12.9*
Restriction of movement	7.0	17.2	12.2*
Hanging by hands or feet	10.5	13.2	11.9
Prevention of urination/defecation	8.4	14.6	11.6
Pulling/dragging/lifting hair	11.9	11.3	11.5
Deprivation of medical care	6.3	11.9	10.2*
Electrical torture	5.6	10.6	8.1
Psychological torture			
Threats to death	14.7	25.2	20.1*
Verbal abuse	14.7	23.9	19.3
Isolation	14.0	22.6	18.3
Blindfolding	12.6	21.9	17.3
Mockery/humiliation	12.6	21.9	17.3
Threats against family	11.9	19.2	15.6
Continuous danger of being killed 1	7.0	18.5	12.9*
Denial of privacy (e.g., overcrowding)	6.3	16.6	11.6*
Threats of further torture	7.0	15.9	11.6*
Witnessing torture	4.9	15.2	10.2*
Prevention of personal hygiene	5.6	13.2	9.5*
Fluctuation of interrogator's attitude	6.3	10.6	8.5
Infested environment	4.9	13.2	9.5*

¹ added by Iraqi focus group to Exposure to Torture Scale (SIST, Basoglu)

* significant: $p < 0.05$ (statistics: chi-square tests)

Post-migration living problems

Table 4a shows the 10 most frequently mentioned 'worries about post migration living problems (PMLP) (measured with an adapted list from Silove et al., 1997). Respondents in group 2 reported more problems in 9 out of 10 items. The biggest

significant difference between group 1 and 2 was found in the item ‘worries about no permission to work: 32.2% versus 74.2%. Table 4b shows the mean scores of worries about post-migration living problems All items with a score higher than 2 (ranging from 1 (no worries) to 5 (very worried)) are shown in the table. Asylum procedure-related items (uncertainty about the residence permit, fear to be sent away) and family-related items (missing the family, worries about the family in Iraq, unable to go home in case of emergency) were most prevalent in both groups. In group 2 loneliness and no permission to work were important sources of worries. Overall, group 2 had (much) higher scores than group 1. Items that had mean scores between 1 and 2 were: lack of safe environment children, worries about political friends in Iraq, lack of religious meetings, lack of contacts with people of same religion, delay of marriage and discrimination.

Table 4a. Postmigration living problems in at random samples of Iraqi asylum seekers arrived < six months (group 1) versus > two years (group 2) in the Netherlands, 2000-2001.

PMLP (%)	Group 1 n=143	Group 2 n=151	Total n=294
Uncertainty about the future	62.2	86.8	74.8*
Missing the family	71.3	87.4	79.6*
Worries about family in Iraq	69.2	84.1	76.9*
Loneliness	55.6	78.1	67.0
No permission to work	31.5	74.2	53.4*
Unable to go home in case of emergency	58.0	72.2	65.3*
Housing problems	63.6	68.9	66.3*
Lack of privacy	44.1	59.6	52.0*
Financial problems - self	45.5	57.6	51.7*
Lack of social contacts	36.4	47.7	42.2*

* significant: $p < 0.05$ (statistics: chi-square)

Table 4b shows the mean scores of worries about post-migration living problems (measured with an adapted list from Silove et al., 1997). All items with a score higher than 2 (ranging from 1 (no worries) to 5 (very worried)) are shown in the table. Asylum procedure-related items (uncertainty about the residence permit, fear to be sent away) and family-related items (missing the family, worries about the family in Iraq, unable to go home in case of emergency) were most prevalent in both groups. In group 2 loneliness and no permission to work were important sources of worries. Overall, group 2 had (much) higher scores than group 1. Items that had mean scores between 1 and 2 were: lack of safe environment children, worries about political friends in

Iraq, lack of religious meetings, lack of contacts with people of same religion, delay of marriage and discrimination.

Table 4b. Mean scores of worries about post-migration living problems (range 1-5) in Iraqi asylum seekers < six months (group 1) versus > two years (group 2) in the Netherlands, 2000-2001.

Post-migration living problems ¹	Group 1 n=143	Group 2 n=151	Total n=294
Uncertainty about residence permit	3.78	4.21	4.00*
Fear to be sent away	3.62	3.83	3.72
Missing the family	3.17	3.91	3.55*
Worries about family in Iraq	3.03	3.90	3.48*
Uncertainty about the future	2.90	3.98	3.45*
Unable to go home in case of emergency	2.60	3.36	2.99*
Loneliness	2.50	3.38	2.96*
Housing problems	2.68	3.17	2.93*
Health problems	2.31	2.87	2.60*
No permission to work	1.86	3.72	2.59*
Lack of privacy	2.14	2.73	2.44*
Financial problems – self	2.06	2.68	2.38*
Financial obligations towards family	1.99	2.66	2.33*
Language problems	2.22	2.21	2.21
Lack of social contacts	1.78	2.15	1.97*
Work below level	1.57	2.12	1.85*

* significant: $p < 0.05$ (statistics: t-tests)

¹ score: range from 1 (no worries) to 5 (very worried)

Mental health problems (1)

Table 5 shows the lifetime and 12-month prevalence of psychiatric disorders (measured with the CIDI 2.1, WHO, 1997). The overall lifetime prevalence rate was 54.4%, the overall 12-month prevalence rate was 51.0%. In group 1, post-traumatic stress disorder (PTSD) is most prevalent (31.5%), followed by depressive disorders (25.2%) and anxiety disorders (14%), while in group 2 the depressive disorders score highest (43.7%), followed by PTSD (41.7%) and anxiety disorders (30.5%). There is a significant difference between the two groups for all measured disorders (cluster level), except for the PTSD. The overall prevalence rate (one or more psychiatric disorder) is 42.0% in group 1 and 66.2% in group 2, which is also significantly different ($p < 0.0005$). The differences between group 1 and group 2 apply to both lifetime and 12-month prevalence rates.

Table 5. Lifetime and 12-month prevalence of psychiatric disorders in at random samples of Iraqi asylum seekers < six months (group 1) versus > two years (group 2) in the Netherlands, 2000-2001.

Diagnosis (%)	Group 1	Group 2	Total	Group 1	Group 2	Total
	(n=143)	(n=151)	(n=294)	(n=143)	(n=151)	(n=294)
	Lifetime	Lifetime	Lifetime	12-month	12-month	12-month
Anxiety disorder (cluster)	14.0	30.5	22.4*	12.6	20.5	16.7
Panic disorder and Agoraphobia	3.5	6.0	4.8	3.5	6.0	4.8
Phobias	11.9	16.6	14.3	11.2	11.9	11.6
Obsessive-compulsive disorder	0.0	2.6	1.4	0.0	0.7	0.3
Generalised anxiety disorder	4.9	8.6	6.8	4.2	7.9	6.1
Depressive disorder (cluster)	25.2	43.7	34.7*	22.4	39.1	31.0*
Major depression – single	22.4	35.1	28.9*	20.3	31.1	25.9*
Major depression – recurrent	2.1	6.6	4.4	2.1	6.0	4.1
Dysthymia	0.7	4.6	2.7*	0.0	3.3	1.7*
Somatoform disorder (cluster)	4.9	13.2	9.2*	4.9	13.2	9.2*
Somatization disorder	0	0.7	0.3	0.0	0.7	0.3
Conversion disorder	2.8	9.3	6.1*	2.8	9.3	6.1*
Pain disorder	1.4	11.3	6.5*	1.4	11.3	6.5*
Hypochondriasis	0.7	2.6	1.7	0.7	2.6	1.7
Post Traumatic Stress Disorder	31.5	41.7	36.7	29.4	37.7	33.7
Alcohol dependence	0.0	6.6	3.4*	0.0	6.6	3.4*
Alcohol abuse	0.0	0.0	0.0	0.0	0.0	0.0
One or more psychiatric disorders	42.0	66.2	54.4*	39.9	61.6	51.0*

* significant: $p < 0.05$ (statistics: chi-square tests)

Table 6 shows the figures of co-morbidity. From the entire group ($n=294$), 54.5% has ‘one or more psychiatric disorders’. From the respondents with a depression ($n=102$), 61.1% also had a PTSD, 40.2% also had an anxiety disorder and 19.6% also had a somatoform disorder. From the respondents with an anxiety disorder ($n=66$), 62.1% also had a depressive disorder, 56.1% also had a PTSD and 13.1% also had a somatoform disorder. From the respondents with a PTSD ($n=108$), 64.7% also had a depressive disorder, 34.3% also had an anxiety disorder and 15.7% also had a somatoform disorder. From the respondents with a somatoform disorder ($n=27$), 74.1% also had a depressive disorder, 63.0% also had a PTSD and 33% also had an anxiety disorder.

Co-morbidity is present in both groups, e.g., respondents in group 1 with a PTSD also reported a depression (55.6%), an anxiety disorder (31.1%) and a somatoform disorder (6.7%). Respondents in group 2 with a depression also reported an anxiety disorder (45.5%), a somatoform disorder (22.9%) and a PTSD (62.1%). Many disorders are significantly correlated ($p < 0.05$). Overall, the co-morbidity in group 2 is higher than in group 1.

Table 6. Co-morbidity of lifetime psychiatric disorders in Iraqi asylum seekers < six months (group 1) and > two years (group 2) in the Netherlands, 2000-2001.

Diagnosis (%)	Depressive dis.	Anxiety dis.	Somatoform dis.	PTSD
Depressive disorder (n=36)	X	30.6%*	13.9%*	69.4%*
Anxiety disorder (n=20)	55.0%*	X	10.0%	70.0%*
Somatoform disorder (n=7)	71.4%*	28.6%*	X	42.9%*
PTSD (n=45)	55.6%*	31.1%*	6.7%	X
Group 2				
Depressive disorder (n=66)	X	45.5%*	22.9%*	62.1%*
Anxiety disorder (n=46)	65.2%*	X	15.2%	50.0%*
Somatoform disorder (n=20)	75%*	35%	X	70.0%*
PTSD (n=63)	65.1%*	36.5%*	22.2%*	X
Total				
Depressive disorder (n=102)	X	40.2%*	19.6%*	61.1%*
Anxiety disorder (n=66)	62.1%*	X	13.6%	56.1%*
Somatoform disorder (n=27)	74.1%*	33.0%	X	63.0%*
PTSD (n=108)	64.7%*	34.3%*	15.7%*	X

* significant: $p < 0.05$ (statistics: chi-square tests)

Mental health problems (2)

Table 7 shows the scores of the domains of emotional stress (measured with the SCL-90-R, Derogatis, 1977, 1994). In both groups the highest scores are reported in the domains depression, obsessive-compulsive complaints and anxiety. The scores of these domains are all on or above the cut-off score of 1.75, which is most frequently used for an indication of clinical importance. In group 1 all other domains are under this level, but in group 2 also the domains hostility, somatization, paranoid ideation, psychoticism and interpersonal sensitivity scored above this level. There is a significant difference between group 1 and group 2 on all domains.

Physical health

Table 8 shows the scores of a (self-developed) 22-item list, asking about physical health. The physical health problems were divided in two categories: physical complaints existing more than three months and chronic physical diseases. Almost all (five out of six) physical complaints were more prevalent in group 2. The mean scores of the diseases did not differ significantly between the two groups, except for lung diseases (group 1: 1.4% versus group 2: 7.3%). The prevalence rates of the diseases of the groups together were: heart disease: 7.8%; high blood pressure: 10.9%; liver disease: 0.7%; kidney disease: 9.5%; diabetes: 2.0%; epilepsy: 2.0%; eye problems: 25.2%; ear problems: 9.9%; wounds by accident: 5.1%; hereditary disease: 0.7%; other illness: 6.5%. Perceived physical health is rated from 1 (very good) to 5 (very

Table 7. Scores on domains of emotional stress among Iraqi asylum seekers < six months (group 1) versus > two years (group 2) in the Netherlands, 2000-2001.

Domains of SCL-90-R	Group 1 n=143	Group 2 n=151	Total n=294
	score ¹	score ¹	score ¹
Somatization	1.64	1.94	1.80*
Obsessive-compulsive	1.91	2.44	2.18*
Interpersonal sensitivity	1.51	1.78	1.64*
Depression	1.95	2.52	2.25*
Psychoticism	1.53	1.88	1.71*
Phobic anxiety	1.49	1.70	1.60*
Paranoid ideation	1.55	1.93	1.75*
Anxiety	1.75	2.17	1.97*
Hostility	1.45	1.97	1.72*

* significant: $p < 0.05$ (statistics: t-tests)

¹ mean score of domain divided by number of items of domain

bad) on the question: 'In general, how do you consider your physical health?'. We also asked the participants if they considered themselves physically ill at the time of the interview: the percentage on average was 42.2%. Furthermore 32.0% stated they were actually getting treatment for one or more physical diseases or complaints. Both questions reveal no significant difference between the groups.

Table 8. Perceived physical health, chronic physical complaints and physical handicaps in at random samples of Iraqi asylum seekers < six months (group 1) and > two years (group 2) in the Netherlands, 2000-2001.

	Group 1 n=143	Group 2 n=151	Total n=294
	mean (SD)	mean (SD)	mean (SD)
Perceived physical health ¹	2.87 (1.21)	3.25 (1.14)	3.06 (1.19)*
Chronic physical complaints	%	%	%
One or more physical complaints	38.5	66.2	52.6*
Dizziness with falling	17.5	32.5	25.2*
Headache > three months	15.4	33.8	24.8*
Back problems > three months	11.9	31.1	21.8*
Stomach problems	14.7	27.8	21.4*
Joints problems > three months	14.7	26.5	20.7*
Intestinal problems > three months	9.1	9.9	9.5
Physical handicap	5.6	8.0	6.8

¹ scale of 1 (very good) to 5 (very bad) (statistics: t-tests)

* significant: $p < 0.05$ (statistics: chi-square tests)

Health-related measurements

Table 9 shows the results of quality of life (measured with the WHOQOL-BREF, WHO, 1998) and functional disability (measured with the BDQ, Von Korff et al., 1996). The first two single questions of the quality of life questionnaire i.e.: ‘How would you rate your quality of life?’ and ‘How satisfied are you with your health?’, refer to ‘overall quality of life’ and ‘general health’. The other questions belong to different quality of life domains: physical (seven items), psychological (six items), social (three items) and environment (eight items). Respondents in group 2 reported significantly lower quality of life compared to the respondents in group 1, except for the domain ‘social relationships’. Also, respondents in group 2 reported more limitations in physical and social activities by their health problems compared to respondents in group 1. The lowest score was given by group 2 on the domain of environment. Functional disability was lower in group 2 for both the overall physical and role disability and the single item question of days of disability in the last month.

Table 9. Quality of life and functional disability in at random samples of Iraqi asylum seekers < six months (group 1) and > two years (group 2) in the Netherlands, 2000-2001.

Quality of life	Group 1 n=143	Group 2 n=151	Total n=294
Overall quality of life ¹	2.88 (0.99)	2.23 (1.14)	2.55 (1.11)*
Perceived general health ¹	3.06 (1.15)	2.74 (1.27)	2.89 (1.22)*
Domains:			
Physical health ²	55.08 (19.72)	47.50 (20.72)	51.19 (20.58)*
Psychological health ²	50.00 (15.82)	45.28 (18.70)	47.58 (17.49)*
Social relationships ²	49.38 (22.18)	46.60 (21.51)	47.96 (21.85)
Environment ²	43.57 (14.87)	37.17 (17.27)	40.29 (16.47)*
Disability			
Physical and Role Disability (BDQTot) ³	17.31 (7.43)	19.25 (6.77)	18.30 (7.15)*
Days of disability (BDQdays) ⁴	5.37 (8.24)	7.68 (9.17)	6.56 (8.80)*

* significant: $p < 0.05$ (statistics: t-tests)

¹ scale of 1 (very bad) to 5 (very good)

² scale of 1 (very bad) to 100 (very good)

³ BDQTot: range: 11 (no impairment at all) to 33 (serious impairment)

⁴ BDQdays: range: 0-31 (1 month)

Health service use

Asylum seekers in the Netherlands have access to the healthcare system without financial constraints as long as they are registered with the COA. At the time of the study, medical staff (nurses and doctors) at the asylum seekers centres offered

several services: medical screening shortly after arrival, preventive services (e.g., immunizations) and referral of patients to the general practitioner.

Table 10 shows the health service use in the last two months prior to the interview. The use of nurse/doctor in the centre is higher in group 1 compared to group 2. This finding is, at least partly, explained by the fact that the medical screenings are only applicable to recently arrived asylum seekers like the participants in group 1. There is no significant difference between the groups in the use of the general practitioner and the medical specialist. Drug consumption (analgetics, anxiolytics, hypnotics) is significantly higher in group 2.

Retrospective opinion about the interview

The research question “How do the participants perceive their participation in the interview?” was measured by the response to two statements: ‘The interview was a

Table 10. Health service use and other help-seeking behaviour in at random samples of Iraqi asylum seekers < six months (group 1) and > two years (group 2) in the Netherlands, 2000-2001.

	Group 1 n=143	Group 2 n=151	Total n=294
Use of services last two months	%	%	%
Use of any health service ¹	76.9	66.2	71.4*
Use of any out-patient (o-p) service ²	74.1	52.3	62.9*
Use of any o-p curative service ³	38.5	36.4	37.4
Use of o-p preventive service nurse/doctor in centre	72.0	39.7	55.4*
Use of o-p curative service			
General practitioner	32.9	25.8	29.3
Medical specialist in hospital	12.6	17.9	15.3
Social worker	5.6	6.6	6.1
Mental health worker	1.4	9.3	5.4*
Use of in-patient service hospital admission physical health	1.4	4.0	2.7
Use of in-patient service hospital admission mental health	0.0	0.7	0.3
Use of any drugs	32.2	45.7	39.1*
Use of anxiolytics	10.5	22.5	16.7*
Use of hypnotics	11.9	21.2	16.7*
Use of analgetics	23.8	37.7	31.0*

* significant $p < 0.05$ (statistics: chi-square tests)

¹ includes all regular and alternative services, including drugs, religious rituals/treatment and herbs

² includes all regular out-patient services

³ includes all regular curative o-p services: general practitioner, medical specialist in hospital, social worker, mental health worker

positive experience to me' and 'The interview upset me more than I expected'. The statements were rephrased from Newman et al. (1999). Table 11 shows the results. There were no significant differences between group 1 and group 2. More than half of the participants reported that the interview was a positive experience. Overall 13% reported that they were more upset by the interview than expected, but only very few (2.7%) participants disagreed with the statement 'The interview was a positive experience to me'.

Table 11. Retrospective opinion about the interview in at random samples of Iraqi asylum seekers < six months (group 1) and > two years (group 2) in the Netherlands, 2000-2001.

	Disagree	Neutral	Agree
Group 1			
Interview was a positive experience	3 (2.1%)	65 (45.5%)	75 (52.4%)
Interview upset me more than I expected	70 (49.0%)	59 (41.3%)	14 (9.8%)
Group 2			
Interview was a positive experience	5 (3.6%)	65 (38.3%)	75 (58.4%)
Interview upset me more than I expected	79 (51.7%)	46 (30.2%)	24 (16.1%)
Total			
Interview was a positive experience	8 (2.7%)	122 (41.8%)	162 (55.5%)
Interview upset me more than I expected	149 (51.0%)	105 (36.0%)	38 (13.0%)

As explained in the description of the methodology (chapter 2) we instructed the interviewers to monitor stress reactions during the interview and instructed them to advise the participants to contact the medical staff in the centre in case of any adverse reaction after the interview. It appeared that none of the interviewers reported that they had noted major stress among the participants and we did not get any message from medical staff reporting about participants asking for help after the interview.

The independent physician was contacted only once by a respondent. This respondent was wondering how we got his name and why he was selected. The physician could explain this and the person agreed to participate in the study.

Our conclusion¹ is that in this research project, using personal interviews with the help of fully structured questionnaires, the risks of adverse emotional reactions to the interview were almost negligible.

¹ Only on the results of 'the retrospective opinion about the interview', interpretation and discussion is given here. For all other interpretations and discussions, see the following chapters.

Our findings are in line with the results of a recent study. Jorm et al. (2007) performed a systematic search for studies that examined distress following participation in research that involved the assessment of psychiatric state or associated risk factors. They found 46 relevant studies. Overall, a minority of participants became distressed immediately after participation, with distress more likely in studies of traumatic experiences. They found limited evidence on longer-term effects, but what evidence there is suggests no adverse impact. Jorm et al. (2007) found only one study among refugees. In this study (Dyregrov et al., 2000), none of the adults reported a negative experience, while 100% indicated that the interview was a positive experience. De Graaf et al. (2004) examined the reaction on the CIDI interview in a community service in the Netherlands (NEMESIS). They found that 2.7% experienced ‘quite some’ distress and 9.5% ‘somewhat’ distress.

References

All references can be found at the end of the book.