An evaluation of the mental status of rejected asylum seekers in two Danish asylum centers

Kathrine Hvid Schwarz-Nielsen, MSc San*
& Ask Elklit, Professor, Clinical Psychologist**

Abstract

Introduction: International studies have shown high incidences of symptoms regarding anxiety, depression, and post traumatic stress disorder (PTSD) among asylum seekers of different ethnicities. The aim of the present study was to investigate the presence of symptoms of anxiety, depression, and PTSD among rejected Iraqi asylum seekers in two Danish Red Cross asylum centers. Factors such as the length of stay in an asylum center and the number of traumatic events were considered as risk factors associated with the degree of psychological morbidity.

Method: In 2007, 53 rejected Iraqi asylum seekers from two Danish Red Cross centers completed a survey based on the Harvard Trauma Questionnaire-IV (HTQ) and the Hopkins Symptom Checklist 25 (HSCL-25). The response rate was 36%. The analyses focused on the impact of gender, age, marriage, religion, the length of stay at the asylum center, and the number of traumatic events on the severity of symptoms of anxiety, depression, and PTSD.

Findings: Of all participants, 94% were found to have symptoms of anxiety, 100% had symptoms of depression, and 77% had symptoms of PTSD. The participants had experienced or witnessed an average of 8.5 traumatic events before their arrival in Denmark. There was no significant association between the number of traumatic events, and the symptoms of PTSD. In addition, there was no significant difference in the length of stay and symptoms of anxiety, depression, and PTSD despite the fact that 79% of the participants had stayed in an asylum center for 5-10 years or more.

Conclusion: Despite the limitations of the data, such as the small sample, this study showed that the prevalence rates of psychopathology in Iraqi asylum seekers in Denmark were alarmingly high. Therefore, it is recommended that systematic screening of all detained asylum seekers in Denmark is introduced. Given the degree of mental health problems it is also recommended that procedures be changed and that treatment should be offered to asylum seekers who are detained in Danish asylum centers.

Keywords: rejected asylum seekers, mental health, trauma events, length of stay, posttraumatic stress disorder

Introduction

March 20th, 2003 saw the suspension of the processing of Danish asylum cases and the expulsion of Iraqi nationals from Denmark as a result of the international coalition force intervening in Iraq. However, this was short lived and after only six months the processing of asylum cases was resumed. Recently, there has been renewed interest in the Dan-

*) University of Copenhagen
Panum Institute, Copenhagen
Denmark
trine_hvid@hotmail.com

**) Department of Psychology
University of Aarhus
Denmark
aske@psy.au.dk

ish media regarding issues concerning both asylum seekers conditions and asylum seekers general health while resident in Danish asylum centers. A large number of rejected Iraqi asylum seekers must now return home, although Denmark is still part of the coalition force in Iraq. The majority of these Iraqi asylum seekers have been living in Danish Red Cross centers for several years. The return of such Iraqi asylum seekers may be partly attributed to the Danish media highlighting issues regarding the deterioration of the mental health of asylum seekers while resident in asylum centers.

The number of rejected asylum seekers

The restrictive refugee policy in Denmark has recently contributed to a marked reduction in the overall number of asylum seekers. In 2007 the total number of applications submitted for asylum in Denmark was 2,246. Of these, approximately 50% (1.069) were of Iraqi nationality.[1] In 2007, according to the Danish Immigration Service, 458 Iraqi adults were located in Danish Red Cross centers; this corresponds to approximately a fourth of the total number of asylum seekers staying in Danish asylum centers.[2] The number of asylum seekers waiting for expulsion in 2007 was 749, of which 409 (55%) were Iraqi nationals.[3]

Background

Most of the Iraqi asylum seekers in Denmark originate from an environment which is characterized by uncertainty, fear, and general instability. They have fled their country or have been smuggled illegally into Denmark. Many of them have experienced and/or witnessed abuse, torture, and death. Due to the traumatic events Iraqi asylum seekers have been exposed to prior to their arrival many who arrive in Denmark may already be at great risk of developing a mental health disorder such as anxiety, depression, or PTSD. It is also important to note that not all of the rejected asylum seekers coming from Iraq have been exposed to warfare. The invasion began in 2003, so asylum seekers accepted into Danish asylum centers prior to 2003 may not have experienced active war or battle, but may have been victims of political oppression. Living in an asylum center, with the prospect of having to wait several years for a final decision, may cause a great deal of stress and mental strain. A report from the Danish Immigration Service showed that the length of stay in Danish Red Cross centers increased on average from 313 days to 927 days from 2001 to mid 2005, therefore an increase of 196% in four and a half years.[4]

In recent years, international studies have documented frequent cases of mental disorders among asylum seekers placed in asylum centers, in particular cases of anxiety, depression, and PTSD.[5-18] Silove et al. found that among 38 asylum seekers from 21 different countries, 79% reported exposure to a traumatic event. Of the 30 people with a traumatic history, 37% met the DSM-IV diagnostic criteria for PTSD.[12]

Likewise a number of studies and a recently published Danish study[7] showed that both the placement and the length of stay at an asylum center have an effect on the development of mental disorders such as anxiety, depression, and PTSD among asylum seekers.[20-22]

Aims of the study

The aim of the present study was to investigate the prevalence of symptoms with regards to anxiety, depression, PTSD, and trauma exposure in rejected Iraqi asylum seekers in Denmark. Gender, religion, and length of stay in an asylum center were all considered factors that might influence

symptoms of anxiety, depression, and PTSD. We hypothesized that the number of traumatic events and the length of stay in an asylum center would be associated with the severity of anxiety, depression, and PTSD. In addition, we expected female gender to be associated with a higher level of PTSD.

Method

Procedure and sample

Data collection took place in 2007 at the arrival and departure areas of two Danish asylum centers in Avnstrup and Sandholm. An Arab interpreter from the Danish Red Cross conveyed information directly to the participants regarding their participation in the study and assisted by translating questions and answers about the study. Participants also received a one page written information sheet in Arabic. Furthermore, the participants signed an informed consent to participate in the study. A total of 146 questionnaires written in Arabic were distributed to refugees. Questionnaires were made available on two occasions, which coincided with the distribution of pocket money in the asylum center. Overall 401 adult Iraqis were resident in the two asylum centers. Of 146 participants 53 (36%) participated in the survey. The response rate of 36% is similar to the response rates for these types of studies.[12]

Participation was anonymous and any desire to terminate the study was respected with participants being informed that they were free to withdraw from the study at any point. Participants were made aware that participation would not have any impact on their asylum status nor on the outcome of their asylum procedure should their case be reopened. The study was approved by the Danish Dat a Protection Agency (#2007-41-0099).

To be included in the study participants had to be of Iraqi origin, Arabic or English speaking, more than 18 years of age, and having been rejected for asylum in Denmark. A rejected asylum seeker is defined as a foreign national who has received a final rejection of their application for residence, and is currently in an expulsion position (waiting to be returned to their home country). We chose to study rejected Iraqi asylum seekers because they are highly representative of the inhabitants in the Danish asylum centers and have resided in the asylum detention system for the longest period of time.

Measures

The first part of The Hopkins Symptom Checklist – 25 (HSCL) contains 10 anxiety items and 15 depression items. All items have a Likert scale with four categories ("Not at all," "A little," "Quite a bit," "Extremely,") ranging from 1 to 4. A total score is calculated by adding all 25 items. An average score of >1.75 for anxiety and/or depression and/or the total score of all 25 symptoms determines the diagnosis and has been validated both in outpatients[23] and refugee populations.[24] The total score for anxiety and depression has been shown to correlate highly with both severe emotional distress in terms of anxiety and severe depression as defined in the American Psychiatric Diagnostic System, DSM-IV.[23]

The first part of The Harvard Trauma Questionnaire (HTQ) consists of 17 questions regarding prior traumatic life events. Each question has four possible answers ("Experienced," "Witnessed", "Heard about it," or "No"). The second part is a subjective description of the most traumatic event ever experienced. The third part examines events regarding head trauma. The fourth and final part contains 30 questions about trauma symptoms. The first 16 questions correspond to DSM-IV's three core symptoms regarding

posttraumatic stress disorder (PTSD): re-experiencing (4 items), avoidance (7 items) and arousal (5 items). The Harvard Program in Refugee Trauma developed the remaining 14 questions to describe trauma symptoms particularly related to being an asylum seeker. Each question in part four is associated with a Likert scale divided into four categories ("Not at all", "A little", "Quite a bit", "Extremely"), ranking from 1 to 4. The cut-off score used in most scientific articles is 75, equivalent to an average score of 2.5 as the cut-off score for the diagnosis of PTSD.[25,26] This analysis is based only on data from the first and the fourth part of the HTQ.

Statistical analysis

Mann-Whitney U non-parametric tests were calculated to examine differences in the socio-demographic variables and the average score of anxiety, depression, and PTSD. In order to examine the association between two non-parametric variables a Spearman's rank correlation was calculated. $p < 0.05$ was considered statistically significant for all analyses. Data was entered and processed with the assistance of the Statistical Package for the Social Sciences, SPSS 15.0.

Results

Characteristics of the study population

The sample consisted of 53 (34= 64% male) rejected Iraqi asylum seekers from the age of 18 to 65 years or above (Table 1). Of all participants, 34 (64%) were between 18 and 44 years old with 31 (62%) being married, the remaining 22 (38%) participants were either divorced or never married. Half of the participants were Sunni Muslims, and one fourth were Christian. Thirty of the rejected asylum seekers (58%) were of average socio-economic status in their home country before seeking asylum in Denmark. At the time of the study, the vast majority of the asylum seekers (41 = 79%) had been resident in a Danish asylum center for 5 to10 years or more.

Anxiety and depression symptoms

All 53 participants completed the HSCL-25. The average score for anxiety was 3.12 (SD = 0.77) and 3.14 for depression (SD = 0.58). The overall average score for both anxiety and depression was 3.14 (SD = 0.61) showing that all three scores were above the recommended cut-off score of 1.75 and therefore considered symptomatic. In regards to anxiety, 50 participants (94%) had a greater score than the cut-off score of 1.75 and all participants (100%) had a greater score than the cut-off score of 1.75 on the depression scale. Hence, according to these results only three participants had no clinical symptoms of anxiety, whereas all 53 participants had symptoms of depression. It

Table 1. *Socio-demographic characteristics of the rejected Iraqi asylum seekers (n = 53)*

		n	%
Home Country	Iraq	53	100
Gender	Male	34	64.1
Age	18-24 years	9	16.9
	25-34 years	12	22.6
	35-44 years	13	24.5
	45-64 years	16	30.1
	Above 65	3	5.6
Marital status*	Married	31	62
	Unmarried	19	38
Religion	Shi'it Muslim	8	15.0
	Sunni Muslim	27	50.9
	Christian	13	24.5
	Other	5	9.4
Economic status in home country**	Low	11	21.1
	Average	30	57.6
	High	11	21.1
Length of stay	<5 years	11	21.1
	5-10 years	41	77.3
	>10 years	1	1.8

*) Three answers missing.
**) One answer missing.

was not possible to calculate the odds ratios for the risk of anxiety and depression with regard to gender and length of stay since half of the observations on anxiety had expected scores of less than five and the number of cases of depression was constant.

Looking at the overall average score for both anxiety and depression based on all 25 symptoms and the difference in the socio-demographic characteristics, only religion yielded a significant difference. The Muslim participants had a higher average score on symptoms of both anxiety and depression compared to the Christian participants (Mann-Whitney U($z = -2.54$ $p < 0.01$)).

Trauma and PTSD symptoms

The average score of the 30 symptoms of post-traumatic stress disorder (PTSD) was 3.00 (SD = 0.65). The total score was above the cut-off score of 2.5 and was considered symptomatic. In total, 41 participants (77%) had an average score above 2.5. Of the 41 people with symptoms of PTSD, 25 (61%) were men and 16 (39%) were women. The risk, however, associated with having symptoms of PTSD were higher for women than for men; 84% of the women and 73.5% of the men reached the cut-off score. There were no significant associations between the total HTQ score symptoms and the socio-demographic characteristics.

Table 2. *Harvard Trauma Questionnaire – Part I. The frequency of trauma events witnessed or experienced by asylum seekers (n = 53).*

Witnessed or experienced events	n (%)
1. Lack of food or water	34 (64.2)
2. Ill no access to medical care	38 (71.7)
3. Lack of shelter	26 (49.1)
4. Imprisonment	18 (34)
5. Serious injury	22 (41.5)
6. Combat situation	31 (58.5)
7. Brainwashing	12 (22.6)
8. Rape or sexual abuse	12 (22.6)
9. Forced isolation from others	27 (50.9
10. Being close to death	34 (64.2)
11. Forced separation from family	32 (60.4)
12. Murder of family or friend	32 (60.4)
13. Unnatural death of family or friend	36 (67.9)
14. Murder of stranger or strangers	28 (52.8)
15. Lost or kidnapped	26 (41.9)
16. Torture	22 (41.5)
17. Other frightening situation or felt your life was in danger	21 (39.6)

Trauma events

The majority of asylum seekers 38 (71.7%) had experienced or witnessed illness without access to medical care (Table 2). More than 50% of the participants had experienced or witnessed: Shortages of food or water, combat situations, forced isolation, being close to death, forced separation from their family, murder of a family member or friend, unnatural death of a family member or friend, and murders of strangers. The number of participants who had witnessed or experienced rape or sexual abuse was the lowest reported (12 = 23%). This is probably due to the fact that the response rate for this event, together with brainwashing, was the lowest of all the trauma events. Other studies have previously described similar findings in the field.[25]

The number of traumatic events that the participants had either witnessed or experienced ranged from zero to 17. On average, each participant had witnessed or experienced more than eight traumatic events (M = 8.52, SD = 4.58). Of all participants 23 (43%) had witnessed or experienced between zero and seven traumatic events, 30 (57%) had witnessed or experienced eight or more traumatic events. Although the participants who had witnessed or experienced between eight and 17 traumatic events had a higher average score on PTSD symptoms than the group of those who had witnessed or experienced fewer than eight traumatic

events, the difference was not statistically significant. Also, there was no significant association between the number of traumatic events and having symptoms of PTSD. In other words, the PTSD prevalence did not increase with the number of traumatic events witnessed or experienced.

Length of asylum stay

Forty-two of the participants (79%) had stayed at an asylum center 5 to 10 years or more. Out of 41 participants with symptoms of PTSD, 33 (75%) had been resident in a Danish asylum center for 5 to 10 years or longer. However, there was no statistically significant association between the length of stay and symptoms of anxiety, ($z = -0.52$ $p < 0.60$) depression ($z = -1.59$ $p < 0.11$) and PTSD ($z = -1.09$ $p < 0.27$) (Mann-Whitney U).

Discussion

A number of studies have focused on asylum seekers' mental health while resident in asylum centers. This study is one of the first to focus on rejected asylum seekers. The study showed high prevalence rates for symptoms of anxiety (94%), depression (100%), and PTSD (77%). Previous studies about asylum seekers utilizing the HTQ and the HSCL-25 reported prevalence rates close to 20% for anxiety, 30% for depression, and 45% for PTSD.[7,12]

Other studies have found increased psychological morbidity due to the rejection of asylum, the accommodations, and a long stay in a detention center.[6,22] This study only included asylum seekers in an expulsion position and it is possible that the high symptom scores in this study are reflective of this rejection status. In addition, several studies have documented that asylum-seekers have a higher prevalence of symptoms of anxiety, depression, and PTSD in general compared with refugees and immigrants.[7,13,15] The study also detected small, non-significant gender differences. This is in sharp contrast to PTSD studies in the general population, where women have a greater risk of developing PTSD than men.[27]

With regard to the socio-demographic variables it appeared that being Muslim was associated with a statistically significant increase in symptoms of anxiety and depression. The Muslim participants, compared to the Christians, had a higher average score on anxiety and depression symptoms. One might speculate that those with a Christian faith could feel more comfortable in a country where the official state religion is Christianity.

The study further showed that there were large differences in the severity of the traumatic events the participants had been exposed to. The majority of participants, 38 (71%) had witnessed or experienced illness without access to medical care, whereas 12 (23%) had witnessed or experienced rape or sexual abuse. Other studies have found similar trauma prevalence rates, and the number of witnessed or experienced traumatic events has proven to be of importance for the development of symptoms of PTSD.[7,8] However, this study found no association between the number of traumatic events witnessed or experienced and the severity of PTSD.

Lastly, the study found no significant association between the length of stay at an asylum center and symptoms of anxiety, depression, and PTSD, despite the fact that 79% of the participants had stayed in an asylum center 5 to10 years or more. The length of the asylum stay was thought to be a strong contributing factor with regards to their symptoms. The lack of association is in contrast to earlier studies, which have found significant differences in the degree of

symptoms of mental disorders with length of stay zero to five months and more than six months.[6] An Australian study found similar increased prevalences of symptoms of anxiety, depression, and PTSD associated with staying in a detention center for more than two years.[21] The reason for not finding any association in the present study might be attributed to the extensive length of stay. Speculation could suggest that after a number of years the asylum seekers reach "a distress threshold" after which differences regarding trauma exposure and length of asylum stay are no longer detectable. However, it cannot be ignored that the high level of symptoms of anxiety, depression, and PTSD may have been present when asylum seekers arrived in Denmark and is attributable to the traumatic events they had been exposed to before they left Iraq.

Screening tools

The validity and reliability of the two screening tools (HTQ and HSCL-25) has not previously been tested, nor has a cut-off score for the diagnosis been established with an Iraqi population. However, the screening tools have previously been applied to a group of Iraqi asylum seekers in other studies.[9,10,15,22] Both questionnaires have been subjected to criticism with regards to their ability to predict and assess the number of the mental disorders mentioned above.[25] Common to both screening tools is that people with completely different answering profiles can achieve the same score. A person with severe depression, who scores high on the Likert scale, could obtain the same score answering a few of the questions, as a person answering most of the questions with a low value on the Likert scale.[24]

In addition, both questionnaires have been criticized for being developed based on one particular ethnic group or in one specific clinical setting with particular cut-off scores crucial to the diagnosis. Hence, it may be difficult to utilize the questionnaires with a different group of people without making any changes to the questionnaire. Several studies have suggested different cut-off scores,[26] which may indicate that the characteristics of a specific population may affect the outcome data of the HTQ.[24]

It is important to point out that the HTQ does not take into account the number of times each person has experienced one or more traumatic events, the duration of the traumatic events, or the connection between the traumatic events and the asylum seekers experience of them.[18] A participant may have experienced any event more than once without the screening tool being sensitive to it. Finally, the present study did not include a physical examination or a clinical interview of the asylum seekers. This makes it difficult to see the extent to which self-reported symptoms of anxiety, depression, and PTSD, which are measured by the HTQ and HSCL-25, would match a clinical diagnosis.

Limitations

There are several limitations in the present study due to the moderate response rate and sample size. More comprehensive and prospective studies are recommended in the future. There is also a limitation in the chosen study design regarding the sample selection process. The investigated group of participants may not be representative of the total group of rejected Iraqi asylum seekers in the Danish asylum centers. There is a risk that the rejected Iraqis who were most disabled by their psychological symptoms, where too sick to participate in the study. The possibility also exists that the participants in the study represent a group of asylum seekers with less severe symptoms of anxiety, depression, and PTSD.

Another possibility is that the asylum seekers may have deliberately rated themselves worse than they actually were at the time the study was conducted in order to help their application for asylum. In order to avoid such a potential bias, the researchers stressed verbally and in writing that participation in the study would not have any impact on asylum status as rejected or the future outcome of a resumed case. It would have been beneficial to include a control group with an equal number of non-rejected Iraqi asylum seekers in the study.

Conclusion

The level of psychopathology in the rejected asylum seekers in this study was alarmingly high. The study found a prevalence of anxiety, depression and PTSD at 94%, 100% and 77% respectively. The participants had witnessed or experienced a mean of eight traumatic events, but no association was found between the number of events and the degree of symptoms of PTSD. Furthermore, there was no indication that the longer the participants had stayed in an asylum center, the more severe the psychopathology.

Since the majority of the participants in the study, regardless of the length of their stay at an asylum center, and the number of traumatic events, were found to have symptoms of anxiety, depression, and/or PTSD, it is recommended that systematic screenings at asylum centers be introduced as a standardized routine. These screenings could be used to initiate psychological treatment in asylum centers, necessitated by the extended stays that some asylum seekers have in asylum centers and the high degree of traumatization they have experienced. A recommended supplementary political initiative would be to introduce a time limit for the stay at any asylum center.

Acknowledgements: The data collection of the study was accomplished in collaboration with the leaders of the health care department at The Danish Red Cross centers Avnstrup and Sandholm. An interpreter from The Danish Red Cross and a language officer from The Danish Royal Defence Academy assisted during the data collection. Thanks to all the rejected Iraqi asylum seekers who participated in the study.

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