

# Refugee and Asylum Seeker Self Harm with Implications for Transition to Employment Participation - A Review

By Nicholas Procter, Penny Williamson, Andrea Gordon and Deborah McDonough

It is important to understand and accept that the traumatic experiences of refugees and asylum seekers amplifies the significance of the sense of belonging, identity and purpose as vital mental health concepts.

## ABSTRACT

This article is a review of the literature investigating self-harm in refugees and asylum seekers and the influence that this may have on employment. High rates of physical and mental health issues among refugees and asylum seekers can lead to self-harm and suicide attempts. This can have a lasting impact on refugee or asylum seekers in terms of employability and how they can cope within a working environment. Employers are encouraged to seek a better understanding of the underlying mental health issues of current and future employees from a refugee background. This can be achieved by mental health and human service workers sharing their understanding of refugees and asylum seekers. A broader vision of treatment and care for previous and current mental health distress can improve the social inclusion framework. Further research is justified and necessary on self-harm such as lip-stitching and employment opportunities for asylum seekers and refugees.

Denne artikkelen er en gjennomgang av litteratur som utforsker selvskaade hos flyktninger og asylsøkere, og den innflytelse dette kan ha på tilknytningen til arbeidslivet. De høye ratene på fysisk og psykisk helse-problematikk blant flyktninger og asylsøkere kan slå ut i selvskaade og selvmordsforsøk. Dette kan ha en varig effekt på flyktninger og asylsøkere med hensyn til sysselsettingsevne og hvordan de fungerer i et arbeidsmiljø. Arbeidsgivere oppfordres til å søke en bedre forståelse av den underliggende psykisk helse-problematikk fra nåværende og framtidige arbeidstakere med flyktningbakgrunn. Dette kan oppnås ved at kompetanse innenfor psykisk helse og sosialarbeidere deler sin erfaring og kompetanse om flyktninger og asylsøkere. En bredere visjon for behandling og omsorg av tidligere og nåværende psykiske belastninger, kan forbedre rammene for sosial inkludering. Videre forskning på selvskaading, som for eksempel lip-stitching, og på asylsøkeres og flyktingers arbeidsmuligheter, er nødvendig og berettiget.

SUBMITTED: 05.07.11  
REVISED: 11.11.11  
ACCEPTED: 12.11.11

## Introduction

Social risk factors such as English as a secondary language, unemployment, poor education, asylum status, duration of stay and difficulty with immigration authorities are associated with higher levels of mental ill health among refugees (Bhui et al., 2006; Cohen, 2008; Robjant, Hassan, & Katona, 2009). The concept of social isolation is a known risk factor in suicides in asylum seekers and refugees. This social isolation is exacerbated by the common denominator of the individuals' inability to communicate effectively in English or with other asylum seekers and refugees (Cohen, 2008; Robjant et al., 2009). It has been previously identified that the limited use of interpreters impacts negatively on social isolation and mental health (Cohen, 2008; Robjant et al., 2009).

Refugees bring with them a range of previous experiences, usually traumatic, that influences their employment opportunities, to possible dependence on welfare programmes and other available supports. The hopelessness and loss of future aspirations that accompany such traumatic experiences are risk factors for self-harm which hinders their participation in society, especially as employees.

When evaluating and measuring the fore mentioned traumatic experiences and the health status of asylum seekers and refugees, it is acknowledged that the instruments currently used were not specifically developed with these populations in mind (Hollifield et al., 2002). Hollifield et al (2002) found three instruments (Harvard Trauma Questionnaire, Vietnamese Depression Scale and an unnamed instrument developed by Bolton in 2001) were more appropriate to use within this population and many of the studies within this article reflect the use of these instruments.

The present study summarises peer-reviewed literature on suicidal behaviour among refugees and asylum seekers in

order to discuss its impact on their participation and engagement in the labour market. As such, this study is exploratory and descriptive in its orientation and design.

## Asylum Seekers and Refugees

The term Asylum Seeker refers to a person who has applied for the status of refugee but has yet to be granted this status (Australian Human Rights Commission, 2011). The United Nations High Commissioner for Refugees (UNHCR) routinely publishes reports on the number of asylum seekers in Europe and selected non-European countries. The current report for 2011 states that 358,800 asylum claims were registered during 2010, a 5% decrease from 2009 and 2008. This decrease mainly accounts for a downward trend in claims for Europe. UNHCR reports a 31% increase in claims in Australia and New Zealand compared to the previous year (8,600 compared to 6,600) (United Nations High Commissioner for Refugees, 2011, pg 8). The number of asylum seekers in Australia is far out-weighted by those in other industrialised countries where claims frequently exceed 10,000 (United Nations High Commissioner for Refugees, 2011). In 2010, the top five countries of origin of asylum seekers to Australia, were Afghanistan (1,262), China (1,180), Sri Lanka (585), Fiji (545) and the Islamic Republic of Iran (459) (United Nations High Commissioner for Refugees, 2011, pg 36). A majority (more than 50%) of these asylum seekers originate from countries which are, or have recently, experienced conflict and violence.

This review will concentrate on acts of self-harm among asylum seekers with and without detention experiences as refugees. On the foundation of the understanding so gained, how these experiences may impact upon an individual's subsequent ability to enter the labour market will be discussed.

## Method

Literature regarding refugees or asylum seekers self-harming in immigration detention centres and the community was examined. Topics included experiences that asylum seekers may have encountered during flight to settlement, health issues that have subsequently arisen and then how these experiences and health issues may be associated with self-harm while in immigration detention.

Initial searches in January 2011 indicated that the majority of articles did not appear until 1988, this was therefore used as a cut off date for future searches. Updates to this search were conducted in June 2011 with material relating to employment included in these searches. The following databases were included in the search: Medline, Academic Search Premier, CINAHL, ERIC, PsychARTICLES, PsychINFO, Google, Informit, Scopus and Web of Science. The search terms used to assess self-harm were: refugees, asylum seekers, asylum, refugee, detention, lip sewing, lip stitch, lip sew, lip, hunger strike, self-harm, self-mutilation, wrist slashing, mental health, abuse, systematic abuse, trauma, suicide, physical health and Australia. These terms were combined with each other and with the following appropriate MESH terms: Refugees/psychology\*, Life Change Events\*, Stress, Psychological/complications\*, self-injurious behavior\*, and Immigrants/psychology\*. The search terms used to assess implications for employment were: employment, suicide, suicidal crisis, work, suicide attempt, workplace, and suicide survivor.

From the initial searches conducted there were 846 articles identified, with 95 articles deemed relevant to the topic. All abstracts were read to determine the relevance. Reference lists of those articles deemed relevant were consulted. Twenty additional references were identified. Statistical analyses were not deemed relevant to the objectives of the study. Articles were taken into consideration on the following basis: variations in population (adult, adolescent, child), where the asylum seekers were living (detention facilities or community), or movement from their homeland to the



new country (eg. third world to Western, third world to third world).

Articles that were excluded were done so on the basis of irrelevance to the topic and whether they shed any further light on the topic areas of traumatic experience and self-harm in detained asylum seekers, lip stitching in asylum seekers, and employment in asylum seekers. Twenty-nine publications were included. There was one meta-analysis, three systematic reviews of empirical studies, one critical review of instruments while another is a review of government documents and three are conceptual articles on lip-stitching. Eighteen publications are taken up for description in the Results section, based on their unique contributions to the topic.

The Results section begins with an overview of the traumatic experiences and nature of hardships experienced by refugees/asylum-seekers, their general health status before moving into their mental health, including suicidal behaviour. The research design and other aspects of the methods used in the individual studies are not a part of the Discussion. The findings of this summary are used to discuss the implications that such events may have on employee participation and engagement.

## Results

### *Traumatic Experiences and Hardships*

There are many studies depicting a variety of traumatic experiences for refugees and asylum seekers. Fox and Tang (2000) explored the experiences of 55 Sierra

Leon refugees living in refugee camps and compared them to a group of Cambodians living in refugee camps who experienced the Khmer Rouge regime in the late 1970s (Mollica et al., 1993). Similarities in the frequency rates and type of experience were identified between the two groups. Ninety percent of the participants frequently identified the experiences of separation from family, being close to death, murder of family or friend, lack of food or water and lack of shelter.

The following five experiences were identified by above 60% of the participants, including death of family or friend, ill health/ no medical care, combat situation, lost/kidnapped and the murder of a stranger (Fox & Tang, 2000).

A study by Dolma et al. (2006) on 50 Tibetan refugees of various ages living in the Tibetan Refugee Transit Centre described the hardships that were faced in travelling to Nepal. Over half of the refugees encountered authorities or rebel forces on their trip to Nepal, suffering physical abuse, being detained, and sexual harassment. In contrast, Burmese refugees who had recently arrived in Australia and living in the community (Schweitzer, Brough, Vromans, & Asic-Kobe, 2011) reported the most frequent experiences were: a lack of food or water (73.5%), lack of shelter (69.1%), combat situation (57.6%), ill health without access to medical care (55.9%) and forced separation from family members (45.6%). This contrasts with the experiences recorded by Mandaean refugees



from Iraq in Australia (Nickerson, Bryant, Steel, Silove, & Brooks, 2010). It is reported that the top five experiences encountered by the Mandaean refugees from Iraq living in the community in Australia were: being close to death (49.5%), lack of food and water (42.5%), unnatural death of family or friend (41.3%), murder of family or friend (39%) and ill health without access to medical care (27.9%) (Nickerson, et al., 2010).

### General Health Issues

The physical health of refugees or asylum seekers has been proven over the years to be significantly worse than the general population of their new country (Ekblad, Belkic, & Eriksson, 1996) and may be as a result of traumatic experience. Lie (2002) similarly found that after living in Norway for three years many of the refugees experienced physical health problems including "heart symptoms" (56%), followed closely by bodily aches and pains (40%) (Lie, 2002, pg 419). This study also found that the overall perception of life and health for these refugees was 4.8 (range 1–10), however it is acknowledged that a comparison cannot be made to the results from the original interviews due to lack of reporting (Lie et al, 2001).

Green & Eagar (2010) surveyed the health status of 7,375 asylum seekers detained in Australian Immigration detention centres. There were 52,192 health encounters reported during the 2005–2006 financial year. The most common problems experienced were dental, respiratory or lacerations (percentages unavailable). Those who had been detained for longer than one year had higher mental ill health, psychosocial and musculoskeletal issues (Green & Eagar, 2010). Despite the large number of health care contacts no distinct pattern was observed in the physical health profile of those in detention. Many of the physical complaints changed as detention time increased.

Lorek et al. (2009) explored the physical and mental health of 24 children aged between 3 months and 17 years who had been in detention between 11 and 155 days in the United Kingdom detention centres. During an interview with a psychiatrist, paediatrician or both, the children were found to have compromised physical and mental health. The younger children experienced regression in their language abilities, toilet training and consumption of food.

Older children had begun soiling themselves and had high scores on depression and anxiety scales. These physical health issues often combined with emotional and mental health problems associated with the experiences encountered on the refugees/asylum seekers journey.

### Mental Health Issues

There have been many studies conducted into the mental health of refugees and asylum seekers (Marshall, Schell, Elliott, Berthold, & Chun, 2005; Mills et al., 2005; Mollica et al., 1993; Mornartin et al., 2006; Porter & Haslam, 2005; Ryan, Kelly, & Kelly, 2009; Schubert & Punamaki, 2011; Derrick Silove, Sinnerbrink, Field, Manicavasagar, & Steel, 1997; D. Silove, Steel, McGorry, & Mohan, 1998). A recent systematic review of studies investigating the impact of immigration detention on the mental health of children, adolescents and adults identified high levels of mental health problems in detainees (Robjant et al., 2009). Time in detention was found to be associated with severity of distress. Anxiety, depression and posttraumatic stress disorder were commonly reported, as were self-harm and suicidal ideation. There is evidence for an initial improvement in mental health shortly after release, although mental health effects may be prolonged, extending well beyond the point of release into the community.

In the Netherlands, male asylum seekers living in low security facilities and reception centres are thought to be at increased risk of death from suicide in comparison with the Dutch-born population (Goosen et al., 2011). A systematic review by Fazel, Wheeler & Danesh (2005) explored the prevalence of serious mental disorders in refugees who had relocated to Western countries. It was unclear whether the refugees were living in detention centres or in the community. Among the 6,743 adult refugees in the included studies, 9% had post-traumatic stress disorder (PTSD), and 5% major depression (MD). There was also a large prevalence of comorbidity of mental health disorders.



Table 1: Risk factors for mental health disturbance, self-harm and unsuccessful transition to employment among asylum seekers and refugees

Authors Details	Sample Description	Study design	Findings
Bergmans et al., (2009)	4 female graduates of experts by experience in a psychosocial/psycho-educational group for people with recurrent suicide attempts.	A collaborative case study between the facilitators and graduates of the psycho-social/psycho-educational group. This involved the graduates writing a narrative of their experiences.	Several themes revealed in the narrative analysis: the graduates' sense of self and stigma in the mental health system and as the graduates were on their pathway to obtaining paid employment; how the work environment can be inclusive (or exclude the graduates), managing their mental illnesses and how to navigate the unwritten rules they encounter, when the graduates integrate into professional positions and how others respond if they know about the graduates prior mental health illness and finally the celebration that they have achieved goals in overcoming their mental illnesses.
Bhui et al. (2006)	21 publications on deliberate self-harm. 4 publications on self-harm and suicide.	Systematic literature review exploring self-harm in articles which compare at least two ethnic groups in the UK.	Limited studies were available to use within those articles found due to ethnic classification within the articles. Inconsistencies were found in the adolescent studies. Higher rate of self-harm in South Asian women as compared to South Asian males and white women. South East Asians and those under 35 years at higher risk than others.
Coffey et al. (2010)	17 adult refugees held in immigration detention centres in Australia. 16 males and 1 female. Average age: 42 years. Average time spent in detention centre: 3 years 2 months.	Mixed methods study. Semi-structured interview exploring psychological well being. Quantitative section contained the Hopkins Symptoms Checklist & HTQ.	Themes identified from the detention period: confinement and deprivation, injustice and inhumanity, isolation and fractured relationships, hopelessness and demoralisation. Post Detention Themes: insecurity & injustice, relationship difficulties and changes to view of self.
Cohen (2008)	22 asylum seeker suicide cases available from coroners' files or Ombudsman's reports in the UK. Mean age of those cases 31 years (age range 18-79 years), 21 males and 1 female. 12 suicides were of those in detention facilities.	Originally designed to study clinical records relating to those who had self-harmed in Immigration Removal Centres (IRC) in the UK, it was found that there was not enough information there and that instead individual coroners would be requested to provide data on suicide cases from IRCs.	18/22 had a mental health history recorded, of these 72% had depression, 22% had psychosis and 6% had PTSD. 231 incidents of self-harm requiring medical treatment between 01/04/2005 to 31/03/2006. An estimated 12.8% of self-harm assuming only one self-harm incident per detainee. Self-harm rates may be higher than those that are recorded for various reasons. Rates comparable to UK prison population.
Cox and Minahan (2004)		Theoretical paper describing personal experiences in the Woomera Detention Centre.	Discussion centred on whether lip-sewing is cultural specific, gender specific or an attempt in desperation for attention about their specific situation.
Cunningham & Cunningham (1997)	191 randomly selected records. 110 males, 81 females. Mean age: 36.8 years.	Analysis of service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTIS) in New South Wales (Australia).	Mean symptoms experienced = 6.43 (SD = 3.53, median 6). Depressed mood (60%), chronic pain (58%), disturbed sleep (51%), generalised anxiety (38%), and nightmares (37%).
Dolma et al. (2006)	50 recent refugees in the Tibetan Refugee Transit Centre. Mean age 22 years (Age range: 8-56 years).	Semi-structured interviews were conducted with refugees to determine aspects of their journey and experiences of travelling from Tibet.	Average length of journey to Nepal: 32 days (range: 2-201 days). Encounters with the authorities and the repercussions of those encounters: sexual harassment, physical abuse, extortion, detainment, food deprivation and the physical hardships of the journey that the refugees experienced to get to Nepal.
Dudley (2003)		Review of government policies on self-harm and suicide, with a specific focus on asylum seekers in mandatory detention.	
Ekblad et al. (1996)	80 Studies identified which met the criteria for inclusion.	A review of the literature approaching a meta-analysis exploring mental health in refugee and immigrant groups.	Unemployed status significantly associated with negative mental health outcome ( $p \geq 0.01$ ).
Fazel et al. (2005)	6743 adult refugees from 20 studies.	A systematic review of the literature involving psychiatric surveys that were based on interviews of unselected refugee populations which included diagnoses of PTSD, MD, psychotic illnesses, or generalised anxiety disorder.	Prevalence: PTSD = 9%, MD = 5%, comorbid MD and PTSD = 71% (4 studies)*, comorbid PTSD and MD = 44% (4 studies)**, generalised anxiety disorder = 4% (5 studies), Psychotic illness = 2% (2 studies), PTSD = 11% in child refugees (5 studies).
Fox and Tang (2000)	55 refugees located in refugee camps in Sierra Leon.	Historical comparison study between refugees living in refugee camps in Sierra Leon and a previous sample by Mollica et al., (1993) with Cambodian refugees living in camps on the Thailand-Cambodia border.	Top 10 experiences by refugees living in refugee camps in Sierra Leon: separation from family, being close to death, murder of family member /friend, lack of food or water, lack of shelter, death of family member/ friend, ill health/no medical care, combat situation, lost/kidnapped, and murder of stranger. Top 5 were experienced by 90% of the sample. Top 10 were experienced by 60% of the sample. 49.1% of participants had a score of over 2.5 on the HTQ. A score of over 2.5 on the HTQ is indicative of PTSD.
Goosen et al. (2011)	35 cases of death from suicide. 290 cases of suicidal behaviour treated in hospitals.	Population survey on incidences of suicide and suicidal behaviour from all asylum seeker reception centres in the Netherlands (2002-2007).	Suicide mortality rate of 17.5 per 100 000 per year for asylum seekers, higher rates of suicide among males and of attempted suicide requiring medical treatment among females. 290 cases of suicidal behaviour treated in hospitals.
Green & Eagar (2010)	720 people living in Australian immigration detention centres.	Health record study. Cross sectional survey of random sample from immigration detention centres in Australia between 1 July 2005 and 30 June 2006 (7375 people) categorised into 6 reasons for detention.	Of 7375 people in detention there were 52192 health encounters. This equates to 1.2 health encounters per person, per week. The prevalence of mental illness for those detained above 24 months was 3.6 times higher than those released in 3 months. Frequencies of self-harm: Unauthorised boat arrivals = 17.7%, unauthorised air arrivals = 14.4%, average of all groups in detention = 6.2%.
Keller et al. (2003)	70 asylum seekers who were detained in New York, New Jersey, and Pennsylvania.	Self-report questionnaires.	Frequencies of clinically significant symptoms: 86% depression, 77% anxiety, 50% PTSD. Symptoms were correlated with length of detention. Education in psychological symptoms of released detainees useful. Detention of asylum seekers increased the psychological symptoms of anxiety, depression and PTSD.
Koutroulis (2003)		Opinion piece of own experience working with a detained refugee population in Australia.	

PTSD = Post Traumatic Stress Disorder; MD = Major Depression, GAF = Global Assessment of Functioning, HTQ = Harvard Trauma Questionnaire, UK = United Kingdom; \* Order of disorder: first MD, then PTSD. \*\*Order of disorder: first PTSD, then MD.

Table 1: Risk factors, cont.

Author Details	Sample Description	Study design	Findings
Lie et al. (2001)	462 newly settled refugees living in Norway. Mean age 38.31 years. (range 16–84 years).	Structured interviews were conducted with the newly settled refugees to establish the health status, included the nature and extent of psychological distress, symptoms and signs. Instruments used: Post-Traumatic Stress Symptoms (PTSS-16), HTQ, GAF.	Top 5 Traumatic exposures experienced by refugees: exposed to threat of life (78.1%), separated from family (74.6%), experienced war (72.5%), living in hiding (63%), other extreme experiences (48.3%).
Lie (2002)	240 settled refugees living in Norway. This is a sub-population from the above study.	Follow up interview conducted 28 months after Lie et al. (2001) to determine the change in health status.	47% of group considered health to be good or very good. 56% reported heart symptoms & 40% bodily aches and pain. 7% used antidepressant medication. 12% used sleeping medicine or relaxing drugs. 46% of group were above normative threshold for clinically significant distress at the follow up interview.
Lorek et al. (2009)	24 children living in a detention facility in the UK. Age: median 4.75 years (range: 3 months to 17 years) Time spent in detention: median 43 days (range: 11–155 days).	Semi-structured interviews were conducted by either a paediatrician, a psychologist or both to determine the health status of the children.	Children with complaints: Depression and anxiety = 11, sleep disturbances = 10, appetite disturbances = 11, somatic complaints (headaches and abdominal pains) = 10, 5 children between ages 7–11 clinically depressed, 4 children between ages 7–11 years old clinically anxious.
Marshall et al. (2005)	490 Cambodian refugees who experienced the Khmer Rouge regime and have lived in the USA since before 1992. Average age: 52 years (age range: 35–75 years). Average arrival in the USA: 1983.	Interviews were conducted with earlier refugees to determine their exposure to trauma and violence before and after immigration and to determine the levels of PTSD, MD and alcohol use disorders in the group.	Exposure to 35 possible pre-migration trauma: Mean = 15 (SD = 7.6). Exposure to 11 possible post-migration trauma: Mean = 1.7 (SD = 2.1). Psychiatric diagnoses in the past year: PTSD = 62%, MD = 51%.
Mills et al. (2005)	668 refugees in total from all 5 studies.	Systematic review of literature on prevalence of mental illnesses within the refugee population.	PTSD = 11-23% (3 studies). Anxiety disorders = 25-77% (4 studies). MD. Prevalence = 11.5-57% (5 studies).
Momartin et al. (2006)	49 Persian-speaking refugees with Temporary Protection Visas (TPV) living in the community. 67 Persian-speaking refugees with permanent protection visas (PPV) living in the community.	Comparison study between TPV & Permanent Protection Visa (PPV) holders in regards to trauma exposure, symptoms of PTSD, physical and mental health.	Levels of pre-migration trauma were not significantly different between TPV and PPV holders. TPV holders who had experienced immigration detention centres in Australia identified the experience as causing serious or very serious stress levels. TPV holders had higher scores on all psychiatric symptom measures indicating a greater functional impairment than those who had a PPV.
Nickerson et al. (2010)	315 Mandaean refugees from Iraq living in the community in Sydney. 150 male, 165 female. Mean age: 38 years old.	Cross sectional survey of Mandaean refugees from Iraq living in the community in Sydney, Australia. Specific focus on mental health, trauma experienced and fear for family/friends left behind. Trauma assessed by the HTQ.	A mean of 4.3 types of trauma were experienced by each participant. Higher level of PTSD and depression were experienced by participants with family in Iraq than those who did not.
Porter & Haslam (2005)	56 studies met the inclusion criteria.	A meta-analysis to determine the extent of compromised mental health in refugees.	Comparisons between refugee and non-refugee analysis found that refugees had moderately poorer outcomes. Indicators of poorer outcomes: socioeconomic, socio-political, female, and being older and refugees living in institutional accommodation, restricted economic opportunity, displaced within their own country repatriated to a country they had previously fled, and in a country with unresolved conflict.
Robjant et al. (2009)	10 studies identified which met the criteria for inclusion.	A systematic review on the mental health implications of detaining asylum seekers.	High levels of mental health problems in detainees, such as anxiety, depression, and PTSD self harm and suicide ideation.
Ryan et al. (2009)	Time 1: 162 refugees living in the community in Ireland. Mean age: 31.6 years (range: 17–64 years). Time 2: 70 refugees living in the community in Ireland from the original sample.	Study members were interviewed at two time points to determine a change in distress levels experienced by those who had obtained a secure legal status with those who had not.	The estimates for reported severe distress at T1 = 46–62%, and at T2 = 36–54%.
Schubert & Punamaki (2011)	78 torture survivors, 29 female, 49 male.	Interviews conducted with torture survivors using Impact of Events Scale, Hopkins Symptom Checklist-25 and somatic complaints. Comparisons were made between the following groups: Middle East; Central Africa; Southern Asia; and South Eastern Europe.	Group differences were found in PTSD, depressive symptoms and somatic complaints. Overall the South Eastern Europe torture survivors had more symptoms than the other groups. Women from South Eastern Europe had more symptoms of PTSD and depressive symptoms than the males in all cultural groups. Southern Eastern Europe group of torture survivors had their asylum seeker status marginally associated with anxiety symptoms.
Schweitzer et al. (2011)	70 individuals with a Burmese refugee background living in the community in Australia. Mean age: 34 years (range: 18–80 years).	Structured interviews exploring pre-migration trauma, post-migration living difficulties, depression, anxiety, somatisation and trauma-tisation symptoms.	Top 5 traumatic experiences pre-migration: Lack of food or water (73.5%), ill health without access to medical care (55.9%), lack of shelter (69.1%), combat situation (57.6%), and forced separation from family members (45.6%). Post-migration living difficulties were described as mainly “communication difficulties” or a “worry about family which was not in Australia”. Significant proportions of trauma (26%), anxiety (20%), depression (36%), and somatisation (37%) were found in this population of refugees.
Silove et al. (1998)	Sample of 40 subjects attending English classes at the asylum seeker centre. 21 female, 19 male Mean age: 35 years.	Hopkins Symptom Checklist-25, Health Assessment Charts, HTQ, and the Composite International Diagnostic Interview Schedule (CID).	30 participants had a trauma history. 14 participants met DSM-IV criteria for PTSD. Rate of PTSD in this study was 36.8%. No subjects were receiving specialised psychiatric care.
Silove et al. (1997)	62 Tamil asylum seekers living in the community. 104 Tamil immigrants living in the community. 30 Tamil refugees living in the community.	Trauma, mental health and post-migration difficulties compared between groups.	Mean of traumatic experiences: Asylum seekers = 6.7, Immigrants = 6.3, Refugees = 2.1. Depression scores: Asylum seekers = 1.92 (SD = 0.49), Immigrants = 1.45 (SD = 0.49), Refugees = 1.65 (SD = 0.59).

PTSD = Post Traumatic Stress Disorder; MD = Major Depression, GAF = Global Assessment of Functioning, HTQ = Harvard Trauma Questionnaire, UK = United Kingdom; \* Order of disorder: first MD, then PTSD. \*\*Order of disorder: first PTSD, then MD.



In the five studies which explored child refugees, the prevalence of PTSD was 11%. The National Survey of Mental Health and Wellbeing (Australian Bureau of Statistics, 2007) stated that 6.4% of the total Australian adult population would experience PTSD and a further 4.1% would experience depressive episodes. This means that those who are refugees have a higher probability of experiencing PTSD and depression than the general Australian population.

Marshall et al. (2005) explored the health of 490 Cambodian refugees twenty years after settling in the USA. High rates of psychiatric disorders were associated with the traumas they experienced. The participants were exposed to many traumatic events including near death due to starvation, a family member or friend murdered, witnessing beatings and killings, torture, or experiencing combat situations. These events have been compounded in some cases by traumatic exposures after migration, such as: saw a dead body in the neighbourhood, experienced a home invasion robbery or other type of robbery, chased by others who were trying to hurt them, verbally threatened with serious physical harm, seriously threatened with a weapon and experienced a serious accident in which someone was hurt or died. Sixty two percent of the sample experienced some form of depression and 52% experienced PTSD, while 42% suffered from both depression and PTSD. These rates are much higher than that of the Western population that they live among. There is a growing amount of literature demonstrating that the longer asylum seekers are held in some form of detention, the more their mental health is affected (Cohen, 2008; Keller et al., 2003; Robjant et al., 2009).

### **Forms of Self Harm and Suicide**

A study by Cohen (2008) explored the rate of self-harm and suicide in United Kingdom's (UK) detained asylum seeker population. It was found that there were 231 incidents requiring medical treatment in a 12 month-period for asylum seekers living in detention facilities.

This meant that there was an estimated 12.8% of the detained asylum seeker population who were treated for self-harm injuries. Cohen (2008) also explored the rate of completed suicide in detained asylum seekers. It was found that there were a total of 12 deaths during the period from 1997 to 2005. While this does not appear to be a high number, it is greater than the UK prison population and significantly higher than the national UK suicide rate (Cohen, 2008). Green & Eagar (2010) explored the health of individuals in Australian detention centres. Those detained for unauthorised boat arrival or unauthorised air arrival had the highest rates of self-harm (17.7% and 14.4% respectively). These high rates were well above that of illegal foreign fishers (2.1%), those who overstayed their visas (3.6%) and the average of all the groups in detention (6.2%). There are no specific methods of self-harm mentioned in this study.

Coffey et al. (2010) conducted semi-structured interviews with 17 asylum seekers who had been detained in detention centres in Australia for an average of 3.2 years. While half of those who were interviewed had participated in hunger strikes and other acts of protest, there were five who attempted suicide while detained. A potential bias for the study was due to the study size and therefore it is hard to determine whether these high numbers reflect a true proportion within the entire asylum seeking community.

### **Lip Stitching within Immigration Detention**

Three articles were identified on lip stitching in refugees or asylum seekers in Australia or worldwide. They examined and interpreted the symbolism of the method but did not collect or report empirical data. Koutroulis (2003) describes the experience of working as a psychiatric nurse in a detention centre. The signs of depression, self-harm and suicide ideation described by Koutroulis (2003) were among some of the daily incidences that required managing. Cox and Minahan (2004) explored the

theoretical symbolism of lip stitching and the visual impact it has on those in direct interaction with asylum seekers and viewers of the media. Cox and Minahan (2004) argued that the lip stitching that took place in Woomera in 2002 could reflect an Irigarayan feminist cultural theory with the lip stitching representing the silencing of voices. Dudley (2003) explored the situation of asylum seekers in detention and the rates of self-harm and suicide. The findings from this article include that children were traumatised by witnessing violence in riots, and suicide attempts and that parents were unable to console or comfort their children due to feelings of hopelessness and depression. It was found that self-harming occurred in Woomera which included lip-stitching and hunger strikes to express individual feelings of hopelessness and despair. Lip-stitching is mentioned along with hunger strikes as a method for drawing attention to distress and suffering.

### **Discussion: Challenges for Transition to Employment**

The variety of traumatic experiences of these different refugee groups indicates that there are a myriad of traumatic experiences that refugees may encounter that are likely to pose negative repercussions for their physical and mental health. These physical and mental health issues need to be addressed in the new country to ensure that refugees and asylum seekers can live and experience productive and fulfilling lives in their new country (Cunningham & Cunningham, 1997; Hollifield et al., 2002).

The physical health issues outlined above for both adult and children asylum seekers and refugees vary greatly between the various refugee and asylum seeker populations and encourages that refugees and asylum seekers should be given thorough physical health check-ups and care for the variety of conditions that they may suffer from. The lack of empirical studies on lip stitching in detention centres in Australia or even worldwide is a cause for concern considering the significant symbolic and mass media impact of this act.



The authors recognise that in some countries people with an asylum seeker background are not legally permitted to work, including Australia and the United Kingdom. At the same time, a prolonged unemployment status is a risk factor for suicide in this population, particularly among individuals with a history of trauma (Ekblad et al., 1996). Also important is the knowledge that deterioration in mental and physical health emerges as key constituent components of prolonged immigration detention. Such considerations imply that mental health support for people in detention environment must be the responsibility of all health and human services, not just the local mental health team. The determinants of mental ill health such as previous trauma and distress can also be linked to behavioural disturbance in the detention environment. The well documented risk and vulnerability of asylum seekers as a result of their traumatic experiences prior to and during escape, the cumulative nature of distress and the meaningless and sometimes indefinite conditions of detention are compounded by the long process of seeking asylum in a Western country.

The overview of literature given above has several implications for a better understanding of those with refugee and asylum seekers background that transition to the labour market. People of migrant and refugee background (with or without a history of suicide or self-harming behaviour) face a range of challenges such as language skills, cultural prejudice and discrimination, as well as technical qualifications not being recognised in their new country. A recent UK based study found that the chances of social mobility for new migrant groups (including economic migrants and people of refugee and asylum seeker background) are markedly less than for those of UK born people (Demireva, 2011). Huge differentials exist between new immigrant groups in their employment participation, employment rates and occupational attainment. The disadvantage of EU10, Eastern European, Turkish and Middle Eastern migrants in terms of their probabilities of being active, employed and accessing intermediate positions cannot be explained by a lack of human capital, and their situation is not likely to improve with time. Such differentials are com-

pounded by diminished social capital, social support, and social oppression (Marfleet & Blustein, 2011).

Identifying the life events that predict attempted suicide is an important question for mental health and human service workers. In the study by Bergmans et al. (2009) the experiences and barriers associated with the return to paid employment following recurrent suicide attempts were examined. Employment was identified as providing people with a sense of belonging, sense of identity and purpose, as well as a buffer against economic hardship. For younger adults, the process of recovery that includes small steps or phases (pockets of recovery) toward life is preferred. It should be noted that these factors also hold true for people who do not have a migrant and/or refugee background. What is important is that refugee and asylum seeker trauma amplifies the significance of sense of belonging, identity and purpose as vital mental health concepts. What is not known and needs to be known is the extent to which the consequences of being unemployed and associated financial and housing problems may trigger suicide attempts.



The journey is not always experienced as a steady movement forward, and the potential for relapse in the young people's wish to engage in their relationship with death, can ebb or flow. This information is important – particularly with regard to the co-existence of post-traumatic stress and depression. Studies by Oquendo et al (M. Oquendo et al., 2004; M.A. Oquendo et al., 2007) on the relationship between PTSD and depression in attempted suicide, show that patients with co-morbid major depressive episode and PTSD were more likely to have attempted suicide.

For people previously in suicidal crisis, issues of stigma, shame, guilt and embarrassment were key factors impacting upon transition (Bergmans et al., 2009; Wiklander, Samuelsson, & Asberg, 2003). Taking action to enhance and maintain wellness is extremely important for them. Such activity, if undertaken, can be enhanced by support from health care providers, workplace managers, supervisors and colleagues for successful transition to the workplace. The nature and extent of access to physical and mental health care, especially with regard to specialist treatment is also important. Analysis of previous experiences, and the way in which employment can be healing, is relevant for policy makers at all levels in a host or settlement country (George, 2010). Employers may need to work in partnership with non-government organisations such as specialist trauma counselling services who are aware of shame reactions following previous suicide attempts and might help new asylum seekers as employees as well as those they work with (Wiklander et al., 2003). Flexible work arrangements, respectful, non-judgemental and engaging work practices could make it easier for asylum seekers to cope with transition.

### Conclusion and recommendations

This paper has been an examination of peer reviewed literature regarding refugee and asylum seeker self-harm, followed by a consideration relating to the implications such events may have

on employee participation and engagement. We have presented the conceptual and theoretical consideration relationship of two interrelated topics. Such work is important as people of refugee background come from other lands to settle in new countries, they bring with them a range of distant and recent experiences that influence their settlement and potential engagement with employment. There remains a need for further research in this area providing clearer data and the development of a more detailed conceptual framework for a better understanding of the impact of suicidal and self-harm crises among asylum seekers and a link with transition to employment. Further research is needed to understand the nature, scope and consequences of suicidal behaviour as a risk factor for unemployment and vice versa among refugees and asylum-seekers. At the same time, questions should also be asked about protective factors for individuals in this situation.

There are clear indications that the distressing impact of symptoms and their psychosocial dimensions give rise to mental health problems and mental ill health of an enduring nature. Health and human service workers need to be aware that the struggle to live and build a new life is a process involving a fluid pathway moving between mental health support, community engagement and employment. Employers should invest in knowledge from mental health and human service workers so that there can be broader translation of care and treatment for previous mental health effects as part of a social inclusion framework for the future. It has also been identified that it is imperative to incorporate the use of professional interpreters to reduce the impact of social isolation caused by language barriers in asylum seekers who are detained and living within the community. Programs that trial ways of supporting and engaging refugee and asylum seeker transition phases into the workplace could form the basis of early intervention in suicide prevention for individuals at risk.

### Acknowledgements

*We thank the valuable feedback and advice received from the journals' two anonymous reviewers.*



**Nicholas Procter** is a professor and holds the Chair of Mental Health Nursing at the University of South Australia. Professor Procter has been working collaboratively with consumers, clinicians and sector managers to advance research, knowledge transfer and community engagement with mental health. He is an advisor to the Australian Minister for Immigration and Citizenship through the Council for Immigration Services and Status Resolution, and mental health advisor to the Federal Government's Detention Health Advisory Group. His specific areas of expertise are: risk and vulnerability in mental health, rural and remote mental health services, and community engagement in mental health promotion and suicide prevention.



**Penny Williamson** is a research assistant with the University of South Australia. She has worked as a research assistant for the last five years. Williamson is interested in the areas of mental health and body image. She is currently working on studies on the process of risk and engagement by mental health clinicians.



**Andrea Gordon** is a Research Fellow within the University of South Australia. Dr. Gordon has a research background in substance use and mental health in pregnancy and has worked with this vulnerable population and clinicians involved in their management in order to improve care for these women. Her research focus has recently broadened to other mental health populations and assessing and managing risk and vulnerability.

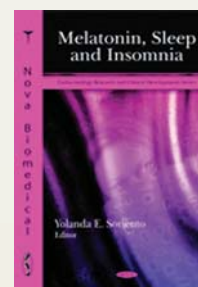


**Deborah McDonough** is a lecturer at the University of South Australia. She is currently involved in mental health research, specifically vulnerability, childhood trauma, and social inclusion.



## References

- Australian Bureau of Statistics (2007). **National survey of mental health and wellbeing: summary of results 4326.0.**
- Australian Human Rights Commission (2011). **Asylum Seekers and Refugees** Retrieved 24 June 2011, 2011, from [http://www.hreoc.gov.au/human\\_rights/immigration/asylum\\_seekers.html](http://www.hreoc.gov.au/human_rights/immigration/asylum_seekers.html)
- Bergmans, Y., et al. (2009). **Moving from full-time healing work to paid employment: Challenges and celebrations.** *Work*, 33, 389–394.
- Bhui, K., et al. (2006). **Mental disorders among Somali refugees.** *Soc Psychiatry Psychiatr Epidemiol*, 41(5), 400–408.
- Coffey, G. J. et al. (2010). **The meaning and mental health consequences of long-term immigration detention for people seeking asylum.** *Soc Sci Med*, 70(12), 2070–2079.
- Cohen, J. (2008). **Safe in our hands? A study of suicide and self-harm in asylum seekers.** *J Forensic Leg Med*, 15(4), 235–244.
- Cox, J. W., & Minahan, S. (2004). **Unravelling Woomeera: lip sewing, morphology and dystopia.** *Journal of Organizational Change Management*, 17(3), 292–301.
- Cunningham, M., & Cunningham, J. D. (1997). **Patterns of symptomatology and patterns of torture and trauma experiences in resettled refugees.** *Aust N Z J Psychiatry*, 31(4), 555–565.
- Demireva, N. (2011). **New Migrants in the UK: Employment Patterns and Occupational Attainment.** *Journal of Ethnic and Migration Studies*, 37(4), 637–655.
- Dolma, S., et al. (2006). **Dangerous Journey: Documenting the Experience of Tibetan Refugees.** *Am J Public Health*, 96(11), 2061–2064.
- Dudley, M. (2003). **Refugees and Remote Populations Contradictory Australian national policies on self-harm and suicide: the case of asylum seekers in mandatory detention.** [Article]. *Australas Psychiatry*, 11, S102.
- Ekblad, S., et al. (1996). **Health and Disease Among Refugees and Immigrants. A Quantitative Review Approaching Meta-Analysis, Implications for Clinical Practice and Perspectives for Further Research. Part I: Mental Health Outcomes.** Stockholm: National Swedish Institute for Psychosocial Factors and Health, The Division of Psychosocial Factors and Health at the Karolinska Institute and WHO's Psycho-social Centre, Stockholm, Sweden.
- Fazel, M., et al. (2005). **Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review.** *Lancet*, 365(9467), 1309–1314.
- Fox, S. H., & Tang, S. S. (2000). **The Sierra Leonean Refugee Experience: Traumatic Events and Psychiatric Sequelae.** *J Nerv Ment Dis* 188(8), 490–495.
- George, M. (2010). **A Theoretical Understanding of Refugee Trauma.** *Clin Soc Work J*, 38, 379–387.
- Goosen, S. et al. (2011). **Suicide death and hospital-treated suicidal behaviour in asylum seekers in the Netherlands: a national registry-based study.** *BMC Public Health*, 11(1), 484.
- Green, J. P., & Eagar, K. (2010). **The health of people in Australian immigration detention centres.** *Med J Aust*, 192(2), 65–70.
- Hollifield, M., et al. (2002). **Measuring trauma and health status in refugees: A critical review.** *JAMA*, 288(5), 611–621.
- Keller, A. S., et al. (2003). **Mental health of detained asylum seekers.** *Lancet*, 362(9397), 1721–1723.
- Koutroulis, G. (2003). **Detained asylum seekers, health care, and questions of human(e)ness.** *Aust N Z J Public Health*, 27(4), 381–384.
- Lie, B. (2002). **A 3-year follow-up study of psychosocial functioning and general symptoms in settled refugees.** *Acta Psychiatr Scand*, 106(6), 415–425.
- Lie, B., et al. (2001). **Traumatic Events and Psychological Symptoms in a Non-clinical Refugee Population in Norway.** *Journal of Refugee Studies*, 14(3), 276–294.
- Lorek, A., et al. (2009). **The mental and physical health difficulties of children held within a British immigration detention center: A pilot study.** *Child Abuse Negl* 33(9), 573–585.
- Marfleet, P., & Blustein, D. L. (2011). **'Needed not wanted': An interdisciplinary examination of the work-related challenges faced by irregular migrants.** *Journal of Vocational Behavior*, 78(3), 381–389.
- Marshall, G. N., et al. (2005). **Mental health of Cambodian refugees 2 decades after resettlement in the United States.** *JAMA*, 294(5), 571–579.
- Mills, E., et al. (2005). **Prevalence of mental disorders and torture among Tibetan refugees: A systematic review.** *BMC Int Health Hum Rights*, 5(1), 7.
- Mollica, R., et al. (1993). **The effect of trauma and confinement on functional health and mental health status of Cambodians living in Thailand-Cambodia border camps.** *JAMA*, 270, 581–586.
- Momartin, S., et al. (2006). **A comparison of the mental health of refugees with temporary versus permanent protection visas.** *Med J Aust*, 185(7), 357–361.
- Nickerson, A., et al. (2010). **The impact of fear for family on mental health in a resettled Iraqi refugee community.** *J Psychiatr Res* 44(4), 229–235.
- Oquendo, M., et al. (2004). **Prospective study of clinical predictors of suicidal acts after a major depressive episode in patients with major depressive disorder or bipolar disorder.** *Am J Psychiatry*, 161(8), 1433–1441.
- Oquendo, M. A., et al. (2007). **Sex Differences in Clinical Predictors of Suicidal Acts After Major Depression: A Prospective Study.** *Am J Psychiatry*, 164(1), 134–141.
- Porter, M., & Haslam, N. (2005). **Predisplacement and postdisplacement factors associated with mental health of refugees and internally displaced persons: A meta-analysis.** *JAMA*, 294(5), 602–612.
- Robjant, K., et al. (2009). **Mental health implications of detaining asylum seekers: systematic review.** *Br J Psychiatry*, 194(4), 306–312.
- Ryan, D. A., et al. (2009). **Mental health among persons awaiting an asylum outcome in western countries: A literature review.** *Int J Ment Health*, 38(3), 88–111.
- Schubert, C. C., & Punamaki, R. L. (2011). **Mental health among torture survivors: cultural background, refugee status and gender.** [Article]. *Nord J Psychiatry*, 65(3), 175–182.
- Schweitzer, R. D., et al. (2011). **Mental health of newly arrived Burmese refugees in Australia: contributions of pre-migration and post-migration experience.** *Aust N Z J Psychiatry*, 45(4), 299–307.
- Silove, D., et al. (1997). **Anxiety, depression and PTSD in asylum-seekers: associations with pre-migration trauma and post-migration stressors.** *Br J Psychiatry*, 170, 351–357.
- Silove, D., et al. (1998). **Trauma exposure, post-migration stressors, and symptoms of anxiety, depression and post-traumatic stress in Tamil asylum-seekers: comparison with refugees and immigrants.** *Acta Psychiatr Scand*, 97(3), 175–181.
- United Nations High Commissioner for Refugees. (2011). **Asylum Levels and Trends in Industrialized Countries 2010: United Nations High Commissioner for Refugees.**
- Wiklander, M., et al. (2003). **Shame reactions after suicide attempt.** *Scand J Caring Sci*, 17, 293–300.



Nrugham L, Prakash VV.  
**Insomnia Among Suicidal Adolescents and Young Adults: A Modifiable Risk Factor of Suicidal Behaviour and a Warning Sign of Suicide?**

In Yolanda E. Soriento (ed). *Melatonin, sleep and insomnia.*  
 New York: Nova Biomedical Books, 2010  
 (utk. 2011), s. 227–47.  
 ISBN: 978-1-60741-859-7

Søvnnforstyrrelser, særlig insomni, er et neglisjert tema på det suicidologiske forskningsfelt. Forfatterne undersøker eksisterende litteratur innenfor søvnpblemer, hovedsaklig insomni, og de ulike dimensjonene ved suicidalitet blant ungdom og unge voksne sammenliknet med voksne. Litteraturoversikten er supplert med noen kasus fra India. Kapitlet konkluderer med at et forhold ser ut til å eksistere mellom insomni og suicidalitet, spesielt når det gjelder gjennomført selvmord, uavhengig av alder. Likevel finnes det altfor lite kunnskap om dette forholdet til at det kan brukes som forskningsvidens, i likhet med de fleste funn på suicidal adferd fra tverrsnittstudier, det være seg epidemiologiske eller kliniske.