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Original articles

The mental state of detained asylum seekers

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The persecution of civilians by the Iraqi forces in Kuwait and subsequent acts of revenge on the Palestinian population have caused widespread revulsion throughout the world. Stories of torture and rape have been described in the Western media and issues of human rights have gained considerable prominence of late. Perhaps now is a good time to examine how Britain responds to the needs of survivors of torture who seek asylum here.

Between 1980 and 1989 an average of 5,600 refugees applied to the British Government for political asylum each year (British Refugee Council, 1990). The number granted full refugee status has been steadily declining and many agencies detect that an increasingly narrow definition of the term refugee is being used. In addition, an increasing number of asylum-seekers are being held in detention after they arrive. It is thought that about a hundred are being held at any one time (Pirouet, 1991). Many of these have suffered torture.

Fleeing one's country to escape persecution is an extremely painful experience. For those detained on arrival in their country of refuge the experience is all the more traumatic. Since 1987 three asylum-seekers have committed suicide while being held under Home Office orders. Through our work at the Medical Foundation we have examined some of those detained and have become concerned by their mental condition.

Psychological reactions to torture

The devastating psychological effects of torture have been well-documented (Turner & Gorst-Unsworth, 1990). The fear of re-experiencing torture forces many survivors to seek refuge far from their homelands. For most this is dangerous and expensive but is undertaken usually with a profound hope of a life of relative freedom and safety in the country of asylum.

Survivors of torture describe preoccupation with images from their trauma: violent nightmares or 'flashback' phenomena. Many are left with the symptoms of post-traumatic stress disorder (APA, 1987) and sometimes with depressive reactions. Their ability to come to terms with the aftermath of their experiences depends to a large extent on the circumstances in which they find themselves after the trauma. Through our work at the Medical Foundation, and in Uganda (Giller *et al*, 1991), we have found that even the most brutalised people can regain some sense of normality, given a positive and supportive environment.

For those who do not have the benefits of such support, the suffering is compounded by a loss of hope and a sense of isolation.

To illustrate these effects we document the cases of ten male asylum-seekers who we saw in detention, pending a decision on their asylum applications. We describe one case in detail which provides an example of the problems faced by detainees.

All the refugees described were seeking asylum in Britain. All reported torture in their home countries.

We found a high level of psychological disturbance in all cases. Symptoms included intense fear, anxiety, sleep disturbance, nightmares, irritability and frustration. Six spoke of feeling that there were "going crazy". All reported depressed mood, appetite loss, and multiple somatic complaints. Nine said that they had frequent episodes of tearfulness and felt completely hopeless.

Definite suicidal ideation was described by four and two had made previous suicidal attempts.

Case example

T is a thirty-three year-old teacher from Central Africa. His father was killed in 1988 by government agents and T subsequently became involved in a political opposition group. In 1990 he was arrested, blindfolded and driven to a secret detention centre where he was held for four months. He was tortured nearly every day. On occasions he was stripped naked and various parts of his body subjected to electric shocks. His testicles were beaten, his food was poor and his cell was filthy with excrement. He witnessed others being killed during electrical torture.

He describes being continually terrified during this period. Immediately following his father's death he had developed palpitations. These became so severe

TABLE I
Ten male asylum-seekers who were seen in detention by the authors

Case number	*Country of origin*	*Where detained*	*Previous exam**	*English speaker*	*Time in detention* (months)
1	Zaire	Pentonville	yes	no	3
2	Zaire	Pentonville	yes	no	4
3	Zaire	Pentonville	no	no	6
4	Zaire	Pentonville	yes	no	3
5	Turkey	Pentonville	no	no	3
6	Turkey	Haslar	yes	no	7
7	Nigeria	Haslar	yes	yes	7
8	Ghana	Haslar	yes	yes	3
9	Suriname	Harmondsworth	no	yes	1
10	Pakistan	Haslar	no	yes	2

*i.e. already documented physical evidence of torture.
Note: Harmondsworth and Haslar are detention centres near Heathrow airport and Portsmouth respectively.

after his arrest that he feared death from a heart attack.

Eventually T was released after his brother paid a large bribe. People from his political organisation arranged an air ticket and he made his way to Britain.

On arrival he made an application for political asylum. This is currently being processed by the Home Office. T was taken from the airport to a detention centre and later to a London prison. When seen by one of us he had been in detention for three months. He found it hard to believe that he was being imprisoned again, in the country where he had sought refuge. He began to experience flashbacks to his detention in Africa, particularly when he was handcuffed while being moved from one place to another. He suffered intrusive memories and nightmares and dreamed of being killed or sent back home. He had a pronounced startle reaction and suffered panic attacks when he heard prison doors banging or other loud noises. The accompanying palpitations provoked worry about the condition of his heart. He is a French speaker and cannot understand the prison officers or his fellow inmates.

T described weight loss not only during imprisonment in his own country but also since his arrival in Britain. He felt depressed and hopeless and said that he cried every night when thinking of his family. He denied suicidal ideation. His symptoms were those of a post-traumatic stress disorder and a reactive depression.

Comment

People fleeing from persecution invest great hope in the country of asylum. Detention on arrival leads to feelings of betrayal and despair. The psychological suffering of such people is intense and is often aggravated by their inability to speak or to understand English. The lack of meaningful communication with fellow inmates or prison officers leads to mutual suspicion. Imprisonment alongside criminals leads to feelings of injustice, humiliation and anger. Those who have endured torture and persecution because of their political and social ideals find it hard to comprehend why they should be included among those accused of criminal offences.

Knowledge of the psychological sequelae of torture has advanced considerably in the past decade. Professionals in the field now understand not only the symptoms but also some of the internal psychic changes in survivors of torture. The Uraguayan psychiatrist, Vinar (1989) spoke of a "demolition" of the person under torture. When such an individual is taken into detention on arrival in his country of refuge, left incommunicado and stripped of his identity by being made to wear prison clothing and mixing with criminal prisoners, this "demolition" continues. The long and difficult process of rehabilitation is made impossible in such an environment. This practice is specifically condemned in the Guidelines issued by the United Nations High Commissioner for Refugees in 1986.

We do not know why the detention of torture survivors is happening in this country at the present time. It would appear that these detentions are often arbitrary (Pirouet, 1991). It is clear that they result in a large degree of unnecessary psychological suffering to people already severely scarred by their experiences of torture and imprisonment.

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A district's view of regional in-patient units for children and adolescents

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Recommendations in the White Paper *Working for Patients* will have a major influence in the field of child health. District consultants have been asked by colleagues and managers to explain and account for current practice in child and adolescent psychiatry, and to plan for the future against a background of serious financial constraint. Similarly, child and adolescent psychiatrists will need to evaluate current levels of use of regional services and consider a relationship where these services may have to be bought from a limited child and adolescent psychiatry budget.

The study was aimed at examining resources presently available in the districts of South West Thames Region and current and projected use of regional services. We hope that, by clarifying what districts would need to purchase in the future, we might assist our own regional units in their development, and help ensure their future survival (Wrate & Wolkind, 1991).

The study

Our questionnaire was sent to child and adolescent psychiatrists in the South West Thames Region, none of whom to our knowledge had in-patient beds. The questionnaire was in three parts, the first examining current provision in each district, such as hospital liaison, emergency services and access to beds; the second examining current knowledge and usage of regional services, within the region and outside it; and the third, projected use of regional services as purchasers.

Findings

Twenty-eight questionnaires were sent out and 20 replies were received (71% response rate). Respondents represented a cross-section of consultants within the region both in experience and in their clinical setting.

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