trauma, mental health & migration

NSUN

Migrants' Rights Network

This zine is co-authored by the Migrants' Rights Network (MRN) and the National Survivor User Network (NSUN).

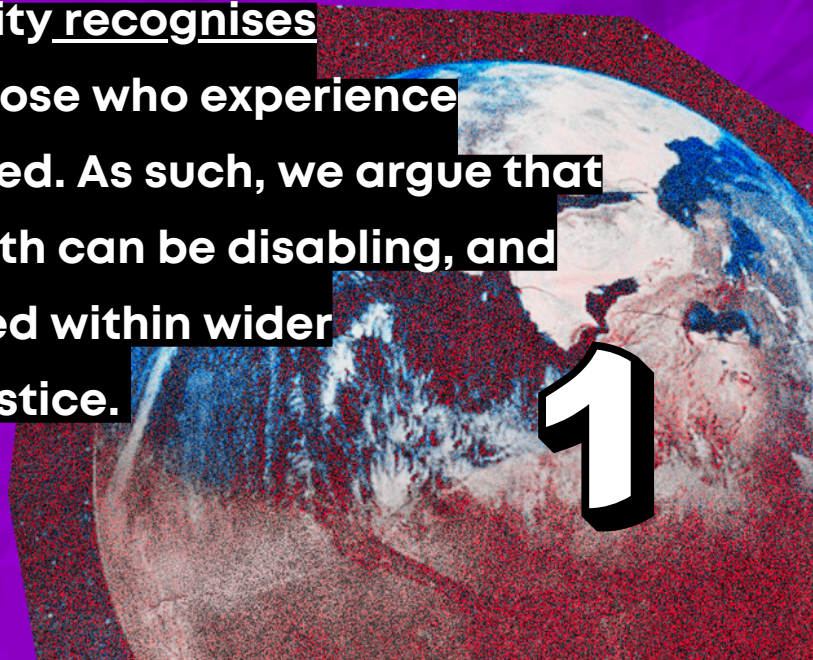
MRN is a UK charity that works alongside migrants in their fights for rights and justice. They co-curate campaigns using anti-oppression practices to create transformational change, extending beyond the individual impact on migrants' lives, to tackle oppression at its source. As a values and lived experience-led organisation, their work in challenging oppressive policies, norms and narratives, is directly informed by the personal experience of their team and wider network.

NSUN is a membership organisation and a network of grassroots, user-led community groups and people who have lived experience of mental ill-health, distress, and trauma. They work to redistribute power and resource in mental health by amplifying and distributing the knowledge that is held by people with lived experience, by creating collaborative spaces, and by building an alternative approach to mental health policy work.

The process of migration and experiences of immigration systems can create or exacerbate mental ill-health, distress and trauma. Specifically, the violence of the border actively produces trauma, with over half of people seeking asylum experiencing mental distress, and with migrants and their children being significantly more likely to be diagnosed with Post Traumatic Stress Disorder (PTSD).

Despite this, dialogue around trauma as part of disability justice, and how that intersects with liberation for migrant communities, remains largely absent. Furthermore, migration policies do not account for the mental health of migrant communities, and mental health policies do not account for the specific needs of migrant communities. Ultimately, the immigration system can cause disablement in the form of trauma, distress and other mental ill-health.

The social model of disability recognises traumatised people and those who experience mental ill-health, as disabled. As such, we argue that trauma and mental ill-health can be disabling, and should therefore be situated within wider discussions on disability justice.



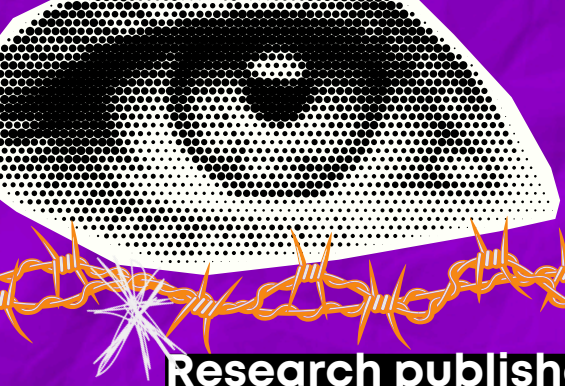
Another useful concept when thinking about the intersection of migration and trauma is ‘debility’. Marginalised groups are forced to live in debilitating conditions by systems like capitalism, imperialism and borders. They might, for example, be forced to flee violent occupation, live in hazardous accommodation, or face workplace exploitation because of their legal status. All of these factors put these groups at greater risk of becoming disabled – we understand people in these situations as living in a state of debility.

What is trauma?

Trauma is an intense emotional response to a distressing event. It can also be caused by ongoing events, such as living in conditions that are stressful, frightening or distressing.

In other cases, trauma can be caused by witnessing harm to someone else or through generational or 'transgenerational' trauma. This is trauma experienced by an ancestor, which is then passed down through generations. For example, there is some evidence that the descendants of Holocaust survivors experience higher rates of mental ill health.

Trauma is something most of us will experience in our lives, but the ways in which it presents itself, however, can vary hugely from person to person. The way trauma interacts with different forms of oppression or aspects of someone's identity also affect how people experience it. We often find that the roots of traumatic events lie in sets of beliefs, norms and policies in society and culture that are "structural and hierarchical in nature". As Staci K. Haines points out in her book The Politics of Trauma, while traumatic events are something we experience as individuals, they are not caused by individual choices or failure.



Research published by NSUN points out that the oft-repeated refrain "mental health does not discriminate" erases the role of systems (for example, bordering and immigration systems) in creating or contributing to trauma or mental ill-health. For marginalised people, systemic discrimination on the basis of race, ethnicity, immigration status, other kinds of disability, gender and/or sexuality can create or exacerbate trauma. Furthermore, treatment models ignore the complex roots and different manifestations of illness for different marginalised groups. With this in mind, then, while nobody is immune to mental ill-health, those on the sharp end of oppressive systems are at a greater risk of experiencing it than those who are not.

The narrative around trauma or mental ill-health in migrant support services or campaigns often focuses on traumatic events people may have experienced in their country of origin. However, they rarely analyse the trauma or mental distress caused by the journey to the UK, or how immigration systems and borders create or reinforce this.

Post-traumatic stress disorder (PTSD)

"Remember when you were young and you fell over and cut your knee. As you cried, a caregiver hugged you, comforted you and told you it would all be okay. So, as you grow up and fall over, your brain recalls the support and tools you were given, and learns how to soothe itself. The difference is with PTSD is you're not given that support, or you aren't sure how to compute what's happened. That's when it can get stuck and PTSD can develop." - Therapist specialising in trauma

In some cases, trauma can evolve into what is known as post-traumatic stress disorder (PTSD), as experienced by 30% of people seeking asylum internationally, according to recent research by the Mental Health Foundation.

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Symptoms can include difficulty controlling emotions and dissociative symptoms such as depersonalisation or derealisation. This refers to a feeling of disconnectedness from the outside world, as if you are looking at yourself from the outside, or just observing your emotions. Some people also experience physical symptoms such as headaches, chest pains or dizziness.

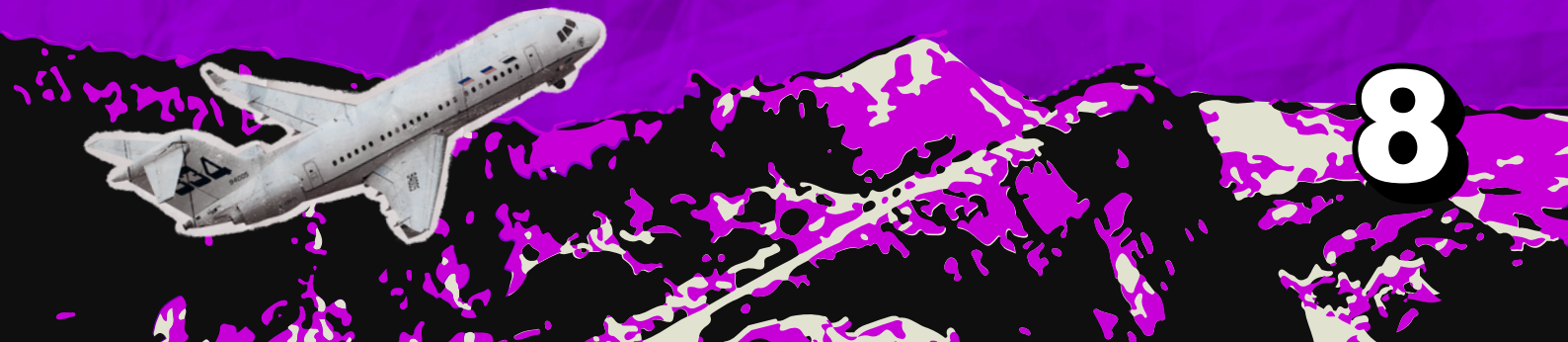
PTSD causes a traumatic memory to become 'stuck', so that people experiencing it perceive that the event is still happening and they are in danger. Trauma itself can provoke physiological changes including rewiring the brain's alarm system, an increase in stress hormones and alterations in how the brain files different pieces of information. This can manifest as 'hypervigilance' – the state of constant high alert to potential threats. Some professionals recognise a form of PTSD called Complex Post-Traumatic Stress Disorder (CPTSD) which can be caused by recurring or long-term traumatic events.

The main NHS-recommended treatments for PTSD include 'talking therapies' and medicine. While the NHS works on the basis that 2 in 3 people who experience mental ill-health after a traumatic event can 'get better' within a few weeks. However, while PTSD is often seen as something that can be 'successfully treated', it is important to remember that people's experiences of mental ill-health are often more complex and non-linear than this way of thinking leaves room for. 'Recovery' – where it is understood to mean reaching the point of no longer experiencing mental-ill health – is not always possible, let alone a predictable, linear process. This is especially true for people who migrate to the UK.

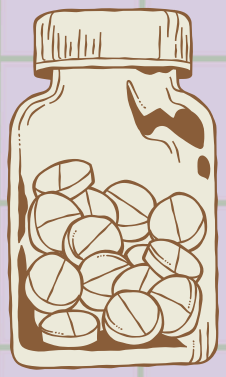
Most people seeking asylum, for example, are moved to new – and often woefully inadequate – accommodation every few months. This can prevent them from accessing specialist PTSD treatment, which often has waiting lists from six months to two and a half years for the general population and sanctuary seekers alike. In cases where it is possible for people in the asylum system to access talking therapies for PTSD in primary care, waiting times for an assessment are often around three months, with a further six months after that before treatment can begin. This is much longer than the Home Office allows many sanctuary seekers to remain in one place, making PTSD treatment almost impossible for many.

If such treatment is so inaccessible for those within the asylum system – who, in theory, have access to healthcare – we can only imagine the difficulty that those without legal status in the UK have in treating PTSD. It is known that, while everyone is entitled to primary care regardless of immigration status, bureaucracy and stigma often keep irregularised people away from surgeries.

Where people who migrate to the UK are able to access PTSD treatment, there are many factors that might interfere with a linear 'recovery'. For those in the asylum system, interviews with case workers who do not use a trauma-informed approach can be incredibly damaging, as can abrupt rejections from the Home Office. Frequent changes of accommodation can also negatively impact mental and physical health, as well as depriving people seeking asylum of the chance to build any sense of community where they are. Similarly, for all migrants experiencing PTSD regardless of immigration status, bad news from family members abroad can be a major setback in their journey towards managing it.

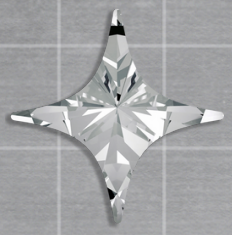


We know that PTSD and similar experiences of mental ill-health can be brought on by numerous complex, intersecting factors. Ultimately, it remains difficult to predict who will be affected by such experiences and how severely. What is abundantly clear, on the other hand, is that people who migrate to the UK face major barriers when attempting to access PTSD treatment.



It is worth pointing out, of course, that not everyone who experiences trauma will go on to develop PTSD. According to the National Health Service, about 1 in 3 people who experience severe trauma will experience PTSD.

Trauma as Disability

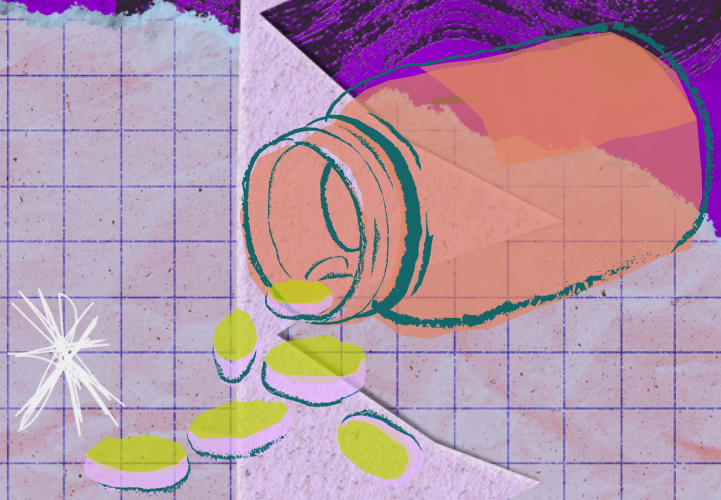


Disability is constructed as "the meeting point between people and an ableist world".

Trauma, like other forms of disability or debility, is not static. Many people go through experiences that are disabling and/or deal with the fluctuating impacts of various impairments. Many migrants also experience debility in the form of expected impairment. Jobs that they are forced to take up because of their precarious status often put them at high risk of injury. Pre-migration conditions – like living under occupation, in conflict zones or in poverty – can also cause people to live in fear of life-altering health problems.

Those who have experienced trauma specifically can be labelled with the blanket term 'survivor'. While for some this is a term of 'empowerment', for others it is simply inaccurate because their experience of trauma does not align with or equate to the notion of survival.

Survival can imply that the harm is limited to a specific incident and refers to a past event. The way that trauma or conditions such as PTSD can manifest means that the individual can be ‘stuck’ or their brain reacts as if still experiencing that incident or ongoing incidents. Furthermore, the sometimes devastating consequences on mental health can often feel like they haven’t ‘survived’ anything. This is particularly true if the traumatic event reoccurs, if the individual has to interact with discriminatory services and structures or is not able to access any support at all. For some, mental ill-health as a result of trauma can also come in waves or have delayed onset which can be brought on by triggers.



Trauma for migrants, including refugees and people seeking asylum

Discussions around mental-ill health and trauma for people who have crossed borders are often narrow. They largely focus on distress or issues arising for people who have fled conflict, violence or persecution. Despite this, there are many other incredibly distressing circumstances in which people are forced to leave their homes, but which arise from the economic consequences of neocolonialism, for example. In such cases, where someone's motivation to cross borders does not fit neatly into Western expectations about what a 'deserving' migrant looks like, people are far less likely to have the trauma of their journeys acknowledged.

Further to this, borders and immigration systems clearly aim to disable and debilitate. Migrants, including refugees, can be traumatised by their experiences of migration or have existing trauma exacerbated.

MRN hears from people who have experienced 'mental devastation' as a result of hostile immigration policies. Threats of deportation or detention, immigration raids, inhumane asylum accommodation are all having a profound negative impact on migrant communities.

However, other aspects of immigration structures such as right to work checks, sponsorship visas, extension applications having no recourse to public funds (NRPF) or surveillance can also cause or exacerbate mental ill-health or trigger trauma.

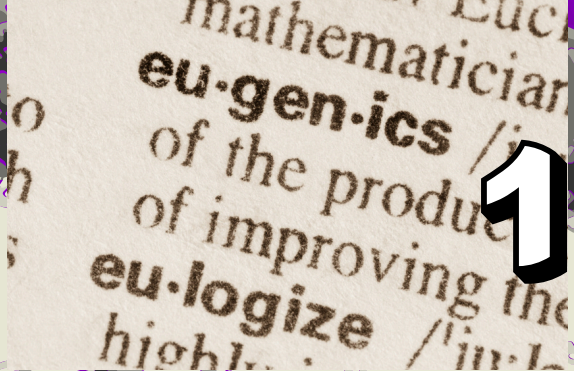
The asylum system and the oppressive conditions people seeking asylum are subjected to is a potent example of the link between trauma, mental-ill health and cruel migration policies. At the end of 2023, it was reported that deaths by suicide in Home Office accommodation have doubled in the last four years. The majority of research into mental ill-health for people in the asylum system focuses on trauma before coming to the UK, but doesn't adequately investigate the trauma caused by the UK asylum system including accommodation or treatment by accommodation staff. Through our community, we have heard of cases in asylum accommodation where individuals have experienced a breakdown or psychotic episode, and have not received the correct care or response- in one incident, accommodation managers responded to an individual who was in distress by calling the police, and removed from the accommodation.

How stigma around trauma impacts migrants, including refugees

Stigma around PTSD and a 'traumatised' individual can disproportionately impact marginalised people, including racialised people and migrants. Racist assumptions that associate racialised groups with the idea of a 'threat' are exacerbated when racialised individuals experience mental ill-health.

In its early inception, psychology was about race. Racist, colonial-era narratives painting colonised people as 'uncivilised' permeated the foundations of some mental health practices including psychiatry. This is the same logic that persists today when people classify migrants as more or less 'civil' – or 'like us' – based on their perceived proximity to whiteness.

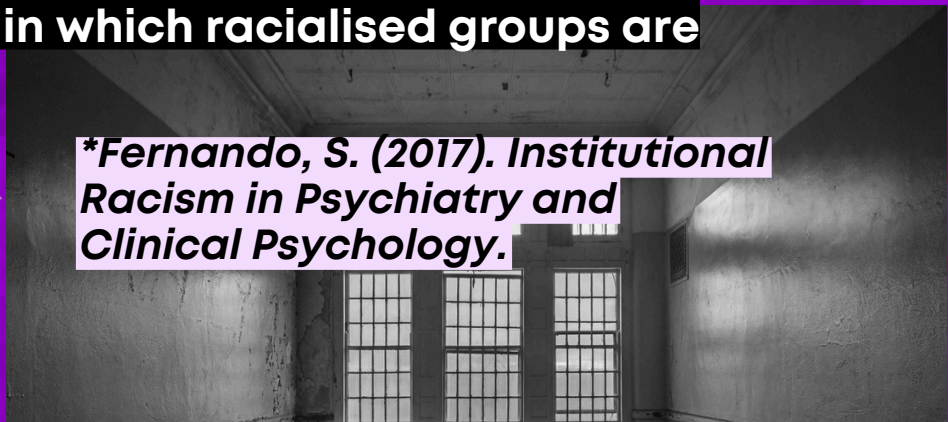
In the 19th and early 20th century, eugenics-based psychology influenced immigration policies in the USA on the basis that racialised people were perceived to be more inclined towards criminal tendencies and psychological instability*. .



White supremacist eugenics and cognitive theories framed racialised people as psychologically inferior, with a particular focus on Black people. Influential psychiatrists and psychologists like Carl Jung in the 1920s and 1930s attributed “peculiarities” ‘ in White Americans’ behaviour to living in “close proximity to Black people”.

Similarly, in the mid-20th century, Black people diagnosed with schizophrenia in UK psychiatric hospitals were simply labelled as ‘dangerous’ for no reason*. By constructing mental-ill health as a symptom of inherent racial inferiority, these schools of thought did deep and lasting damage to the perception of racialised people who experience trauma.

Mental health services as we know them today are constructed on the basis of these White knowledge systems, which continue to inform what is considered ‘normal’ or ‘healthy’. This racism also pervades prison-like, or carceral, institutions in the mental healthcare system and beyond, in which racialised groups are overrepresented.



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As well as inpatient psychiatric facilities, these institutions include immigration detention centres and prisons themselves. These systems and the logic of imprisonment on which they operate is known as the carceral state, which works to oppress and 'disappear' racialised communities. Up to 4,500 people in mental health crises were unlawfully held in police custody in England and Wales in a year, and Black people are four times more likely to be detained under the Mental Health Act than the general population. This carceral approach to mental health or crisis effectively punishes or criminalises people instead of giving them the care they need.

The intersection of mental health stigma – which should be understood as a form of ableism – and racism, including Islamophobia, manifests in the immigration system and 'counter-terrorism' measures. According to a Medact report in 2021, a racialised Muslim is at least 23 times more likely to be referred to a mental health hub for 'Islamism' than a White British individual is for 'Far Right extremism'. Medact found that people without diagnosable mental health 'conditions' are at risk of being pathologised on the basis of political expression or precarious social status, including immigration status. Furthermore, the Vulnerability Support Hub initiative – a "secretive counter-terrorism police-led mental health project" – understands migrants (written in the guidance as "migrants and asylum seekers") with 'complex needs' like trauma as having "unmitigated" terrorism risks.

Photo credit: Campaign for Psych Abolition

Barriers to accessing support: lack of access, racism and carceral systems

Despite high rates of mental distress among migrants, including people seeking asylum, accessing support is difficult. In addition to previously mentioned barriers, mental health provisions fail to consider how gender classifications influence treatment. The diagnosis of 'conditions' that are often largely attributed to women, such as 'borderline personality disorder' – in itself arguably a problematic medicalised label to describe trauma-related mental-ill health – or the inadequate definition of sexual assault all fail to account for the complexity of illness and violence in a unequal world. For racialised and/or migrant women, who are constructed as inherently vulnerable and in need of saving, dismissal or infantilisation due to gendered norms in healthcare remains all too common.

"I have a therapist and I think it('s) great to have someone to talk to about what I am going through. Of course most men discard the importance of having a therapist... I think a lot of men, especially from Africa, think therapy would bruise their masculinity." - Man seeking asylum from Nigeria, aged 25

With the majority of people in the asylum system being identified as men (60% in the year ending June 2023), harmful patriarchal norms around masculinity and mental health can also impact access to support. Gendered stereotypes, which force men to perform masculinity by repressing their emotions, place expectations on men which cause them to feel unable to ask for practical or emotional support.

"I am a man, I have to be strong. Going to the hospital to speak to a stranger about your problems is a sign of weakness. Honestly, I do not see the point." - Man seeking asylum from Sudan, aged 27

As previously explained, mental health also incorporates racist knowledge systems from initial access through to diagnosis and treatment. Racialised groups are more likely to be subjected to coercion and violence when experiencing mental distress, and services remain uncertain how to engage with ethnic and religious diversity. Coercion can take the form of pressuring someone into treatment, threats, the use of force to make someone accept a treatment or intervention that have been refused, or forms of restraint.

Racism, gender/cultural stereotypes and immigration status – to name a few – can all impact someone's willingness to engage with mental health services. However, a lot of the onus in existing discourse around why some migrants, including refugees, don't engage with these services is often placed on them. It reduces the very real barriers to healthcare access for migrants down to ignorance or not knowing what provisions are available to them. While this could be one factor, this logic fails to account for systemic issues in healthcare that may prevent someone from using services.

Photo credit: Campaign for Psych Abolition

Transformational approaches to mental health care

Approaches to mental health and disability justice must be included within our struggle for transformational systemic change and liberation movements. The ‘treatment gap’, between values and practice when it comes to ‘patient-centred’ mental health care highlights the progress that is yet to be made in this area. Across mental health services, there is insufficient appreciation of “the whole person” and acknowledgement of the social determinants of mental ill-health.

Individualistic, neoliberal approaches to mental-ill health and disability mean that responsibility to be healthy is placed on the individual, while the impact of oppressive structures is obscured. Problematic narratives about “looking after ourselves” encourage us to blame ourselves when we experience mental ill-health, rather than interrogating these structures that so often create or exacerbate it.

Such reductive ideas about health also serve to prevent us from addressing systemic racism, which can only be done through a completely transformational or abolitionist approach. A transformational approach to mental health, including experiences of it that arise from trauma, demands a complete reframing of our attitude. Ultimately, the question is: can mental healthcare systems be transformed when they were never designed to help marginalised people and are so clearly grounded in racist eugenics theories? The answer is no.

This is where we can learn from movements for the abolition of the psych disciplines. There is a growing movement against the current psychiatric establishment, including forced treatment, psychiatric incarceration in hospitals, legal restrictions on people with certain diagnoses, and police powers to detain people as 'mentally ill'. An abolitionist approach to society focused on community strength and support can tackle the punitive, isolating and individualistic logic that underpins mental healthcare as we know it. Mental health services do not have to be sites of punishment and incarceration.

'Mentally ill people deserve respect, autonomy, compassion, and community care. We believe in non-punitive, patient-centred treatment, absent of the current harmful, traumatising psychiatric 'solutions' that are forced upon us. Mental illness will always exist but will be greatly reduced by tackling the systemic oppression that causes and exacerbates poor mental health.' - Campaign for Psych Abolition

There is also much to learn from disability justice frameworks in the fight for migrant justice. Crucially, the Disabled people's movement demonstrates that we must move beyond surface-level representation and 'inclusion' in favour of a struggle that dismantles disabling norms and advocates for systems change. For Disabled migrants, including those experiencing trauma or mental ill-health, that means dismantling the deadly immigration system and border regime. Indeed, we also cannot dismantle disabling barriers without a robust, intersectional understanding of what those barriers are. Meaningful and holistic forms of care can only be fully achieved once the oppressive structures that create or exacerbate mental ill-health are dismantled.

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