

# The mental health of migrant people: Western medical systems facing a globalized society

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## Abstract

The mental health of migrant populations represents a challenge for the cultural and organizational assumptions of Western welfare systems, and it touches on and problematizes forms of civil coexistence in democratic societies. Starting from scientific literature analysis, the article discusses how the scientific debate is marked by theoretical and methodological characterizations that affect the understanding and representation of the phenomenon and influence the construction and the stability of social and personal identity of migrant people. The prevalence of the refugee and asylum-seeking population in samples of epidemiological studies and the distorted representation of the actual mental health conditions of the majority of migrants are discussed. Methodological choices, in particular the frequent use of standardized data collection tools and classification systems of medical-psychiatric derivation, tends to neglect the phenomenological and etiological heterogeneity of the phenomenon.

## KEYWORDS

key topics, key topics, migration, race and ethnicity, social psychology, sociology, subjects, subjects, cultural diversity, subjects, sociology of health, aging, and medicine, subjects, sociology of health and illness, subjects, sociology of mental health

[Corrections added on 06-Sept 2022 after first online publication: CRUI-CARE funding statement has been added]

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## 1 | INTRODUCTION

The mental health of migrant populations is a relevant issue because it represents a challenge for the cultural and organizational assumptions of Western welfare systems. It questions the values, guiding principles, policy choices and operational tools put in place to try to safeguard the overall physical, mental and social well-being of a population that is potentially vulnerable due to the critical issues that drive the decision to migrate. This is an intrinsically complex topic as it emerges from the interaction between biographical factors, mental health and migration, whose effects on people's quality of life and social identity are still a matter of debate. The epistemic communities and scientific knowledge play key roles in comprehending the phenomenon and defining the classificatory systems comprising the main legitimate sources for policy making about health and social intervention strategies at the national and trans-national levels (Fassin & Rechtman, 2009). In this article, we attempt to delve into the processes of constructing this knowledge because we believe that even scientific production, like any human product, is not immune to cognitive bias, which can lead to misrepresentations of the phenomenon (McGann et al., 2011). This is particularly true when dealing with a subject, namely mental health in migrants, which is already elusive in itself, and which, moreover, spans different disciplinary fields and epistemic and professional communities. Whilst this article does not claim to be exhaustive or representative of the scientific debate on the subject, the aim is to provide a critical reflection on the most recent epidemiological and psychiatric scientific literature, starting from the interpretative perspective of the sociology of migration and the medical sociology.<sup>1</sup> Moving from constructivist premises, these two fields of study have been essential in bringing out the social and political dimensions that are involved in both identity and ethnic integration processes and in the development and adoption of classificatory, diagnostic and therapeutic tools within the framework of evidence-based medicine (Bastide, 1965; Pian et al., 2018). The analytical gaze of sociology of migration has consented to focus on the motivation behind migrations, paying close attention to phenomenon's heterogeneity and people's agency: migration is considered in its processual development in which, as we will see in this paper, the post-migration living difficulties (PMLD) seems to play a crucial role. We analyze how theoretical and methodological choices can affect the understanding and representation of the phenomenon and jeopardize the construction and the stability of social and personal identity. Furthermore, we examine how the theoretical choice to identify migrants within the refugee and asylum-seeking populations, a theme in many epidemiological studies, may lead to a distorted representation of the overall phenomenon. Methodological choices, in particular for the frequent use of standardized data collection tools and of cultural insensitive medical classificatory systems, may compromise the phenomenological and etiological heterogeneity of the mental health conditions in this population and expose them to the risk of a medicalizing drift, a phenomenon that has already been significantly discussed in the sociology of medicine with respect to numerous aspects of human life and their translation into medical diagnostic categories (Dew et al., 2016).

## 2 | OVER-REPRESENTATION OF MIGRANT POPULATIONS IN MENTAL HEALTH DISORDERS

Epidemiological studies conducted on migrant populations have determined that immigrants are generally in better physical health than natives. This is the so-called *healthy migrant effect*, which is especially prevalent in the initial months and years of residence in the country of arrival (Close et al., 2016). Physical wellbeing decreases over time as a result of the progressive aging of migrant populations and unhealthy housing and working conditions. The healthy migrant effect also depends on their degree of visibility to social and health services; a certain amount of time passes before migrants develop the knowledge and skills they need to access these. It is only at this point that they become statistically visible and their problems begin to leave traces in clinical studies and scientific reports (Kai Hou et al., 2020; Rivera et al., 2016).

In the field of *mental health*, however, this effect appears to be less evident or even non-existent. It has been proven that immigrants suffer more common mental disorders (CMD), especially depression, post-traumatic stress disorder

(PTSD), anxiety, and serious psychopathological disorders, than local populations (Blackmore, Boyle, et al., 2020; Close et al., 2016). Several epidemiological studies have tried to explain this paradox by focusing on refugees and asylum seekers themselves, the context of their arrival, and on female immigrant populations. In Blackmore et al.'s study (2020), 31% of refugees and asylum seekers suffered from disorders associated with PTSD or depression. A further 11% suffered from disorders associated with anxiety and 1.5% with psychosis. While disorders associated with depression and PTSD seem to be stable among those who have resided in the country of arrival for 4 years, anxiety disorders tend to decrease over time. Even more worrying are the data presented by Close et al. (2016); namely, depressive disorders affected 44% of subjects, anxiety disorders 40%, and PTSD disorders 25%–36%. In Keller et al.'s study (2017) of the Mexico–United States border, 32% of the subjects (from El Salvador, Honduras, and Guatemala) reported symptoms associated with PTSD<sup>2</sup> and 24% with depression. Similarly, Chen et al. (2017) revealed that 31% of asylum seekers in Australia suffered from PTSD.

Disorders associated with PTSD affect 23%–36% of refugee children and adolescents, while 14% and 16% suffer from depressive disorders and anxiety, respectively (Blackmore, Gray, et al., 2020; Close et al., 2016). In Blackmore, Gray, et al. (2020), attention deficit hyperactivity disorder (ADHD) affected 9% of subjects and oppositional disorder 1.7%. Disorders associated with PTSD appear to affect the female migrant population more, especially refugees coming from countries that violate international human rights standards<sup>3</sup> and from the African continent. Suicide rates among asylum seekers are also above average (Patel et al., 2017).

The higher incidence of CMD among asylum-seekers compared with resident populations has emerged from the World Mental Health Survey<sup>4</sup>: disorders associated with depression affect 12% and PTSD 3.9% of the general population but, as we have seen, the figures are much higher for asylum-seekers.<sup>5</sup> Only anxiety (16%) and psychosis (3%) affect refugees to a lesser extent than the rest of the population. Four to five percent of children and adolescents in the general population have CMDs; the figure for the same group among refugees is 14%.

Researchers have also examined the prevalence of post-partum depression syndrome (PPD) among the female immigrant population (although this is not limited to refugees). Using data gathered through the Edinburgh Post-Natal Depression Scale (EPNDS), average rates seem to be similar to the general population (12%), but the figure rises to 19% among women from South Asia and the Middle East (Bulut & Brewster, 2021). Fellmeth et al. (2015) examined the mental health of pregnant immigrant women or mothers of new-borns on the border between Myanmar and Thailand and discovered that the risk of mental disorders was three times greater during pregnancy and the first year of the child's life. Ten to forty percent of the study population was affected.

### 3 | THE LACK OF ISOMORPHISM BETWEEN THE MEDICALIZATION OF THE MIGRATORY EXPERIENCE AND THE PERFORMATIVE USE OF DISEASES

An analysis of the epidemiological literature revealed the difficulty in identifying investigative tools that have the ability to explain the complexity of the phenomenon in question. As Blackmore, Boyle, et al. (2020) and Close et al. (2016) have pointed out, the use of standardized research tools such as the Hopkins Symptom Checklist, the Harvard Trauma Questionnaire, the eight-item PTSD-8, and the Kessler Screening Scale for Psychological Distress (K6) are compiled through self-reports. They have certain cognitive limitations, such as the failure to expand on the living conditions of the respondents (which we will discuss in the next section), as well as translation problems and the cultural interpretation of psychological moods. The option to organize the answers according to standardized diagnostic criteria, in addition to producing high error rates—studies also show very different results—does not overcome the absence of isomorphism between the cultural expression of a state of mind and its clinical interpretation (Devereux, 1970). Illness and diagnostic categories do not belong to the same epistemological domain because the former includes complexities relating to biographical experiences, intersubjective relationships, personal interpretations, and cultural frameworks (Beneduce, 2007), while the latter comprises abstract categories and proprieties developed through codified procedures by scientific communities and research entities in (mostly) Western countries (McGann et al., 2011). The

overlapping of these two different systems of meaning determines the *medicalization* of the migration process, which is codified as merely a risk factor, underestimating its biographical dimension. Medicalization, that is, the juxtaposition of a medical category with a social behavior or a personal condition such as hyperactivity, drug addiction, or migration, can easily become an instrument of control and population containment if there is no awareness of the ethnocentric nature of the phenomenon (Lusardi, 2019). Additionally, Gutierrez-Vazquez et al. (2018) claim that the absence of any kind of “selection” in the country of departure is the main explanation for the higher diffusion of CMD among the immigrant population, and similarly with physical health. Other researchers (Rousseau & Frounfelker, 2019) have suggested that the entire immigrant population should undergo PTSD disorder screening soon after they arrive in the host country.

Medical semiotics assumes that disorders associated with bodily functions are linked with the malfunctioning of the organism or psyche, without considering the process of attention, interpretation, narration, and social presentation of the relationship with one's self (Beneduce, 2007). Subsequently, the manifestation of a symptom is not simply biological and objective data. Instead, interpretation is always required, and its meaning is constantly socially negotiated (Kirmeyer & Sartorius, 2007). The lack of awareness among healthcare professionals and policymakers of the structured and structuring nature of medical knowledge (Bourdieu, 1972) risks the production and reproduction of deceptive and ethnocentric categories (Kleinman, 1988) that can affect migrants' quality of life and the intercultural dimension of care (Sicot & Touhami, 2015).

The procedural choices (i.e., data collection and protection of the rights of the people interviewed) and practices (i.e., methodological criteria and tools) involved in a scientific study affect both the data interpretations and results and the ethical positioning of researchers with respect to the subjects, about whom knowledge is being produced (Caldairou-Bessette et al., 2017). Culture and health should therefore not be regarded as two distinct and separable domains but as interconnected and representable heterogeneous sets of personal and institutional practices (Bourdieu, 1972); cognitive models (Douglas, 1986); narrative forms (Berger & Luckmann, 1966); and patterns of social interactions (Goffman, 1967). The theoretical construct of *acculturation stress* is thus particularly problematic (Berry, 1997; Berry & Sebatier, 2011). Acculturation stress can be traced back to the distance from the social context of origin and the protective function of traditional culture and the effort required to understand and apply the cultural codes of the country of arrival (Zajde, 2011). Carta et al. (2005), for example, in their systematic study of migration in Europe, define migration as an experience of loss and upheaval.

This suffering, which has been described as chronic and multiple stress syndrome in immigrants (or Ulysses syndrome), comprises seven dimensions: family, status, friendships, language, culture, home, and ethnic group. For the authors, the absence of these elements of rootedness exposes deprived individuals to the risk of mental disorders. Another point of view is that one presented in Nap et al. (2015) studies. They have examined acculturation among immigrants from Turkey, Surinam, and Morocco in the Netherlands. While the Surinamese seemed to be well integrated into Dutch society and the Moroccans discreetly so, the Turkish population was more closed and traditionalist. According to the authors, the conservation of traditional values and habits among the Turks led to acculturation stress, which helps to explain the high rates of mental disorders among that group. To overcome the negative effects caused by cultural distance, some have encouraged the use of medical and nursing staff with the same migratory background or planning clinical interventions for the entire ethnic community (Salami et al., 2019). However, this culturalist perspective risks amplifying the importance of the relationship between people and place of origin and nationalist or ethnic rhetoric (Malkki, 1995), while, the chance of developing symptoms and their incidence seems to be linked to different social variables, for example, the reason for migration, cultural remoteness, and the ability to mediate with the social structures in the country of arrival (Fassin & d'Halluin, 2005). Indeed, it may be useful to consider the phenomenon of internal migration, or movements that take place within the same national context, often from agricultural to urban contexts, with the aim of undermining long-standing nationalist prejudices linked to colonial history that still afflict the psychological and ethno-psychiatric disciplines, as Beneduce (2007) has observed. The aforementioned studies highlight the social suffering that results from new environmental, housing, and working conditions, and participation in the local community in an urban context (Miao & Xiao, 2020; Xiao et al., 2018).

Other studies that stress the social and psychological suffering of family members (especially minors) who remain in the country of origin after a family member has migrated are also relevant (Vathi & Duci, 2016; Wu et al., 2015). In these situations, the trauma caused by migration has not only clinical connotations; the uprooting from the country of origin and the biographical experience of the reconfiguration of affective relationships within the family context must also be considered. Overcoming the culturalist interpretation also makes it possible to devote greater attention to individual agency and personal ability to develop strategies of resilience and the *strategic use* of disease and the associated medical categories. The extant literature has also verified that immigrant populations are highly resilient (Antoniades et al., 2018), especially when they are young and connected with the family or the ethnic network, when they have good schooling, and when they have a legitimate residence permit; contrary to what some may believe, the opposite applies in 80% of cases.<sup>6</sup>

Resilience has been studied in temporary detention camps located in Turkey (Loyd et al., 2018), a country with one of the highest numbers of refugees. Several NGOs are engaged in assisting refugees and in initiating procedures for issuing humanitarian visas or political asylum. Registration, protection, and administration rely on what Ticktin (2011) called the *medicalization of political experience*, that is, the use of medical-psychiatric knowledge and operational tools to categorize migrants and thus guide the outcome of requests; at the same time, this is the context in which migrants may return to the strategic and performative use of the disease to facilitate civil and political recognition (Fassin & d'Halluin, 2005). Moreover, Fassin and Rechtman (2009) defined *bio-legitimacy* as the strategic accentuation of one's mental suffering. The incorporation of social processes (Csodas, 1990), in which the immigrant or refugee participates, leads to an active transformation of one's location in the world and a strategic and performative use of the disease, which can become an instrument of *social claim* (Wang, 2018). Therefore, the macro-social dimension that characterizes migration as a global phenomenon, which is associated with a model of *moral economy* (Fassin, 2011) that includes world consumption and labor market systems, impacts both the micro-social dimension of interactions and the process of identity construction (Bottura & Mancini, 2016; Fassin & d'Halluin, 2005).

#### 4 | POST-TRAUMATIC STRESS DISORDER: BETWEEN PREVIOUS TRAUMA AND LIVING CONDITIONS IN THE COUNTRY OF ARRIVAL

The scientific literature has addressed, in particular in the epidemiological and medical fields, the topic of the mental health of migrant people on the basis of the phenomenology of vulnerability that first considers refugees and asylum seekers, and among them women and children. The migratory process as a wider and more complex phenomenon has been analyzed in five principal dimensions: personal/family, political, economic, social, and cultural (Massey & Sánchez, 2010). Refugees are a small minority and account for around 3% of all international migrants in high-income countries, 25% in middle-income countries, and 50% in low-income countries.<sup>7</sup> Most refugees and asylum seekers live in conflict areas such as Turkey, Lebanon, Palestine, Jordan, Uganda, Pakistan, and Colombia, while less than a quarter of all international migrants are found in countries of the Global North, such as the United States, Europe, Canada, and Australia, in which the majority of epidemiological and medical studies have been conducted. Such over-representation leads to an underestimation of the complexity of other migration experiences; for example, male migrants are considered to be less vulnerable than others in the same position (Arsenijević et al., 2018). Another shortfall is the over-representation of incidences of previous traumatic experiences in the development of social suffering in migrant populations; refugees are trying to escape from war, political conflict, and discrimination, and this often forces them to face long journeys along routes of exploitation, on which they can be subjected to further harassment.

To improve this representation, it might be useful to look at the living conditions in the destination country. Several studies have illustrated that social suffering increases with the length of stay in the country of arrival, mainly because of living conditions (Kai Hou et al., 2020; Rivera et al., 2016). The mutual relationship between pre-migration traumatic experience (PMTE) and PMLD seems to contribute to either an improvement or worsening of the person's

well-being. Nevertheless, not all those who have been subjected to trauma develop serious illnesses, but stressful living conditions (which affect all international migrants, not just refugees) seem to have a more significant statistical correlation (Bilecen & Vacca, 2021; Chen et al., 2017). A confirmation of this hypothesis can be found in foreign populations over the age of 65 who have resided in their country of arrival for more than 10 years (Flores Morales, 2021) and in studies of processes of re-traumatization that can aggravate psychotic disorders caused by childhood traumas or generic factors (Bas-Sarmiento et al., 2017). Further confirmation comes from a study carried out in Sweden by Linder et al. (2020), in which half of the patients diagnosed with a mental disorder belonged to the poorest fifth of the population and had lower schooling rates. However, a migratory background does not seem to affect the presence of diagnoses.

The stressful and precarious living conditions faced daily by the foreign population and asylum seekers in the country of arrival have been classified in a daily stressor model (DSM), which includes reduced social capital, stigmatization and discrimination, and little-to-no accessibility to welfare services (Kai Hou et al., 2020). The legal status of the foreign person or refugee can be unstable for several years, both because of job insecurity (which can affect the non-renewal of the residence permit) and the length of bureaucratic processes, which are often marked by variable degrees of arbitrariness. This precariousness affects the well-being of the foreign person, as the study conducted by Massimiliano Aragona et al. (2020) regarding Chinese refugees residing in Italy shows: the decrease in social suffering is related to obtaining legal refugee status. With regard to social capital, distance from the family unit, especially that between parents and children, has an undoubted negative effect (Keller et al., 2017). The existence of a wide, well-structured ethnic community can have ambivalent effects. Living with co-ethnics could have a positive effect because it can buffer the potential detrimental effect of discrimination thanks to ethnical and relative solidarity (Alba et al., 2018). However, the presence of the ethnic community could provoke some negative effects for individuals because it may encourage self-stigmatization and closure to local culture. This also has the ability to damage relations with welfare services (Bettmann et al., 2015), especially when mental disorders are associated with substance abuse (McCann et al., 2018). Consequently, it is advisable for immigrants to cultivate both dense social networks within the ethnic group to which they belong and more extensive relationships with wider civil society, for example, through participation in neighborhood associations, training courses, work experience, and cultural initiatives. To use the terminology elaborated upon by Robert Putnam (2002): the *bonding* function of share capital should always be combined with a *bridging* function. The incentive to participate in the horizontal dimension of social capital can also alleviate the negative effects of low participation in the vertical dimension (i.e., contact with institutions and centers of power) caused by the legal status of the immigrant person (Sundell Lecerof et al., 2016).

A reflection on the mental health of the foreign population, in addition to considering individual characteristics such as legal status and personal social capital, cannot fail to take into account how the organization of health services, tools, and procedures affect accessibility and patient behaviors (Quaglia et al., 2020), as well as the development of a degree of trust in the welfare system of the country of arrival (Terraneo & Tognetti Bordogna, 2018). Difficulties in accessing services seem to be linked to a lack of knowledge of the organization of the health system and the bureaucratization of access procedures, as well as language barriers (Guégan & Rivollier, 2017); indeed, linguistic intermediation and educational skills play a fundamental role in promoting access to care (Béal & Chambon, 2015; Pian et al., 2018). Nevertheless, the low rate of use of health services is not only associated with language barriers, but also socio-political phenomena, racism, and discrimination. The scientific literature often underestimates the impact of racial segregation on social suffering and poor access to health services, especially among non-black minorities (Yang et al., 2020). Discrimination is not only apparent in access to services, but also the quality of the care those services offer (Satinsky et al., 2019). They usually provide more medicalized treatments for the foreign population, compared with those for the natives, and guarantee security and public control in contexts of greater tension and social conflict (Younis, 2021).

Finally, discrimination affects the workplace in particular (Di Napoli et al., 2017). In recent years, there has been an overall deterioration of the labor market: lower wages, greater competition, and precarious and often unhealthy working conditions are common. This situation produces systemic inequalities whose effects harm the foreign

population in particular, especially since work is often the main motivation behind migration, and personal and family expectations are involved. It is no coincidence that personal well-being often worsens as a result of the loss of work. Past economic and financial crises have affected the foreign population three times more than the native population (Massey & Fischer, 2000). In conclusion, the suffering of migrant people not only comes from the political conflicts, social violence, or economic deprivation from which they want to flee. Instead, suffering exists between the country of origin, passage, and arrival, and in relation to the agency of each person (Loyd et al., 2018). The deepening of the relationship between mental health and living conditions in the country of arrival, as well as the overcoming of the biomedical paradigm and culturalist interpretations, mean that psychological well-being and suffering intersect different dimensions, including biological, emotional, cultural, social, economic, and last but not least, political (Bastide, 1965; Farmer, 2003).

## 5 | CONCLUSIONS

In this article, we wanted to interrogate the scientific literature to analyze the way in which it approaches the issue of mental health in migrant populations. Indeed, political decision-making typically finds its rational basis and legitimacy through recourse to scientific expertise (Fassin & Rechtman, 2009; McGann et al., 2011). This is particularly true when the problem at hand concerns health and medicine. In the analysis of the literature, three trends emerged that may negatively influence the understanding of the phenomenon and the policy decisions taken on this erroneous basis. The first concerns the representation of the phenomenon: the characteristics, needs and resources attributed to migrants. The phenomenology that can be found in the epidemiological literature returns a population flattened across refugees and asylum seekers. This is indeed a very fragile and vulnerable population which requires specific attention, but it is also highly limited in number. Extending the results of studies carried out on samples composed by refugees and asylum seekers to the entire migrant population risks misunderstanding the phenomenon's heterogeneity and people's agency: specifically, the actual motivations that initiate the migratory path are concealed, the real migratory trajectories are hidden, and personal and social resources are underestimated. A second trend that can have problematic implications concerns the distance that exists between the reality known through quantitative instruments and the real health conditions of people, especially in such a heterogeneous and changing field as PMLD. Sample surveys are essential in understanding the distribution of a phenomenon and testing hypotheses about how it works. However, they are useless in their attempts to grasp it in its idiographic dimension, which aims to capture the living conditions of people in their context of life—lifestyle migration as comprehensively as possible (Benson & Osbaldiston, 2016). Furthermore, in order to overcome stereotypes, it is also essential to interrogate the empirical field with tools that are able to render unprecedented and intrinsic characteristics. Relying exclusively on standardized data collection methods significantly restricts the effective understanding of the phenomenon, as has begun to be discussed within the medical community (Greenhalgh et al., 2016). The third trend, linked to the second, concerns the medicalizing drift that may result from applying standardized classification systems typical of the medical-psychiatric epistemic domain to such a heterogeneous and changing field such as this. The development of evidence-based medicine, the current dominant paradigm in the medical-psychiatric area, favors the proliferation of such classification systems as decision-making supports for diagnosis and therapeutic purposes (Lusardi, 2019). The literature has already evidenced that these tools can enable reductionist readings of the actual conditions they seek to classify. Thus, behaviors and conditions linked to exceptional biographical experiences and/or to unfamiliar cultural backgrounds can be brought (even with the best of intentions) within pre-established cognitive categories which, on the one hand, help to place the problem and the person within the framework of the national health system, but, on the other hand, also force their identity and actual needs to fit within the medical domain and to healthcare organizations (Ticktin, 2011).

From this literature analysis, several future research directions could also be drawn. More research is needed on the mental health issue among undocumented immigrants and how the sociopolitical process of “illegalization”

could affect undocumented migrants' wellbeing (De Genova, 2022). Another topic, related to the first, concerns the heterogeneities across healthcare systems in countries in the Global North and how these heterogeneities produce great differences in accessibility and mental health treatment for migrants. Indeed, the immigrant, even after living in the country of arrival for many years, experiences discriminatory living and working conditions that create stress and social isolation and militate against inclusion. The societies in the countries of arrival are therefore called upon to reduce the impact of discrimination and social injustice and facilitate agency and resilience among immigrants. This would allow them to use welfare services to their full extent and participate in civil life. To move in this direction, appropriate theoretical approaches and heuristic tools should be developed (or used more widely if they already exist) to reveal the complexity of the migratory phenomenon in its health declinations. The temptation to use cognitive lenses that—although just as effective as standardized and/or universally codified indicators—tend to lead to misunderstandings of the political and symbolic-cultural dimensions of the concrete life trajectories and living conditions of migrants must be resisted.

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### ENDNOTES

- <sup>1</sup> We considered the most recent scientific articles (inception January 2015) published in psychiatric and epidemiological journals; the broad (free text) string search “Migrants” OR “Immigrants” AND “Mental health” OR “Mental illness” AND “Vulnerable migrants” OR “Migrants agency” was applied to the Google Scholar database. As inclusion criteria, we considered thematic relevance, the journal's rating in the field of reference, and the number of citations of the article.
- <sup>2</sup> PTSD afflicts those who have been exposed to an event that qualifies as a “traumatic” stressor (i.e., threats or experiences of death, injury, or sexual violence) and who present with persistent and distressing symptoms that fall within three clusters: (1) repeatedly re-experiencing the trauma; (2) avoidance of activities and stimuli associated with the trauma; and (3) heightened arousal, such as irritability. From its inclusion in the DSM-III (1980), PTSD is a complex and problematic category that derives from a historical process of the reification of trauma and social suffering (Beneduce, 2016).
- <sup>3</sup> The list of these countries is contained in the Political Terror Scale, which is based on annual reports on human rights practices published by Amnesty International, the U.S. State Department, and Human Rights Watch (<https://www.politicalterrorscale.org>, accessed 05.11.2021).
- <sup>4</sup> <https://www.hcp.med.harvard.edu/wmh/>, accessed 05.11.2021.
- <sup>5</sup> The percentage of PTSD disorders is 8.8% among the native Northern Irish population. The main explanation for this can be traced back to the decades-long political and social conflicts in Ireland as a whole.
- <sup>6</sup> <https://www.ohchr.org/EN/Issues/Migration/Pages/StudiesAndReports.aspx>, accessed 05.11.2021.
- <sup>7</sup> <https://www.unhcr.org/news/press/2020/12/5fcf94a04/forced-displacement-passes-80-million-mid-2020-covid-19-tests-refugee-protection.htm>, accessed 05.11.2021.

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