People seeking asylum in the United Kingdom have had a wide range of experiences, and they have reacted to these in many different ways. Having reached the point of claiming asylum, most people's internal and external worlds are likely to feel unsafe and uncomfortable. The asylum system itself then has powerful effects.

Before the detailed discussion of how mental health care and support can best be offered to those who do come for help (Chapters 5–11), we are going to raise some questions about the prevalent models for understanding their experience and how we may expect them to have reacted to it. We will discuss alternative perspectives to ‘trauma’ and ‘illness’ in recognising the profound disruptions that have affected people, and the readjustments they are trying to make.

Although everyone seeking asylum will have their own unique life story, they all arrive with dislocation, multiple losses, and uncertainty about the future in common. Almost all will have experienced or witnessed violence, some will have suffered sexual violence, and some will have been tortured. All have lost their homes, wider social networks, and social status, but it may only be on arrival here that the specific shared experience really begins – the engagement with the asylum system and all it entails. People’s experience of this system then becomes a powerful determinant of how they process all that has happened before.

Some may well have had positive, affirmative experiences along the way too: acts of kindness, new intimacy, discovering unexpected strengths, being able to help others. Their challenge has been to find a way to carry on living, and perhaps to grow and develop as a consequence, rather than be overwhelmed and disabled by what has happened and is currently happening to them. Simply having reached the United Kingdom has been, for most, the result of many determined acts of survival. Others, less lucky or with fewer resources, will not have made it.

Critiquing the ‘trauma and illness’ model

Advocates for those who seek asylum may, at times, portray them as vulnerable, ‘traumatised’ victims, in need of services and support. This is, of course, part of the truth, but not all of it. Sometimes issues that are not thought of as having been trauma will be more important to people, such as bereavement or separation. There is also a risk that people can only be thought
of as needing help if they are victims, not if they show signs of strength and independence – perhaps the very strength and independence that has enabled them to reach the United Kingdom.

The word ‘trauma’ has a wide popular usage, often with an implication that its meaning is self-evident. Often, though, there is confusion or imprecision as to whether it is the event itself or the person’s response that is being referred to. Going back to basic definitions, a trauma may be either a wound or injury, or the act of being wounded. Sometimes ‘trauma’ is used to describe the actual event that causes a wound, rather than the wound itself – but of course not every assault causes a wound, even if many do, and that does not necessarily diminish the seriousness of the assault.

The too-ready use of the words ‘trauma’ and ‘traumatised’ risks presupposing the effect of the experience on the person and pathologising normal responses. It creates a set of expectations about how a person should feel and behave that, if not met, may limit their access to assistance and even cause their credibility to be called into question.

If one person has strengths and coping skills that another does not, does this mean that they have necessarily endured or suffered less? A further complication is that some events seen as ‘traumatic’ in some communities, such as in the affluent West, may be part of daily life in the community from which someone seeking asylum originates. This does not, of course, mean that such events will be without adverse effects, but the event, and its impact, will be psychologically constructed in a very different way.

In addition, the word (as well as the concept) ‘trauma’ may not translate easily into the languages spoken by those seeking asylum, which creates a challenge, especially when working professionally or therapeutically with them. As an example, ‘trauma’ translated into Arabic relies upon words that more readily equate to shock or stress/distress. These do not have the same connotations as ‘trauma’ does in English, or English-speaking cultures, and can sound odd and artificial when used as substitutes.

For all these reasons, throughout the book we generally refer to ‘adverse experience’ rather than ‘trauma’. This may sound an overly neutral or understated term – but this very neutrality creates an onus of explanation as to what, exactly, someone’s adverse experiences were, rather than relying upon a ‘catch all’ term with an immediate emotional impact, but with many inherent assumptions and possible confusions.

The wide range of possible reactions to adverse experience has both individual and collective roots – and we need to be careful how we describe and distinguish these. In this context, another difficulty with the ‘trauma’ discourse is that it places the person’s suffering in an individual realm of illness or damage. Yet, many events and experiences that are termed ‘trauma’ occur in a social and political context. In their book *The Empire of Trauma* (2009), Fassien and Rechtman, each of whom is both a psychiatrist and an anthropologist, explore ‘the politics of suffering’, noting that reference to trauma can obliterate other aspects of an individual’s experience and what has happened, defining an outcome and reducing it to a set of symptoms. They note that this Western psychological framework may silence other realities. Power is held by a growing number of ‘trauma experts’ who diagnose what has happened, and Fassien and Rechtman eloquently question the loss of dignity that is suffered when someone’s word and experience seem to need to be validated by a doctor or other professional.

At the same time, the popular use of the word ‘trauma’ has expanded to cover many forms of distressing experience, and at times ‘post-traumatic stress disorder’ (PTSD) is depicted as almost synonymous with any emotional upset resulting from life’s difficulties. In professional usage, PTSD is, of course, more tightly defined, but it remains a contentious example
of reactions to adversity being individualised and medicalised. This ‘medicalisation’ is not necessarily done by doctors!

In current practice, the usual focus for mental health services working with people who have suffered serious adversity is the assessment for, and the diagnosis and treatment of, ‘psychiatric disorder’, such as PTSD, depression, and anxiety. There are some difficulties, both theoretical and practical, with this paradigm. Clinical diagnoses may be a helpful practical tool for identifying sets of difficulties, with the intention of offering help, but they are only one perspective to draw upon in understanding what it feels like to be seeking asylum. What happens when we experience adversity? What happens when our lives are turned inside out? What happens when we are the (perhaps unwelcome) guest of another? When our lives, and the stories we tell about ourselves, are scrutinised? The ‘illness’ narrative offers some answers to these questions, but other narratives are available.

Broad challenges to the pathologisation of behaviour and experience featured prominently in the ‘anti-psychiatry’ controversies of the mid-twentieth century, and these remain a powerful perspective on all psychiatric diagnoses. Individual biological approaches ignore the intersectionality of such matters as gender, power, and discrimination – yet this wider context needs consideration when thinking about our responses to adverse events.

Even within the clinical paradigm, there are many ways of understanding what drives or maintains the associated symptoms, such as Ehlers and Clark’s cognitive theories, Brewin’s dual representation theory and Foa’s fear conditioning theories (Nijdam and Wittmann, 2015). Yet, there is no simple answer as to why some people face enduring disturbances and why some people recover. There is a rich range of potential variation, and so any ‘one size fits all’ approach will be limited in its impact. R. D. Laing (1967) noted that things are meaningful in their context and relationships, and this is an important consideration when thinking about the responses to adverse events of those within the UK asylum system. The stories that are often missing or lost in a mechanistic ‘diagnostic’ approach involve paradigms of adversity that place it within wider social, cultural, ecological, and political domains.

Ignacio Martin-Baro, the ‘liberation psychologist’ who developed a social model of trauma, notes that ‘mental health and illness are both a part of, and a result of, social relationships. The question of the mental health of a people leads us to analyse the specific character of their most common and significant interpersonal and intergroup relationships’ (Martin-Baro, 1996, p. 111). The radical psychiatry movement would view trauma and expressions of related distress as arising from oppression and alienation, being victimised by the social, political, and economic systems in which you live (Steiner, 1975). The ‘Power, Threat, Meaning’ framework (Johnstone, Boyle, et al., 2018) is another relatively new development that considers how messages from wider society can increase our feelings of shame, self-blame, isolation, fear, and guilt, and offers another way to classify experiences that brings social aspects to the fore.

We humans have been designed to be able to respond to threats to life. What is considered a traumatic event by me may not be considered so by you, nor will we react in the same way, even if we share the same perspective. Adverse life events do not necessarily lead to diagnosable psychiatric conditions.

How we experience such events, and how we express ourselves, may look vastly different; there is no inevitable outcome following devastating events. Our individual differences are shaped by a range of factors, including the personality we have, the lives we have led, the communities we are part of, the connections we make, the circumstances we live in, the power we hold, the resources we can access, and our sense of hope for the future.

One of the authors (NM) once read a ‘Reason for Refusal’ letter from the Home Office in which the asylum decision-maker commented on the client’s mental well-being and stated that
(to paraphrase) they did not believe that someone would respond in this way to the experiences described. This opinion was then used in determining credibility. It is important for us to accept that our subjective views are influenced by a wider systemic framework. Discourses on how people should experience their hardships influence our responses, just as discourses on who is a ‘deserving’ or ‘undeserving’ migrant influence our reception and service provision.

Some events, for example a violent bereavement (such as seeing your parents murdered) or life-changing personal injury, will have a major impact on us all but, even then, there will be significant differences in response. One person may be possessed by their need for vengeance, whereas another may try and accommodate to ‘the will of God’ or offer forgiveness. Similarly, if subject to persecution or other threats, one person might stay put, whilst another might flee. One person may become embittered and preoccupied with what has happened; another might be catalysed into reparative action, greater intimacy with those around them, or creativity. None of these responses means that an event has been any less, or any more, potentially damaging. The impact is in many ways a function of the person’s personality, with its multiple roots and components, both personal and collective.

Some alternative models

Following adverse events, we typically undergo some adjustments. These may, for example, involve experiences of emotional numbing, intrusive thoughts, hyperarousal, insomnia, or nightmares. Such adjustments are often transient in nature and dissipate over the following weeks or months. Such resolution, of course, depends upon the adversity itself having resolved. For people seeking asylum, their psychological disturbance may in fact be prolonged by a set of acute and chronic circumstances, which we will discuss later.

As well as the wider social and political narratives, biological understandings that draw upon our nature as animals may also be of help clinically, in offering alternative readings of people’s experience. It is always useful to have broad theoretical leverage in forming clinical hypotheses before testing them in practice – so long as our theories are not thought to be ‘objective’ truth.

Attachment theory

Attachment theory roots our behaviours and internal experience in the instinctive attachment to our caregivers. Humans, in common with other animals, experience contentment in proximity to, and distress at separation from, those to whom they are attached. We develop our understanding of ourselves and others within our early caregiving relationships, as well as our ability to think and to manage emotions. As adults we continue to have powerful instinctual drives to seek proximity to those we feel attached to, especially when under stress.

In this way of thinking, our capacity for reflection, our confidence, and our positions of optimism or pessimism are shaped by our early attachment experiences. Our attachment styles shape our later internal and external experiences of safety and danger, and our reactions to offers of assistance that come our way. The nature and quality of one’s attachment, both in life and as they have been internalised, is also intimately related to ‘narrative competence’ (Holmes, 1993): the ability to tell the story of one’s life, and of the family or community in which one lives. If our early attachments have been compromised by fear and insecurity, amongst many other things, this will shape our responses to adverse events that come later – and our ability to describe what has happened.

Involuntary dislocation and the loss of home, family, and friends disrupt both our external and internal attachments, which are the foundations of our sense of self. Our linguistic, emotional, cognitive, and behavioural contexts are all lost – and much consequent distress may
be understood from this perspective. In time, new attachments need to be formed, to other people, groups, and places – and the opportunity to establish such powerful connections may go a long way towards relieving distress.

When thinking about emotional regulation in general, it is important to consider the impact of shared historical narratives and dynamics on both the individual and the community’s ‘here and now’ experiences. Many communities have oral traditions that share stories of conflict, discrimination, oppression, poverty, and disease. The impact of these histories on future generations needs to be held in mind when considering responses to further adversity. Unresolved loss, previous adversity and ongoing fear all impact on attachment patterns. This can be shared across generations through traditions, stories, observational learning, witnessing of parental behaviours, and our minute-to-minute interactions with others. Often, multigenerational disturbance has been mediated by insecure attachments in conjunction with violence, health-limiting behaviours such as substance use, and a sense of hopelessness. There is a growing body of literature informing debates on multigenerational experiences of adversity, looking at such issues as the Holocaust, the Nakba (the mass exodus of Palestinians that led to their displacement today), and the experience of Indigenous communities across the globe. On a field trip to Palestine by one of the authors (NM), nearly everyone encountered had a family member who was in prison, many others had family members who now lived abroad, and everyone had a family story of Nakba. It was profoundly moving and troubling to witness a child of thirteen talking about growing up to become a martyr. At times we work with communities who collectively experience a wound. As one person on the field trip put it, ‘where is the “post-” in these experiences?’

**Affective neuroscience**

Affective neuroscience (Panksepp, 2010) has broadened the conceptual framework used to think about how our instinctual endowments affect internal experience and behaviour. Attachment and nurturing behaviours are seen as aspects of seven basic ‘emotional command systems’ that shape our reactions to our earliest experience, and the way our personalities develop (Panksepp, 2010; Mizen and Hook, 2020). The systems have been mapped in anatomical, neuropharmacological, and functional terms, in a way that emphasises the connections between the different paradigms.

Much study of the effects of adversity, framed as ‘trauma theory’, focuses on neuroanatomical and neurophysiological correlates of symptoms, as a means of both refining concepts and designing possible treatment interventions. Therapeutic methods have evolved from a variety of such understandings, such as the widely employed ‘polyvagal theory’ (Porges, 2009). However, as has already been discussed, critics contend that the concentration upon the ‘scientific’ can facilitate turning a blind eye to the other determinants of distress and disadvantage, such as the social and political.

Leaving these issues aside for now, the essential idea of affective neuroscience is that instinctual drivers are ‘centre stage’ when we emerge into life, powerful but not rigidly fixed in how they operate. They shape our reaction to our earliest experience as our personalities start to develop. We then learn from, and adapt to, novel experiences and their consequences accordingly throughout our lives. Everyone’s predisposition to certain patterns of functioning, in terms of these command systems, will influence both the types of experience they are likely to seek out or bring about, and the ways in which they are liable to respond to them.

Involuntary migration, leaving home in difficult circumstances and heading into unfamiliar terrain and experiences, will activate a plethora of instinctive behaviours. The systems proposed by Panksepp are part of what a mammal automatically falls back upon in situations
of novelty and challenge, when routine and prior experience cannot be relied upon. They may come into powerful play when danger threatens or takes its toll. These are the situations where people discover things about themselves that they ‘never knew’ – and, in myth, art, and literature, they are scenarios long associated with personal and spiritual growth and the development of wisdom. At the same time, people may also discover things about themselves that they are uncomfortable with, such as a capacity for ruthlessness and self-interest when survival is under threat – and some may struggle to come to terms with this afterwards.

Grief and growth

The widely recognised and well-understood role of grief as a healthy means of processing loss suggests a useful alternative paradigm. Grief is recognised as normal, healthy, and necessary – despite all its attendant desolation and distress. It is a process with a purpose, not a static set of symptoms. Commonly used models include those of Elizabeth Kubler-Ross (1969), and the ‘Dual Process’ model (Stroebe and Schut, 2001), which is helpful for its idea of oscillations between being loss-oriented and restoration-oriented.

By grieving we come to terms with the loss of those to whom we are deeply attached. Each person's grief is different, but it is made up of largely recognisable components, and its essence is the movement between various states of mind whilst readjusting to a new reality, both internal and external. Not all stages are required, nor need they arise in any specific order, but there is an overall shape to the process which we all share when we go through it. The distress and disturbance become gradually less consuming with time, as a position of acceptance is reached. People may sometimes be depleted and chronically disabled by bereavement, but more usually they integrate it into ongoing daily life, and frequently they find it an opportunity for psychological growth and development.

There is as yet no widely accepted analogous model for the psychic integration of life-changing adverse experience – exemplified by the fact that there is no well-recognised name for such a process. However, growth following adversity is well-recognised, both anecdotally and academically. ‘Post-traumatic growth’ (Tedeshi and Calhoun, 2004) is a term used for positive psychological change experienced following adversity and other challenges, when an individual's adaptive resources and ways of understanding the world and their place in it are put to the test. As a result, there can be ‘life changing’ shifts in thinking and relating to the world, which may also affect someone's sense of self and the way they attribute meaning. This goes some way towards the formulation of a process analogous to grief, although it emphasises growth, rather than (for example) mourning and acceptance. It is, however, an important idea in that it emphasises that doing well after adversity is more than a simple issue of showing ‘resilience’, often understood as the ability to survive and maintain the status quo. Renos Papa-dopoulos (2007) has additionally coined the term ‘adversity-activated development’, which emphasises that any personal growth may be a direct result of the adversity itself, rather than ‘post-traumatic’ and due to having been wounded in some way.

There has also been some thought given to the protective function of the PTSD-complex symptoms from an evolutionary perspective. Here, psychological and behavioural responses that are often identified as ‘symptoms’ are also understood in terms of their survival function. Key symptom groups involving avoidance and hyperarousal may have important self-protective value whilst danger prevails, whilst re-experiencing can be interpreted as an ongoing process of ‘digestion’, integrating new, powerfully disruptive experience into pre-existing cognitive structures, both to prepare the person for future encounters with the same or related threats and to challenge ultimately unrealistic beliefs about the benign nature of the world or one’s own invulnerability (Silove, 1998).
Helpful as the ideas of post-traumatic growth and adversity-activated development may be, there is a risk that they may be seen as minimising or disregarding the damaging and destructive aspects of experiencing or witnessing horrific things. Whilst this is in no way what is being implied, any discussion of possible positive outcomes needs to be approached with sensitivity and care. Not everyone, by any means, can identify positive outcomes to their suffering. Some of us carry a sense of damage, of being wounded, for the remainder of our lives – and many more of us carry both the positive and the negatives, perhaps in tension, and not necessarily integrated. Clients have often talked of being both sick and well at the same time.

Box 3.1 summarises some of the ideas discussed herein that may be useful in considering psychological responses to adversity.

<table>
<thead>
<tr>
<th>Approach</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Trauma theory’ and PTSD</td>
<td>Offers a well-established empirical framework for identifying and responding to specific needs that, if undiagnosed or misdiagnosed, may be ignored or responded to inadequately. Applications draw on a number of understandings, including neurophysiology, neurochemistry, and cognitive science.</td>
</tr>
<tr>
<td>Cognitive psychology</td>
<td>Formulations focus upon disruption or damage to established cognitive structures (such as beliefs about oneself or the safety of the world), in addition to more diffuse distress. ‘Trauma-focused’ therapy draws largely on such formulations.</td>
</tr>
<tr>
<td>Socio-political understandings</td>
<td>Mental health and illness are both a part of, and a result of, social relationships. ‘Trauma’ and related distress arises from oppression and alienation in interpersonal and intergroup relationships, such as being victimised by the social, political, and economic systems in which you live.</td>
</tr>
<tr>
<td>‘Liberation psychology’</td>
<td></td>
</tr>
<tr>
<td>‘Power threat meaning’ framework, and others</td>
<td></td>
</tr>
<tr>
<td>Attachment theory</td>
<td>Attachments influence how people cope with adversity, with new environments and with offers of help. Each person needing asylum has had their external and internal attachments disrupted, experienced according to the nature of their pre-existing internalised attachments.</td>
</tr>
<tr>
<td>Affective neuroscience</td>
<td>Situations that threaten our equilibrium activate automatic physiological changes with accompanying emotional and behavioural responses. Extreme situations can lead to people discovering aspects of themselves they were unaware of, and may even be shocked by, but are part of the normal human repertoire.</td>
</tr>
<tr>
<td>‘Intergenerational trauma’</td>
<td>Adversity affects future generations. Attachment relationships, community narratives, and ongoing adversity mediate this.</td>
</tr>
<tr>
<td>Healthy ‘physiological’ adaptation to life-changing adversity</td>
<td>We lack widely accepted theories of overall adaptation in response to complex adversity, or even a readily recognisable name for such processes. Models of grief may provide a helpful analogy.</td>
</tr>
<tr>
<td>‘Post-traumatic growth’ Adversity-activated development’</td>
<td>Adversity may lead to psychological growth (and wisdom) as well as harm.</td>
</tr>
</tbody>
</table>

Psychological symptoms after adversity

Despite the limitations of the diagnostic model discussed here, it does offer a well-established way of codifying people’s suffering. Awareness of the critiques is important to inform how it is deployed, but they do not mean that the approach has no value, if used thoughtfully and with an understanding of its limitations.

Again, we must think about what is implied by the use of specific words. In the context of mental health and illness, someone’s overall state is thought about in terms of the presence
or absence of ‘symptoms’, which may be specific behaviours or reports of internal experience. However, even the use of so apparently straightforward a term as ‘symptom’ carries a value judgement and is culture-bound.

The ‘symptom’ is usually defined along the lines of ‘a feeling of illness or physical or mental change that is caused by a particular disease’ or, more broadly, ‘any single problem that is caused by and shows a more serious and general problem’ (Cambridge Online Dictionary: https://dictionary.cambridge.org). We lack any readily comparable word that conveys a more neutral sense, to indicate a similar phenomenon that is not inherently pathological and may even be developmental. In addition, people from different cultures might label their experiences differently, or may not even have words for things that we place great significance upon in the affluent West. The idea of ‘feelings’ themselves is in many ways culture bound. However, for want of a better concise and readily understood term, we will continue to use ‘symptom’ throughout this book in the usual way, but with this caveat.

Undergoing severe adversity, whether specific distinct events or a series of events, perhaps against a background of disruption and dislocation, has profound effects. On an individual level, a wide range of symptoms can arise (see Box 3.2), and these vary in nature from being quite concrete and physiological (such as poor sleep or sexual dysfunction) to abstract and existential (such as shame or suicidality). At the time of reaching the United Kingdom, or any other place of relative safety, people are likely to be troubled by any number of these.

**Box 3.2 Some common symptoms after adversity**

- Anxiety
- Overarousal
- Tearfulness
- Anger
- Irritability
- Guilt
- Shame
- Avoidance
- Emotional numbing
- Difficulty relating to others
- Suicidal impulses
- Vivid memories of, or ‘flashbacks’ to, adverse events
- Memory impairment
- Poor concentration
- Loss of appetite, weight loss
- Poor sleep or no sleep
- Nightmares
- Dissociation, depersonalisation, derealisation
- ‘Psychotic’ experience or belief
- Substance use
- Sexual dysfunction
- Physical complaints with no demonstrable organic cause
As well as suffering the general effects of violence and involuntary dislocation, some may also have been tortured. Torture involves intentional acts, deliberately causing psychological as well as physical suffering. The torturer relies upon an empathic understanding of those in their power, using emotional and psychological insight into their victim's state of mind to inflict harm in a way that goes well beyond the physical – to damage and disable that person in terms of how they function both as an individual and as a member of their community. Some means of torture may not even be physically damaging – the injury is to the person's sense of self, identity, and role. When the torture itself has ended they may be left with profound, intended, psychological effects that compromise their ability to go forward in the world. This will particularly be the case if they have yielded to the torturers and betrayed people or ideals they hold dear. Some of this will show itself through the type of general symptoms listed in Box 3.2 – but the effects go well beyond immediate symptoms, into realms of identity and agency, self-worth, and ability to trust. All subsequent experience may become distorted by shame, guilt, and fear.

Sexual violence, which may be inflicted for its own sake or as a means of torture, has specific effects, over and above any physical impact (such as injury, infection, and pregnancy). Symptoms of avoidance are common and intense, probably due to the intimate nature and associated feelings of humiliation and shame. Sexual violence and rape are usually taboo subjects, and those who have been subject to sexual assault (both women and men) fear being shunned or even blamed by their family and community if they disclose it. Dissociation is also common, particularly when people are asked to describe their experiences (Bögner et al., 2007).

Shame and guilt are also prominent in ‘moral injury’ – which occurs when a person has found themselves acting counter to their conscience and values, perhaps as a result of coercion (such as with child soldiers), or having to make choices that harm others in extreme circumstances. It can be profoundly disorienting to discover you are not the altruistic person you thought you were – anger, ‘moral disorientation’, and feelings of shame, betrayal, and having betrayed others may be prominent.

When people are seen in mental health settings, great care is taken to identify and assess suicidal impulses. People who have been involuntarily displaced have had the underpinnings of their lives cut away, and they frequently question the meaning of life and whether they wish, or indeed are able, to ‘go on’. For some, this takes the form of actual suicidal impulses, but there is great variation in the nature and intensity of such impulses and they are influenced by a multiplicity of factors, not least the situations they are in at the time. Actual suicide is a relatively rare event, in comparison with the number of people who might have some form of suicidal impulse – and as well as factors that provoke suicidality, there are many that protect against it.

The striving to get to, and reaching, a place of safety selects for highly motivated survivors. At the same time if, once having reached the place where they thought they would be safe, they become demoralised, disempowered, and disappointed, this may increase risk – and adverse events in their asylum claim may precipitate actual acts of self-harm.

The Office for National Statistics in the United Kingdom does not hold information on suicide statistics by ethnicity or asylum status. However, those seeking asylum may have several well-recognised ‘risk factors’ by virtue of their situation, over and above the individual's own existential stance, and their life experiences and reactions to them. These are listed in Box 3.3
It is also important to be mindful that not all responses to distressing situations and experiences are necessarily familiar. This calls to mind people we have worked with whose identity was, or became, confused, perhaps not as a way of hiding from the system, but as a way of hiding from (or even trying to find) themselves. One client would often change his appearance in distinctive ways, sometimes in response to people he had met in real life. For example, for a month-long period after attending the local mosque, he wore traditional Islamic clothing; on other occasions he would mimic well known movie characters, not only copying dress style but other aspects of their demeanour.

As well as indicating illness, damage, and disability, or even a process of coming to terms with all that has happened, some ‘symptoms’ may simply be a direct response to the immediate situation, especially if that situation is frightening, frustrating, or constraining. As will be considered later (see section on ‘Justice’), direct emotional responses to the frustrations of the asylum system, the periodic emotional shocks of decisions, and the demands of the process (such as interviews or tribunal appearances) may be interpreted by others as disturbances or personal failings. Placing an emphasis on symptom reduction risks overlooking the possibility that the symptoms could also be a show of resilience, since we are all biologically primed to respond to threat, and sometimes what is called a ‘symptom’ could also be framed as an immediate, potentially adaptive, response to adversity.

What helps people rebuild their lives?

Following serious adversity, there needs to be a process of reintegration and readjustment, perhaps analogous to grief. As with grief, it may well be painful or profoundly disturbing. Psychic pain needs to be experienced, not evaded, if healing is to take place – but it also needs not to be so overwhelming or disabling that growth is impossible.

Given the right conditions, suffering may have a creative outcome, in addition to the pain and disturbance that is caused. As we have discussed, this is more than simply resilience, if we define this as the ability to survive and remain intact – it is a matter personal growth and development. Positive and negative outcomes from adversity are not mutually exclusive, and any one person’s reaction is likely to involve a range of both, in varying degrees and at various times. The balance is, in many ways, determined by the circumstances in which a person finds themselves when the initial adversity has abated.

Psychosocial models of health consider not only the role of our human capacities (such as physical strength and fitness, or knowledge and skills) in shaping our well-being, but also our systems of meaning, drawn from cultural beliefs and values, and our wider access to physical, economic, and environmental resources. Each part of the overall system impacts on the other,
and therefore health cannot be viewed solely through the lens of the individual. Importantly, we are shaped by experiences of the power that others hold over us, and the power that we ourselves hold. Such experiences may involve oppression, stigma, or discrimination – but also experiences of agency, empowerment, and respect. There are always multiple factors and mechanisms at play.

Box 3.4 offers a summary of some of the multiple factors that assist and enable people in recovering from severe adversity and involuntary dislocation. The structure draws on the ADAPT (Adaptation and Development After Persecution and Trauma) model devised by Derrick Silove, an Australian psychiatrist (Silove, 2013). Our content is based on conversations with people in clinical settings in the United Kingdom, identifying themes that are well substantiated by the available literature.

<table>
<thead>
<tr>
<th>Important areas</th>
<th>Examples from personal accounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety and security</td>
<td>No immediate threat of attack, injury, or coercion</td>
</tr>
<tr>
<td></td>
<td>Food and clothing</td>
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<tr>
<td></td>
<td>Safe, secure living arrangements</td>
</tr>
<tr>
<td></td>
<td>Help with pressing problems such as injury, pain, and sleeplessness</td>
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<tr>
<td></td>
<td>Stable civil society</td>
</tr>
<tr>
<td></td>
<td>Knowing you won’t be returned to danger</td>
</tr>
<tr>
<td>Interpersonal bonds and networks</td>
<td>Knowing loved ones are safe, and getting the help they need</td>
</tr>
<tr>
<td></td>
<td>Maintaining contact with family and friends</td>
</tr>
<tr>
<td></td>
<td>Shared mourning or remembrance rituals</td>
</tr>
<tr>
<td></td>
<td>Friendly interactions with new neighbours</td>
</tr>
<tr>
<td></td>
<td>Routinely being treated with respect and feeling accepted in daily life</td>
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<tr>
<td></td>
<td>Meeting other people, with opportunities for lasting new relationships</td>
</tr>
<tr>
<td></td>
<td>Feeling loved and able to love others</td>
</tr>
<tr>
<td></td>
<td>Belonging to a community or communities</td>
</tr>
<tr>
<td></td>
<td>Being able to call on others for help</td>
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<td>Helping others, having a role</td>
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<td>Identities and roles</td>
<td>Feeling validated for who you are, what you do, and what you offer</td>
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<td>Dignity</td>
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<td>Being able to make decisions, large and small, about your own life</td>
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<td>Developing language skills and local knowledge whilst being able to preserve core elements of cultural identity</td>
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<td>Having past achievements recognised, including the endurance and effort needed to reach safety</td>
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<td>Having the chance to use established skills and knowledge</td>
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<td>Having an interest and occupation, such as employment, education, caring, or sport, to take pride in, be valued for, and distract from preoccupying problems</td>
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<td>Opportunities to make a contribution to society</td>
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<td>Justice</td>
<td>Feeling believed and validated</td>
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<td>Having recognition of injustices and suffering endured</td>
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<td>Being able to anticipate an acceptable future, and a better future for any children.</td>
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<td>Being helped to feel that life can be ‘fair’ – it has positive things to offer as well as adversity</td>
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<td>Meaning</td>
<td>Being encouraged and helped to hold on to hope and optimism</td>
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<td>Faith, spirituality, political beliefs – and the chance to re-establish ways of expressing these</td>
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<td>Finding ways of integrating adverse experiences into a coherent sense of self, and of the world</td>
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<td>Having space for psychological and spiritual reflection and development</td>
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Safety and security

Writing in the 1940s, the American psychologist Abraham Maslow (the son of Ukrainian Jews who had fled persecution) influentially described a ‘hierarchy of human needs’, wherein fulfilment of the more basic needs is required before we can attend to ‘higher’ levels (Maslow, 1943). More recent thinking is generally both less hierarchical and less categorical, seeing needs as plural and interactive, but the crucial point Maslow makes about some needs having to be met before others can be addressed still holds. Broadly speaking, people first need physical safety, food, shelter, and the company and support of others if they are to do well after catastrophic experiences.

Our clients often talk about their physical safety, and conversations can pendulate between past, present, and future perceptions of being safe. People say things like ‘I came here to save my life’ and ‘I can’t go back, I will be killed’ when they try to explain their circumstances.

Safety is partly about getting away from threat, and partly about reaching somewhere stable and secure, where your future well-being can be relied upon. Stability also comes from no longer being exhausted, in pain, and tormented by fear and intrusive memories; from being able to manage one’s internal reactions to external stimuli, feeling settled with a degree of routine and structure, and from reliable access to resources.

People may seek out clinical support to make changes in their lives to help them develop a sense of both internal and external safety. This might mean access to psychological support in a crisis or having help in managing emotional discomfort. Sometimes people are simply searching for ways to get a good night’s sleep, or to concentrate and remember appointments.

When they feel safe, people become able to ‘return the past to the past’, adjust to their new circumstances, and develop some acceptance of the things that they have lost.

Interpersonal bonds and networks

Our family, friends, and community, the roles we play, and our place in society all help to determine our well-being, identity, and sense of purpose and meaning.

Once safety has been achieved, it helps even more if you know that your family and friends are also safe, and that you might be reunited with them. It helps, too, to be supported by others who encourage you in believing that things might change for the better, and that you have opportunities despite all that’s been lost. Positive responses from others help you make and maintain new relationships – and in turn these relationships may enable you to work through difficulties with trust, shame, and the loss of self-confidence. Integration with others from the new community in which you find yourself may also allow you to develop language skills, and to understand ‘the way things work’ in your new home. A phone top-up card is a high-value item, as it enables all of this. If you have children, it is important to know that they have opportunities, perhaps greater opportunities than you have yourself.

If you have lost contact with family, then family tracing is everything. One client made contact ‘out of the blue’ years after therapy had ended, simply to share that they had found their family after years of searching; it had been a constant theme of therapy, and I (NM) felt honoured to be given the news so long after the therapeutic connection had ended. In the United Kingdom, the process of family reunion can usually only begin once refugee status has been granted, and it can take a long time, but often clients report the prospect of this to be key to their hopes for the future.

Identity and role

If you have experiences of being respected, treated with dignity, and seen as an individual, it helps to rebuild your self-respect and self-worth. Having control over our own lives can
ground our sense of who we are as we adapt to major changes. This might be through choosing where we live, what we do, what we eat, what support we access and to whom we tell our stories.

In the longer term, acquiring language skills and undertaking education or vocational training, or getting the chance to use our pre-existing skills, can have a powerful effect. The chance to try new things, to develop, and to experience some agency in becoming and achieving what we want can further develop a sense of identity, status, and achievement, through having something to take pride in. Such experiences go a long way to enabling someone to deal with what might otherwise feel like overwhelming senses of loss and insecurity.

People in therapy often want to discuss ‘who they were’ or ‘what they had’, sometimes, it seems, as a way of justifying their existence in the United Kingdom, and showing, perhaps, that they are ‘good enough’ to be welcomed. It also helps them remember previous assets and achievements and gives them the chance to let others know about these too. People’s stories are often rich sources of cultural and political information about their countries of origin. The opportunity to share traditions and have them appreciated can be rewarding for all involved.

People’s ability to adapt to their new circumstances and find opportunities to reconnect with what they have lost may vary with age. This is partly the direct effects of ageing itself, and partly due to where they are in a professional or social life cycle. Often children can access support to learn a new language more readily than their parents, as well as being quicker on the uptake. Parents often talk about trying to live with ‘two cultures’ present in one home as their children adapt at a different pace from them.

Justice

To seek asylum is often to seek a measure of justice, or reparation, in the wake of violations of human rights already experienced. An integral part of such justice is to have one’s request for safety listened to and considered carefully and humanely. Being treated with respect and dignity while awaiting a decision is important too.

A sense of justice can also be more abstract – a matter of whether ‘life’ or ‘God’ is being fair – and the types of positive experience already discussed play a great part in establishing this.

Finding a meaning in life

How we make sense of adversity depends on how events unfold, the experiences that come our way, and our responses to these. The way that we are responded to by others plays a great part too. If we feel acknowledged, recognised, and appreciated, this increases our sense of ‘mattering’ and enhances our chances of making sense of adversity.

Faith, religion, and spirituality are central to many people’s lives. They may confer hope, purpose, and meaning, an expectation of direct protection by God, an acceptance of fate, and protect against suicidal impulses.

Often people explore many ‘why’ questions as they strive to restore balance and transform adverse experiences. Asking ‘why did this happen?’ and ‘why did it happen to me?’ is often the starting point for making sense of life journeys. People are helped if they can find a way to reconnect with ideas and beliefs that they find meaningful or important but may have lost contact with. This can include cultural traditions and the ability to have them valued and recognised, and exploring spiritual perspectives on life and change.

Mustafa Alachkar, a UK psychiatrist of Syrian origin, has examined the experience of some of his compatriots granted refugee status in the United Kingdom (Alachkar, 2022). He observed that the collective nature of refugees’ experience – the fact that many people are in the same situation – is a defining feature of their suffering, and it seems to play a positive role in helping them cope as they realise they are not alone and will always find others who are in

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a worse position than their own. We have heard such reflections many times in clinical practice. Although this position might be criticised as ‘downward comparison’ and perhaps a form of denial (either personally chosen, on some level, or imposed), it seems to be an important adaptive way forward for many, offering at its best an outward-looking and compassionate perspective on their situation and that of others.

Many people we have met are strongly motivated to ‘give back’ in return for the support that they have experienced from others, or to help others who have suffered as they have. This might be through dedicating themselves to supporting people newly arrived and seeking asylum, by looking for careers in areas such as social care or community work, or campaigning for social change. Sometimes people choose to share their stories, both privately and publicly, thereby becoming educators, perhaps as part of a striving for social justice more generally.

The importance of context
Each person’s social and intrapsychic worlds mirror, influence, and feed back upon each other. The potential for positive adaptation depends on the availability of internal, external, and interpersonal resources that can be mobilised to meet challenges. The outcomes are shaped in turn by society and its politics. The boundary between healthy and maladaptive psychological responses is thus indistinct and fluid, varying with time, context, and culture.

Effects of the asylum process
Sadly, the UK asylum system, as described in Chapter 2, often creates conditions that are the opposite of those considered above. At best, this neglects the things that people need in order to do well after life-changing adversity; and at worst, it confounds and counteracts them. Negative experiences upon, and after, arrival in the United Kingdom can have a profound effect on people’s emotional and cognitive life, and are especially damaging if those people are already struggling psychologically. In psychiatric terms, being subject to the UK asylum system is often a potent precipitating, exacerbating, and maintaining factor for illness.

People seeking asylum identify several key areas that contribute to poor mental health, including chronic insecurity and fear of being returned, isolation, poverty, and inactivity. (Strang and Quinn, 2019; Foley, 2020). Research has shown the impact on their mental health from lack of social integration and support (Bogic et al., 2015; Brewin et al., 2000), the use of detention (Robjant et al., 2009; Silove et al., 2007), the processes of the asylum system itself, and experiences of racism and stigma (Quinn, 2014). It is easy to see how these factors can undermine much that helps people rebuild their lives.

Safety
Waiting for an asylum decision leaves people in a limbo of fear and uncertainty about the future which can last for many years (Foley, 2020). During this time, they may be relocated multiple times beyond their control and without their consent. They may experience community hostility or overt abuse, based on their race or asylum status. If therapeutic help is needed to develop a greater sense of internal security, there are many barriers to getting this, and to continuing it once started.

Practical issues include the challenges of living on asylum support, such as squalid or unsafe accommodation and support payments that fail to arrive, or even destitution. Problems navigating unfamiliar systems (health, transport, education, etc.), dealing with incomprehensible paperwork, and living on minimal income are a constant.

This chronic insecurity ensures that fear is an active part of people’s daily life, and they may also become alert to threat in daily news and current events. One client reported that
Seeking asylum and mental health

‘the Home Office is scary, I haven’t read one good story about them. Sending boats back. I do not want to be alone with them.’ The long wait also means that people’s experience of other significant ups and downs, which characterise all life experiences, comes on top of already substantial stressors.

One client who frequently expressed suicidal thoughts described the impact of the asylum system as making him ‘unable to survive and climb out of this hole.’ He spoke about how he cried ‘all the time,’ did not sleep until six in the morning, frequently did not eat for days, fell due to dizziness, and often did not remember how he got to places. He often behaved in impulsive ways that brought additional difficulties and found it difficult to self soothe, operating in a highly aroused way. He felt that his inability to change anything substantial about his circumstances, coupled with his fears for his missing family, was the source of his emotional distress. He adapted to the distress by finding ways to ‘numb it out’ and relied on street-bought prescription drugs to manage his feelings.

Detention in an Immigration Removal Centre is greatly feared. Many people are required to report regularly to Home Office facilities, and it is well known that you can be taken into detention at this point, with no warning. The days leading up to reporting can be dominated by anxiety and dread, and although this subsides if the reporting proceeds without incident, it is only a matter of days before it all starts to build up again. Detention itself causes high levels of distress and has been shown to worsen mental health on many indicators (Baggio et al., 2020).

Interpersonal bonds and networks

Loneliness and isolation are ubiquitous. People have lost their old networks, been separated from most or all of their family and friends, and may be suffering bereavement as well as struggling to develop new connections. Efforts to make new relationships can be brought to nothing by repeated enforced moves. People also often face unfriendliness, hostility, or overt racism from the ‘host’ communities in which they have been placed.

Being unable to work and having to subsist on minimal financial support tailored to meet only the most basic of needs means that poverty is likely to limit all social contact while waiting for a decision on an asylum claim. Phone credit may have to be carefully saved for and used sparingly. Many are unable to buy a bus pass or pay transport costs, needing to walk everywhere, in all weathers, limiting where they can go and who they can visit.

Delays in asylum decisions also delay the possibility of family reunion and can have a huge impact on families. One client had her first grandchild born outside the United Kingdom whilst waiting for resolution of her claim. Unable to hold the baby, she said ‘I don’t want to feel hopeless, weak, vulnerable or lost, but I do.’ Where family members are missing, the ‘ambiguous loss’ (Boss, 1999) of living without knowing their fate can bring about an enduring distress more painful than being certain of their death.

Identity and roles

Albert Bandura (1997) identified ‘self-efficacy’, people’s belief in their ability to exercise control over themselves and the events that affect their lives, as the foundation for motivation, well-being, and personal accomplishment. People with an outstanding asylum claim are highly unlikely to achieve this by virtue of the restrictions to which they are subject.

There is little chance to engage in meaningful activity. Each day could be characterised as a battle against loneliness, boredom, and isolation, simply an opportunity to ruminate about past events or future outcomes. Such rumination can be a significant driver of depression and anxiety. People often describe their inability to use time productively, feeling at a loss as to

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who they are, and what their life means. One client’s description of a typical day was ‘we go to
the charity shops, complain about the prices’. Another commented ‘I am dying through lack of
activity, I can predict exactly what tomorrow will be, I get up, brush my teeth, watch TV, watch
TV, watch TV, nothing else happens.’

One of the main opportunities to start re-establishing oneself is through attending Eng-
lish language classes. However, not everyone can access these, and many people report feeling
disengaged and unable to concentrate as their troubles are ‘too big’.

James Foley (2020) researched the United Kingdom’s key narratives surrounding inter-
national protection and noted vulnerability, ‘deservingness’, threat, bogusness, and crimin-
ality as key themes within the humanitarian debate. Refugee voices in Foley’s study reported
experiencing ‘hostility, obstruction or what was perceived as a stance of entrenched disbelief
within the asylum system’. Papadopoulos (2007, and Chapter 13, this volume) warns against
the drive for society, organisations, and individuals to ‘oversimplify’ the response to those
seeking asylum and dehumanise people through creating an image of them as either resource-
ful and resilient or else traumatised and helpless. Yet, this is a strong pull.

Mother, daughter, lover, wife, sister, husband, son, brother, professor, panel beater, cook,
businessperson, student, farmer, grandparent, young, old, LGBTQI+, with or without
religion – all of these multiple identities get reduced to one: ‘asylum seeker’, a person who has lost their
home, their possessions, and their status. Many clients have expressed shame because of their
delegitimisation and loss of identity. There is a stigma experienced by virtue of being in the
asylum system, a form of collectivised shame, a deviation from what is considered acceptable
(Scambler, 2009). They feel in receipt of a message that it is ‘not OK’ to be here, to be yourself,
and to experience things the way that you do.

In many ways, society’s attitudes towards people seeking asylum condemn them to victim-
hood, to being unequal, and having to rely upon ‘supporters’, be they psychotherapists, hous-
ing support workers, lawyers, or community activists, to get by. The fact that people have been
extraordinarily resourceful and resilient in surviving catastrophic events, and reaching here
in the first place, is often overlooked – or even used to cast doubt on whether they are ‘genuine’.

**Justice**

When people face multiple deprivations, stressors, and perceived injustices, some express
anger, sadness, or rage in response. If they come to other people’s attention because of this,
and these people don’t understand or are unsympathetic to the situation that has led to their
response, it may simply be interpreted as ‘bad’ or disturbed behaviour.

When every brown envelope arriving might be a terrifying asylum decision, determining
our future, how many of us might become ‘emotionally dysregulated’? How many of us might
become suspicious or distrustful in response to a sense of injustice, whilst trying to navigate a
changed social role and identity and an uncertain future?

One of the things we have been consistently impressed with throughout our clinical work
with people seeking asylum following major adversity is how in touch they are with recognis-
ing systems of oppression and power imbalances in their relationship with others. Experi-
ences of injustice are adverse life experiences in themselves – and injustice is a psychological,
as well as a legal, human rights issue (Silove, 2013). Our psychological responses to injus-
tice are both emotional and cognitive. We make new meanings when we experience unfair-
ness, meanings that affect our subsequent experience and may cause us to reinterpret the
past. Persistent preoccupation with cumulative injustices of the past can play a central role in
maintaining psychological symptoms following exposure to persecution and human rights
violations (Silove, 1999; Rees et al., 2013).
Many people we have worked with have reached a point where they lament how they have been received by the United Kingdom, disappointed that the country is not the bastion of human rights that they had expected it to be.

One of the authors once received a referral for psychological support for someone who now has refugee status. He described the years he had spent in the asylum system as 'too painful, it was like living in a cage', before reflecting poignantly on the all-important times he had lost with his family, seeing his children grow. It was seven years since he had seen his wife and children – seven years of waiting and hoping to be reunited. He then said that a highlight of his recent life, after having been granted leave to remain in the United Kingdom, was being able to tell his accommodation provider’s housing officer to ‘get out my house’ during a property inspection. He had finally felt empowered to do this without fear of the consequences, after years of annual visits with people pointing at things and asking ‘Where did you get this? Why do you have that?’

**Getting help**

You arrive in a strange land full of fears and hopes, whilst trying to digest extreme and challenging experience. Who can you look to for help? How might you get it? How can you even formulate or describe what you need, over and above the basics for ongoing life?

The UK asylum system does attend to some of the most basic needs: accommodation and financial support are provided to most people from the outset, albeit problematically, as described in Chapter 2. However, psychological needs are disregarded, and are often intensified. This increases distress and disturbance – and, thus, people’s symptoms.

People can access help in several ways: informally through new friends and community and religious groups, and more formally through voluntary sector organisations, social services, and the National Health Service.

Health services are geared towards recognising and responding to symptoms and illness, rather than overall predicaments or other types of need. For those seeking asylum, whose symptoms have arisen for many different and complex reasons as we have been discussing, an illness model has several possible meanings. Some may be relieved to be offered a perspective from which their ill-being is recognised as part of a process outside themselves: an illness that absolves them of personal responsibility and frees them from fears that they are inadequate, possessed, or insane. It is important to recognise that the ‘health’ perspective can be experienced as neutral and non-blaming, even affirming, and that people appreciate this. More culturally congruent beliefs about what it what one is experiencing are not necessarily more helpful.

*I had a lot of panic attacks, tearfulness, nightmares. I would fall down screaming, I had flashbacks, anxiety, depression, but I thought it was demons because that’s what they say back home. People started telling me this is called panic attacks, but at first, I didn’t recognise I had PTSD.*

Emma

Alternatively, ‘mental illness’ diagnoses may be experienced as stigmatising people further, locating their problems within themselves rather than originating from what has happened to them and the unjust actions of others. There may be connotations of weakness, inadequacy, or deviancy – and hopelessness, guilt, and shame may all feature in someone’s reaction to being deemed mentally ill. As a result, people may play down their difficulties and minimise their symptoms in a desperate attempt to appear ‘normal’ or strong.

The clinical approach is made more problematic, as we have discussed, by the paradigm of ‘trauma’ wherein only specific parts of people’s experience are attended to, and held
‘responsible’ for, the state that they are in. People often cannot access support for their mental well-being due to post-migration stressors. Indeed, in our experience such stressors are often used as a reason not to offer mental health support. When treatment is focused on ‘trauma’, all other suffering, and everything else that is contributing to the person’s difficulties, risks getting forgotten.

In so many ways, getting help is contingent upon being ‘ill’ or ‘wounded’, rather than being a resilient person of courage and tenacity who has fallen on hard times. This in turn reflects how the United Kingdom, and indeed many nations of the West, can be viewed as responding to people seeking asylum as contingent on them behaving in certain ways (Goodman and Kirkwood, 2019).

However, despite the critiques, ideas of ‘mental health’ and ‘mental illness’ are likely to remain the basis of the care provided by mental health services. For all its faults, this care, in one form or another, is widely available and can offer much that is of value, as we will discuss. Some voluntary sector organisations have different models, perhaps more culturally, politically, or spiritually focused, and it is important that these alternative models also inform practice. The interplay of different perspectives and approaches within the one overarching model is a key theme of the remainder of this book, and the issues will be thought about in more detail as we cover the processes of assessment, formulation, diagnosis, and treatment.

References


Emma, talking about how she found she found help:

My GP wasn’t understanding at all. She was a … Muslim, and I had got hurt by extremist Mus- lims. She knew I was Muslim … and when she started asking me do you drink, she gave me a judgemental look. I had a panic attack at the GP.

I got married to a Libyan guy in the UK. It was a religious marriage, I did it just to make myself safe by being with a man. This man tortured me. He prevented me accessing education. All the time I was upset. He would rape me. At that time I didn’t know that this is called rape. … Even my mum said ‘how dare you condemn your husband for rape, it is his right’. My mother said I couldn’t make a complaint because Allah would get upset with me. To change that in my mind took a while. …

Then one day I drank bleach. The ambulance took me to hospital. I couldn’t speak for one week. They said why did you do it? I said it was a mistake. I thought if I said I tried to kill myself they will send me back or put in jail. Because in Libya that is what happens. So I was covering up for that man. I didn’t know the law but he knew the law. He complained to the police that I stole from his flat and made a false statement.

A nurse came to me in the middle of the night and found me crying in silence, I couldn’t even make a voice to cry. She opened the curtains and she approached me and she sat on the edge on the bed. She hugged me, she said ‘I believe you got hurt. I know you’re a victim. I believe you that you didn’t steal from your husband. You need to tell us.’ She spoke slowly in English. I said ‘I’m scared’. She said ‘why?’ I said ‘they’ll take me to jail’. She said ‘no one will take you’. She explained to me the law. She said ‘the law means he is going to be in jail not you. Are you ready to talk?’ And I said yes. She called the police, the police came and my journey with mental health started there.

They found all the bruises. They put me on the right track with the mental health team. This was after one year in the UK, suffering in silence, thinking it was demons, thinking I was OK, thinking they were going to take me to jail. Then I had all the support. The rape crisis team, [name] there she supported me a lot. Then I did two years of therapy with Dr [name], EMDR, I got all the help you could imagine ...

[What I’d like to say to clinicians is] try to look, and discover who needs help and offer the help like the nurse. To try to see what is inside. ‘OK’ doesn’t mean safe. I used to say ‘I’m OK’ [but] plan to kill myself. I always put a smiley happy face on and inside I was dying. I use it to hide that. In the hospital too many people came to me and looked at me, said ‘do you want to tell us why you drank the bleach? No? OK’ Then they went away.

(There is more from Emma on page 149, and in Chapters 3, 9 and 10.)