Migration, mental health, PTSD and Independent Living

Independent Living Institute

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1 Background

This paper was written as a part of the authors internship with the Independent Living Institute (ILI) in Stockholm Sweden. The internship was from January until the end of March 2024. Both persons supported ILI in the project Reciprocal Integration and the Right to Employment contributing with their own expertise in the fields of mental health and migration. The project has as a focus to increase the hiring capacity of migrants with disabilities. Information on the project can be found at: https://disabledrefugeeswelcome.se. The Independent Living Institute works to promote opportunities for individuals with disabilities for more personal and political power, self-determination, full participation and equality through information, education, lobby and project activities. The website with more information is: https://www.independentliving.org.

It is important to acknowledge that individuals who have recently fled their home country may have experienced trauma. Therefore, this paper aims to emphasise the importance of health, especially mental health. Good integration into society and the labour market can only be achieved with successful healthcare.

2 Introduction

This paper aims to provide an overview of mental illness in the context of migration and employment based on mental illness as "post-traumatic stress disorder". A comparison is made between Sweden and Germany with differences analysed. The aim of the paper is to provide background information on the link between mental health, migration, and employment and thus to contribute to raising awareness of mental illness in our society and in the world of work.

This paper has the following structure: To gain a basic understanding of this topic, it is first necessary to provide an overview of mental health and mental illness. Two different models are used to provide a comprehensive explanation of each term.
The next step is to link mental health to migration. This chapter examines the psychosocial effects that can result from violence and flight experiences and provides an overview of different types of trauma.
The following chapter discusses the mental health condition PTSD. After a detailed description of the disorder, the potential challenges of the diagnosis are presented.
The topic of PTSD is then linked to the topic of migration by examining the work of migrant reception centres. It also looks at ways of successfully treating those people who have been affected. The topics of mental health and employment are then linked and the effects of the mental health services on the labour market is examined.
Finally, there is a brief summary of the findings.

3 Mental health

The topic of this Paper is mental health, which is why the term 'mental health' is explained at the beginning.

3.1 What does mental health mean?

In the past, the definition of health in medicine was primarily based on the absence of illness. A person was considered healthy if he or she was not ill. This implied a clear separation between the body and soul (cf. Franzkowiak/Hurrelmann 2022).
However, in 1946, the World Health Organisation (WHO) redefined the concept of health to address its multidimensional nature. In the WHO definition, health is defined as: ... "a state of complete physical, mental and social well- being and not merely the absence of disease or infirmity" (World Health Organisation n.d.).
Therefore, mental health is considered an essential component of overall health, with a relationship between mental health, physical health, and behaviour, as explained in more detail in the next point.
It is important to note that illness and health can have different expressions in different cultures, countries, historical periods and social classes. Nevertheless, the basic meaning of the WHO definition remains universally valid (cf. Herrmann et al. 2004, pp.12-13).

The WHO defines mental health as: "state of well-being in which the individual realizes his or her own abilities, can cope with the normal stress of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (WHO 2001, p.1).
This definition emphasises the importance of mental health as a basis for general well-being and the individual's ability to make an active contribution to the community. It is crucial to note that health and illness can coexist, and people exist on a continuum between the two. Therefore, a clear separation is often not feasible (cf. Herrmann et al., 2004, pp.12-14).

3.2 What is a mental illness?

WHO defines mental disorder (illness) as a disturbance in a person's mental health, often characterised by a combination of distressing thoughts, feelings, behaviours and established relationships with others (cf. Psychische Gesundheit: Faktenblatt 2019).

3.2.1 Explanation based on the Biopsychosocial Model

The bio-psycho-social model offers a fundamental perspective for explaining the development of mental disorders. The bio-psycho-social model suggests that there are various factors - biological, psychological and social – and they combined can lead to mental

disorders. The model emphasises that biological, psychological and social factors work together to contribute to the emergence and development of mental illness. Biological influences (e.g. genetic predisposition), psychological factors (e.g. traumatic experiences such as escape or war) and social influences (e.g. social isolation or lack of a supportive network) play a crucial role. This interaction makes it clear that a mental disorder develops for multifactorial reasons. It is important to explain that the influencing factors and the clinical pictures can vary from person to person (cf. Egger 2005 pp. 3-12).

3.2.2 Vulnerability-Stress-Model

The Vulnerability-Stress Model is used in clinical psychology to describe a person's vulnerability. Vulnerability itself describes a person's tendency to develop a mental disorder. Vulnerability consists of biological factors (genes, trauma) and psychosocial factors. That combined with additional stressors (e.g. separation) can lead to a mental disorder. Protective factors, on the other hand, have the ability to reduce stress and vulnerability, thereby reducing the risk of developing a disorder. Examples of protective factors include family relationships, the work environment and therapeutic support. However, it is important to recognise that there are also risk factors that are in contrast to protective factors. These factors make the individual's life more difficult and can increase vulnerability. An example of this could be a low level of education. (cf. Schneider/ Niebling 2008, pp. 5-7).

3.2.3 Diagnosing diseases

Psychiatric diagnoses are made through comprehensive tests of the patient, taking into consideration various aspects of their health and behaviour. A preliminary diagnosis is usually made first, based on the available information and observations. This preliminary diagnosis serves as a starting point for further tests and observations (cf. Schneider/ Niebling 2008, p.7).

Diagnosis plays a crucial role in communication, in medicine and in its healthcare networks, so that everyone understands each other. Various classification systems, such as the International Classification of Diseases (ICD), have been developed to standardise and uniformly record disease states. The ICD categorises the individually diagnosed condition of a patient into a specific classification category. The classification category that best matches the clinical picture is determined through thorough checking. This process enables standardized coding of diagnoses, as described by Schneider and Niebling (cf. 2008, p.7).

3.2.4 Comparison of mental illnesses in Sweden and Germany

This is a comparison of the statistics on mental illness in Sweden and Germany.

3.2.4.1 Sweden

In Sweden, there has been a rise in mental stress among children, teenagers, and young adults, particularly in the last decade. According to Dalman et al. (cf. 2022, p. 4), the country has one of the highest rates of depression and sleep disorders among children in Europe.
The prevalence of depressive symptoms in Sweden's population ranges from 8,1% to 9,6%, exceeding the EU average of 6,6%. Germany is also above the average with 8,8 – 9,4 (cf. Hapke et al., 2019, p. 65).
In addition to the most common mental illnesses, there is also PTSD that increases over time. A European study conducted in 11 different countries reported a prevalence of PTSD ranging from 0.38% to 6.67%. In Sweden, the lifetime prevalence was found to be 5.6% in that study (cf. Rahman et.al 2022).

3.2.4.2 Germany

In Germany, anxiety disorders, depression, sleep disorders and alcohol dependence are common mental disorders. According to the Robert Koch Institute, 15% of the population experience anxiety disorders each year (cf. 2016, p.43).
In 2021, mental illnesses and behavioural disorders were the leading cause of hospitalisation for children and adolescents in Germany. Of all hospital treatments in the age range of 10-17 years, 19% were for mental or behavioural disorders (cf. Statistisches Bundesamt 2024).
In addition to these mental illnesses, post-traumatic stress disorder (PTSD) is also prevalent. The prevalence of PTSD in the general population in Germany ranges from 1.5% to 2.3%. Women are estimated to have a higher probability of suffering from PTSD, at 10-12%, compared to men at 5-6% (cf. Wissenschaftliche Dienste Deutscher Bundestag, 2016).
However, according to a study by the AOK, around 74.7% of refugees living in Germany have experienced trauma (cf. BafF n.d.).

3.2.4.3 Conclusion of the comparison

Both Germany and Sweden are facing an increase in mental illnesses, with anxiety disorders and depression being the most common in Germany, and depression and sleep disorders being prevalent among children, adolescents and young adults in Sweden. For PTSD, there is a difference in prevalence between Sweden 5.6% (cf. Rahman et al.) and Germany 1.5-2.3% (cf. Wissenschaftliche Dienste Deutscher Bundestag 2016).

4 Migration and Mental Health

For migrants arriving in a new and foreign country, their own state of health is of fundamental significance. It is only possible to reach one's full potential with complete physical, mental and social well-being. The terms "asylum seekers", "refugees" and "migrants" are often treated as synonyms. However, it is important to know the difference between these categories. Migration includes all forms of spatial mobility and is a general term for all people who arrive in another country with a specific intention to spend a certain amount of time there. However, the term migrants does not mean any tourists, but rather temporary and permanent immigrants with a valid residence permit or visa, asylum seekers and undocumented migrants (cf. OECD 2016, p. 8).

The following paper will have a focus on the migration form of forced migration or flight, in which people have left their home country due to a specific emergency situation (cf. Kasper 2021, pp.10-11).

The Geneva Refugee Convention defines refugees as people who are "[…] forced to flee their own country and seek safety in another country. They are unable to return to their own country because of feared persecution as a result of who they are, what they believe in or say, or because of armed conflict, violence or serious public disorder. Many have been forced to flee with little more than the clothes on their back, leaving behind their homes, possessions, jobs and loved ones. They may have suffered human rights violations, been injured in their flight, or seen family members or friends killed or attacked." (UNO-Flüchtlingshilfe 2024).

Asylum seekers are according to the United Nations Refugee Agency defined as persons seeking asylum in a foreign country (cf. UNHCR o.D.).

4.1 Psychosocial effects coused by violence and flight

Refugees are exposed to various psychological stress due to the individual living conditions in their countries of origin, their personal history of flight and the situation in the new country (cf. Domenig 2001, 2007; Loncarevic 2007, as cited in Kasper 2021, p.13).

Even before a person decides to leave their hometown, their mental health is influenced by various situational factors and living conditions. These include for example armed conflicts and war, which have an enormous impact on a person's well-being. Other forms of directly or indirectly experienced violence can be rape or torture, which have a significant impact on a person's mental health (cf. Gäbel et. al. 2010, as cited in Kasper 2021, p.13).

Flight is also related with leaving family, neighbours and friends. Many migrants are confronted with material and personal loss and traumatic experiences during their flight, as

well as being exposed to psychological and social stress. A large number of women and children experience sexual abuse during their flight. Many of those involved persons have difficulties in handling such experiences and often a trauma arises as a result (cf. Wieselgren 2017, p.11).

Many refugees are accommodated in refugee camps during their flight. During the escape process, many migrants choose risky escape routes, such as crossing the Mediterranean in inappropriate and overcrowded boats, which also causes huge stress for the refugees. Some people lose their lives and others lose relatives on the flight (cf. Geisel et al. 2015, as cited in Kasper 2021, p.14).

Upon arrival in a new country, various factors can negatively impact the mental health of a person with experiences of flight. These include, for example, uncertain and difficult circumstances during the asylum procedure and the temporary accommodation situation in shared accommodation centres, which can be seen as problematic due to the ethnic diversity and experiences of people with refugee backgrounds (cf. Kasper 2021, p.14).

Added to this is the process of coming to terms with what they experienced before and during their flight. This psychosocial stress is exacerbated by the stress of uncertain future prospects and acculturative stress. Acculturative stress refers to stressful situations that arise during the process of adapting to a new culture (cf. Razum et al. 2016, as cited in Kasper 2021, p.14).

People who have experienced flight cannot automatically be labelled as ill. Nevertheless, they are particularly vulnerable or at risk of illness due to the complex interrelationships of their life circumstances and experiences in connection with their flight. In addition, anxiety, restlessness, difficulties in concentrating, nightmares and sleep disorders are symptoms that are significantly more common among migrants compared to the general population (cf. Kasper 2021, p.14).

4.1.1 Types of traumatic incident in life

As described in the previous chapter, refugees are exposed to a whole range of long-term threatening situations over the course of their lives. The term "trauma" comes from Greek and means "wound" and encompasses the effects on the mental health. The term includes the fact that experiences of violence can have serious psychological consequences for people due to emotional wounds (cf. Flory/Krebs 2017, p. 11.).

The life of many refugees is marked by long-term threatening situations such as persecution, murders and cases of sexualised violence. A distinction is made between the trauma types one and two. If a single, temporary and unexpected situation triggers traumatisation, this is referred to trauma type one. An example would be a rape or a traffic

accident in which a person only narrowly escaped death. Trauma type two is referred to as a man-made disaster. Intentional and man-made violence has the aim of degrading the affected person and destroying his or her personality. Trauma of type 2 are significantly more difficult to process due to the associated loss of trust in others, insecurity and self-doubt, the feeling of permanent threat, worthlessness and weakness. Feelings of helplessness and hopelessness occur more frequently and the probability that previously experienced traumatic experiences will be repeated is considered to be very high by those affected (cf. Flory/Krebs 2017, pp. 12-13).

Almost all traumatised people experience specific trauma-related symptoms in the immediate aftermath of the trauma, such as unwanted stressful memories, anxiety, and the avoidance of trauma-related stimuli. In most cases, these symptoms are only temporary. However, in fifteen to twenty-four per cent of those affected, these symptoms persist, and trauma-related disorders occur (cf. Margraf/Schneider 2009, p. 106).

4.1.2 Trauma- related disorder

People who have been exposed to traumatic experiences react in different ways to the psychological stress. It is common for trauma-related disorders to develop. Several clinical diagnoses can be summarised under the term trauma-related disorders. These can include post-traumatic stress disorder (PTSD), depressive disorders, addiction disorders, immuno-logical disorders (such as asthma), cardiovascular disorders or anxiety disorders. It is not uncommon for several trauma-related disorders to occur simultaneously. In this case, this is known as comorbidity. Studies show, for example, that around eighty-eight per cent of patients with PTSD also have another diagnosis of a mental disorder (cf. Flory/Krebs 2017, p. 14).

5 PTSD in general

In addition to depression and anxiety disorders, post-traumatic stress disorder (PTSD) are the most common trauma-related disorders among refugees and migrants (cf. Margraf/ Schneider 2009, p. 106).
International studies indicate that the rate of PTSD among refugees can be around ten times higher than in the general population (cf. Fazel, Wheeler/Danesh 2005, as cited in Flory/Krebs 2017, p.13).
In general, post-traumatic stress disorders can be considered as a reaction to traumatic experiences and stress which, due to their type and extent, clearly go beyond what would be imaginable according to general life experience and which have a disease value due to their intensity and trauma consequences (cf. Margraf/ Schneider 2009, p. 106).

5.1 Causes of PTSD

The causes of post-traumatic stress disorder (PTSD) always come from incisive experiences in which the affected person either became a victim themselves or was involved in the incident as an eyewitness (cf. Margraf/ Schneider 2009, p. 108).

Regions which are affected by armed conflicts, increased public violence or repeated serious natural disasters show an increased prevalence of PTSD. However, studies show that the respective probability of developing PTSD after a trauma is approximately the same in different countries. The vast majority of all cases of PTSD are due to directly experienced war events and cases following rape and sexual abuse (50-65 of all incidents). A smaller percentage (3-11%) is due to traffic accidents, approx. 5% to cases following natural, fire and fire-related disasters and 2-7 of cases due to witnessing accidents and acts of violence (cf. Breslau et al. 1998, Kessler et al. 2005 as cited in Margraf/Schneider 2009, p.108).

Such a life incident usually happens unexpectedly for the affected person and because they see no possibility of initiating a positive change. The affected person sees themselves as a victim trapped in his or her own situation and usually just wants to wait and hope that they survive (cf. Margraf/ Schneider 2009, p. 108).

Many people with PTSD have a fundamental mistrust of the world, other people and themselves and have problems trusting other people, see the world as bad and unfair and see themselves as inferior to other people. The trauma leads to psychological changes, with the result that affected people blame themselves for what has happened, see themselves as being insane, regard their life and fate as hopeless and are convinced that they will not be able to live much longer (cf. Margraf/ Schneider 2009, p. 109).

5.2 Risk and protective factors for PTSD

Whether a person develops post-traumatic stress disorder as a result of a trauma depends on various factors. On the one hand, it depends on the type, severity and frequency of the traumatic experience, but also on their vulnerability and individual resistance factors. An important resource is resilience, also known as psychological toughness, which means that a person has certain protective factors that can protect them from negative health effects. Resilience can therefore be seen as a process that ensures adaptation to significant sources of stress, trauma and threats (cf. American Psychological Assoziation 2019, as cited in Kasper 2021, p. 14).

Risk factors for post-traumatic stress disorder include previous childhood trauma (abuse and others), lower intelligence and education, female gender and younger age at the time of traumatisation (cf. Margraf/ Schneider 2009, p. 108).

5.3 Identification of PTSD/ /identification mechanisms

Post-traumatic stress disorders (F43.1) are classified as reactions to severe stress and adjustment disorders (F43) according to the International Statistical Classification of Diseases and Related Health Problems (ICD10). The diagnosis is based on specific characteristics that are described in the ICD (cf. Schneider and Niebling 2008, p. 7).

For a diagnosis, the patient must be directly or indirectly confronted with the trauma and exhibit symptoms from each category for at least one month (cf. Barnhill 2023).

Post-traumatic stress disorder is characterized by the simultaneous occurrence of symptoms from multiple groups (cf. Margraf/Schneider 2009: 106).

PTSD is generally diagnosed based on four categories: *intrusive symptoms, active avoidance, altered states of arousal and reactivity,* and *negative alterations of cognition and mood* (cf. Barnhill 2023).

Intrusive symptoms involve reliving traumatic experiences, such as repeated, disturbing or painful memories, recurring nightmares, flashbacks, intrusive images and physical reactions when confronted with a psychologically stressful situation (cf. Barnhill, 2023; Margraf & Schneider 2009, p. 106).

People with PTSD may experience sensations that are similar to those experienced when a trauma occurred (cf. Margraf/Schneider 2009: 106).

Another form of post-traumatic stress disorder is characterised by *active avoidance* of emotional and cognitive responses to the traumatic experience (cf. Barnhill, 2023). This can lead to avoidance of situations and activities associated with the trauma. Furthermore,

trauma can result in emotional numbness, a limited range of emotions, and reduced participation and interest in significant activities (cf. Margraf/Schneider 2009: 106).
People with post-traumatic stress disorder often also exhibit an *altered state of arousal and reactivity*. This category includes sleep disorders, outbursts of anger, increased irritability, memory and concentration difficulties and increased startle reactions (cf. Barnhill 2023).
The category *Negative alterations of cognitions and mood* describes memory gaps related to the traumatic event, exaggerated negative beliefs about oneself and the environment, and feelings of alienation from other people (cf. Barnhill, 2023).

In addition to the aforementioned diagnostic criteria, there are other symptoms that may indicate post-traumatic stress disorder. These include a marked impairment in social or occupational functioning that cannot be attributed to physiological, medical, or substance use factors (cf. Barnhill 2023).

5.4 What are the potential challenges in diagnosing PTSD?

Making a diagnosis of PTSD is sometimes more difficult than expected, which is why this chapter explains the difficulties and why misdiagnoses can occur in some cases.

5.4.1 Clients

Individuals with PTSD often avoid talking about their feelings because they cannot or do not want to think about the traumatic experiences they have had (cf. Post-traumatic stress disorder (PTSD) 2021).
It is common for people with PTSD to believe that the symptoms they experience, such as avoidance, numbness and amnesia, will help them get over the trauma. They may not realise that these symptoms are actually caused by PTSD. One reason why a diagnosis of PTSD is often missed is that affected individuals are typically very unwell during acute phases, making it difficult for them to remain hopeful and believe in a positive future. This sense of hopelessness often leads to a refusal to seek help (cf. Post-traumatic stress disorder (PTSD) 2021).
Misunderstanding caused by a lack of information about PTSD is also a major problem. Post-traumatic stress disorder (PTSD) can affect anyone, although it is often assumed that only those who have served in the armed forces can suffer (cf. Post-traumatic stress disorder (PTSD) 2021).

5.4.2 False diagnosis

People with post-traumatic stress disorder may be misdiagnosed with depression or anxiety (cf. Post-traumatic stress disorder (PTSD) 2021).

There is also the possibility that people with post-traumatic stress disorder may develop other mental or physical health problems, meaning that PTSD may go unrecognised. Physical health problems include not only purely physical illnesses, but also 'medically unexplained physical symptoms' such as: gastrointestinal complaints, headaches and pain syndromes, which may lead to another condition being diagnosed instead of PTSD (cf. Post-traumatic stress disorder (PTSD) 2021).

As explained in the previous section, PTSD can also occur in combination with other physical and mental illnesses. For this reason, it can happen that people with PTSD also have problems with psychic factors such as addiction or relationship problems. These problems can be caused by PTSD and may be more obvious than the PTSD itself (cf. Post-traumatic stress disorder (PTSD) 2021).

5.4.3 Stigmatisation of mental illnesses

Mental illnesses are strongly prejudiced and stigmatised in society, which means that individuals not only suffer from the illness itself, but also from social exclusion(cf. EMBO reports 2016).

Historically, stigmatisation dates back to ancient Greece, where 'stigma' was a brand for criminals and slaves. People with mental disorders or disabilities were treated similarly to slaves and criminals, imprisoned, tortured and murdered. In the Middle Ages, mental illness was considered a punishment from God, often thought as being possessed by the devil. People were burned at the stake or locked up in asylums. During the Enlightenment, progress was made by removing chains from psychiatric wards and creating special facilities for those with mental illness (cf. EMBO reports 2016).

But under Hitler, people with mental disorders were again murdered or sterilised to prevent them from reproducing. The number or people was estimated to be 300,000 with mental illness and/or mental retardation (cf. Hohendorf 2016).

The stigma of mental illness remains a problem in today's society, with a lack of education and understanding. Despite progress, discrimination still exists (cf. EMBO reports 2016).

An unfortunate aspect is that not only people who have nothing to do with mental illness, but also mental health professionals can sometimes have negative attitudes towards people with mental illness. This can be avoided by getting to know the person and not rushing to judgement based on their illness (cf. Department of Health 2015).

Stigma can lead to isolation and shame in certain communities. The result of this stigma is that many people do not seek help for fear of being judged negatively. It is therefore very important to recognise mental illness in society by talking about it more openly and promoting normalisation (cf. Department of Health 2015).

6 PTSD among refugees and migrants

6.1 Migrant reception centres

In order to achieve the successful integration of migrants and to be able to treat illnesses and complaints successfully, it is important to make a diagnosis as quickly as possible. The first step should be a systematic assessment of the health status of refugees and migrants. In most host countries, medical examinations are carried out directly at the beginning of the asylum procedure or upon entry (cf. OECD 2016, p. 47).

The following section looks at healthcare for refugees in Sweden and analyses the framework conditions, benefits and rights. Refugees have the right to a voluntary and free medical check-up during the asylum procedure. This medical check-up is called "Health Examination (HE)" (cf. Asylum Information Database/European Council on Refugees and Exil 2023).

The responsibility for HE is in the hands of the county councils. Sweden is one of the few countries that also examines asylum seekers for mental illness and mental health as part of the routine health check at the start of the asylum procedure. In most other countries (including Germany), this is not the case. Healthcare for asylum seekers is limited to urgent medical care that cannot wait. The urgency is assessed by the doctors themselves. Many critics consider the concept to be ambiguous, as the phrase "urgent healthcare" is too open to interpretation (cf. Delilovic et al. 2018).

The right to access urgent healthcare services for asylum seekers in Sweden is guaranteed by the Swedish Reception of Asylum Seekers Act (LMA). However, this only applies to asylum seekers; it has not been legally established for other migrants. Based on the current data, participation in the health examinations is very low. The reasons for this have not been clearly researched, but it is assumed that it is due to the limited available information (limited access to information, mistrust, lack of clarity regarding the meaning and purpose of the check-up). There is also a lack of specific data and information about the work in the reception centres, which makes it clear that there is a large gap in the research in this sector (cf. Delilovic et al. 2018).

In comparison to Sweden, the first examination in Germany is focused on the identification of infectious diseases. There is no screening for mental illnesses in particular. Due to legal regulations, migrants are obliged to take part in these examinations. The result cannot officially have any influence on the asylum procedure. In order to achieve successful integration and a future for all refugees, any health problems must be diagnosed as quickly

as possible so that successful treatment can be achieved (cf. Bundesministerium für Gesundheit 2016).

It has been established that the length of the asylum procedure has a significant impact on the prevalence of mental illness. The longer the waiting time, the higher the prevalence of a mental disorder or health problem. Stressors to which refugees are exposed during or after their flight are one of the decisive factors (cf. DGPPN 2016).

In the first eighteen months, the healthcare services to which asylum seekers have access are limited to urgently needed services. After these eighteen months, they are entitled to social services (cf. Asylum Information Database/ European Council on Refugees and Exil 2023).

6.2 Difficulties in the identification of PTSD

It is usually not easy to diagnose mental illness in migrants and refugees, so the possible difficulties in diagnosis are discussed here.

One difficulty is that migrants may sometimes be less aware of help services than the local population. One reason for this may be that migrants have a different understanding of illness than people who have lived in the country all their lives and therefore have a different educational, life and migration background (cf. Westhoff 2012).

Stigmatisation of mental illness and cultural differences in understanding mental health may also play a role (cf. EMBO reports 2016).

Another barrier for migrants and refugees is the lack of services in their mother tongue. They often need an interpreter for medical appointments, which places a personal burden on them. As an effect, migrants find it difficult to express their medical conditions correctly (cf. Westhoff 2012).

Another important point is that general practitioners and social workers are not yet sufficiently trained in the mental health symptoms of other cultures, so they sometimes lack specialised knowledge (cf. DGPPN 2016).

6.2.1 Cultural Differences in Mental Illness

Migrants and refugees often come with ideas about illness and health that may be unfamiliar to professionals in the countries they going and their institutions. This can make counselling more difficult, as the health professional's and the refugee or migrant's views may not coincide (cf. Misle Dürr/Laame 2020).

The bio-psycho-social model is used in many societies and countries to explain mental illness. However, there are significant cultural differences which mean that in some regions

mental health problems are interpreted in terms of the cultural background rather than the model. In certain cultures, the view of illness takes a twist by seeing it as divine punishment without fully understanding its actual cause. These illnesses are seen as the result of magical influences or possession. An example of this is the "evil eye", which is seen in many Muslim and Christian cultures as the cause of sudden illness. The idea is that negative energies or evil forces are responsible for the appearance of mental illness, which is an alternative perspective to the bio-psycho-social model (cf. Misle Dürr/Laame 2020).
Mental health problems are often more stigmatised in collectivist societies and those affected are often seen as insane, which can lead to hiding in order to preserve family honour. In such contexts, the healing process is expected to be influenced by cultural and social factors, with mental illness often projected on the physical body and represented by somatic expressions, which can lead to misdiagnosis (cf. Misle Dürr/Laame 2020).
In medicine, somatoform disorder occurs when psychological or social problems are projected onto the body (cf. Misle Dürr/Laame 2020).
This can lead to misunderstandings when, for example, refugees with somatoform back pain do not understand why the doctor recommends exercise therapy (cf. Misle Dürr/Laame 2020).
An example from a study on depression and cultural differences provides a more detailed insight. Depression occurs in all cultures, but the symptoms and manifestations vary according to the cultural context. The WHO surveyed five countries (Switzerland, Canada, India, Japan, Iran) and found that guilt was reported by 68% of the Swiss population in cases of depression, compared with only 32% in Iran. In Iran, however, 57% of respondents reported signs of physical illness (cf. Assion et al. 2014).
In summary, physical complaints often point to mental illness in many non-European cultures.
The severity of somatic complaints varies based on gender, level of education, and social status. In contrast, the Euro-American concept of depression focuses on symptoms such as guilt, fatigue, lack of energy, and depressed mood. Collecting epidemiological data is challenging due to the cultural differences in symptoms. So far, there has been a lack of a widely accepted methodological approach that adequately considers cultural differences. Many tools for diagnosing mental illness have limited applicability when it comes to cultural factors, making them less useful for non-Western populations (cf. Assion et al. 2014).

6.2.2 Criticism of pathologisation through the diagnosis of PTSD

In the discourse on trauma among migrants and refugees, post-traumatic stress disorder is often directly assumed. However, such a hasty diagnosis leads to many misunderstandings

and limitations, which are explained in the following. From a clinical perspective, trauma is reduced to internal psychological and neurobiological processes in the brain. The causes of trauma are described as a strong stress stimulus that the affected person is unable to cope with. With the help of the diagnosis of PTSD, the affected person receives a certificate that they are ill and have a disorder. The problem behind this is that social circumstances, political violence and current precarious living conditions are rendered invisible if they are merely described as a stress stimulus. In addition, the deficit perspective only looks at the person's illness and the person is no longer seen as a survivor of human rights violations. The diagnosis recognises that the person's psyche has been severely affected by the violence they have suffered. However, dealing with the consequences and the origin is shifted to the individual and social abuses become privatised. On the other hand, such a diagnosis serves to be able to assert claims for treatment and compensation. If trauma-related disorders are diagnosed, this can therefore have a stigmatising and pathologising effect on the one hand, but on the other hand it can also lead to relief, as diagnoses serve to classify and name reactions after a trauma for the affected persons themselves, but also for their relatives. It is important to keep reminding oneself that traumatised people are not "disturbed", but that their reactions are appropriate responses to massive violence. For this reason, a trauma-sensitive approach to refugees is essential. A trauma-sensitive approach includes recognising and taking into account the social and political circumstances and not simply referring to the clinical diagnosis (cf. Flory/Krebs 2017, pp. 15-16).

6.3 Proposed solutions and options for overcoming obstacles

The WHO states that a comprehensive, multidisciplinary and inclusive approach is necessary to respond to the mental health needs of migrants (cf. World Health Organization: WHO 2021).

The challenge for governments in each country is to incorporate human rights, including the right to healthcare and other support, into national and political plans and strategies with the aim of reducing health inequalities and thus counteracting the violation of human rights (cf. Delilovic et al. 2018).

Recommended approaches to overcome barriers according to WHO for mental health care utilisation among migrants and refugees would be the following:

Firstly, clear information should be provided about the rights to access basic mental health care and how services can be utilised so all refugees and migrants can make use of their rights. This can be done with the help of reception centres, PR work, educational work in

schools and in religious and cultural institutions. Access to healthcare should be as low-threshold and non-discriminatory as possible, regardless of whether psychiatric services cover the services financially and regardless of legal status. Communication should be made easier for all migrants by adapting communication to the individual's needs and, depending on the situation, interpreters and cultural mediators can also be called in. Care for the person in need should be person-centred, taking into account and respecting cultural differences (cf. World Health Organization: WHO 2021).

According to the German Society of Mental Health the affected person should be supported in fulfilling their basic needs (accommodation, nutritional security and integration into society) in order to reduce further stressors and burdens (cf. DGPPN 2016).

Primary contact persons should be better trained with regard to mental health symptoms. In addition, awareness of the psychosocial situation of asylum seekers should be raised in initial reception centres and culturally sensitive screenings should be carried out. It is important to strengthen outreach structures, such as a social psychiatric service, as well as specialised facilities such as psychosocial centres for victims of torture (cf. DGPPN 2016).

In order to improve mental health support for marginalized migrants in Sweden, migration officers, teachers, doctors and other people who work directly with migrants should be made more aware of the indicators of trauma. They often lack the feeling that they have the right tools to deal with traumatised people (cf. Swedish Red Cross 2019).

In addition, leading representatives of immigrant communities, migrant associations and trained counsellors from the countries of origin should be involved, as they can help to build trust, reduce stigmatisation and increase the level of use of health services (cf. OECD 2016, p. 47).

The Independent Living Institute and the project Disabled Refugees Welcome conducted from 2017 - 2020 refer to what they call double competence or that counsellors should themselves have experience from migration and of disability to gain the trust of the migrants with disability. This was proved throughout the project as Disabled Refuges Welcome succeeded in supporting many migrants with disability and still have many people from this target group contacting ILI for support. There is information on double competence and many other issues in the area of migration and disability in the ILI handbook “The road to reciprocal integration” https://disabledrefugeeswelcome.se/wp-content/uploads/Road.pdf.

Working with peer support is another recommended method so that individuals meet others sharing the same experience as well as the strategies they have found that work in solving different problems that arise. Peer support is one of the Independent Living core principles which can be found on the European Network for Independent Living https://enil.eu/wp-content/uploads/2022/06/Principles-of-Independent-Living.pdf.

6.4 Care, support and treatment of PTSD

In order to be able to process traumatic experiences, it is important to create an environment in which the migrant feels safe and secure. It is important to reassure the persons suffering from PTSD that they are far away from the place where they experienced the trauma and that they should always be reminded that there is no danger at the moment. You should also take time to listen when traumatised people want to talk about their experiences and demonstrate understanding for the anger, fear and despair that arises. As a non-professional, you should listen but not ask too many questions, as otherwise traumata can be activated and reinforced. In addition, you should not make your own diagnoses in this case and accept it if the person initially does not want to accept help. It is always helpful to work in a resource-orientated way and remind the people what they have already achieved and what difficulties they have already overcome. This can boost self-esteem and confidence. It can also be helpful to create a regular daily routine together with the traumatised person in order to establish routines and strengthen their sense of well-being. It is important for traumatised people to receive support from friends, family and acquaintances. This should be encouraged through counselling, even if those affected are very withdrawn. If refugees are plagued by recurring memories and nightmares and often seem very jumpy, irritable, depressed or aggressive, discussions with doctors and psychotherapists can be useful (cf. BundesPsychotherapeutenKammer (BPtK) 2016, p.6).

The disorder PTSD is characterised not only by intrusive, vivid memories, frightfulness and nightmares, but also by more long-term consequences such as problems and difficulties in education and the workplace and conflicts in interpersonal relationships. For this reason, it is important to respond effectively to the needs of refugees and to provide psychotherapeutic interventions that are customised to the individual (cf. Lechner-Meichsner n.d.).

6.4.1 National guidelines for the treatment of PTSD

The Swedish National Board of Health and Welfare has developed national guidelines for the health and medical care of people with PTSD. The guidelines were published in 2020 and serve as recommendations to the healthcare system (cf. The Government Office n.d.).

An important recognition that can be drawn from these guidelines is that post-traumatic stress disorder is a serious condition that affects many people, including many refugees. Good care and support ensures that a lot of suffering can be spared and that those affected quickly feel better. A questionnaire alone is not enough to assess the state of health, which is why an initial assessment at the health centre is important. Every person with PTSD should also have the right to seek psychological treatment from psychologists, doctors and social workers. In some circumstances, it is important that not only the person affected but also their immediate social environment receives the necessary support and help. Close family members are often exposed to high levels of stress due to the illness, which can be alleviated with meaningful support (cf. Brené/ Edbom 2020).

7 Summary of supporting institutions

Various institutions in Germany and Sweden offer migrants support for mental stress. In this context, various support organisations in Germany and Sweden will now be discussed.

7.1 Support System Sweden

In Sweden, there are several local health centres and services available for migrants who require medical attention. The Swedish Red Cross has been working since 1995 with treatment centres for migrants who have suffered trauma related to armed conflict, flight and torture. Svenska Röda Korset can assist migrants by providing information about their healthcare rights in Sweden and facilitating their access to medical facilities. Counselling is available at no cost, and interpreters can be arranged if needed. The centres have professional teams consisting of psychologists, social workers, psychotherapists, doctors, and interpreters who work closely with those affected to aid in their recovery (cf. Swedish Red Cross, 2019).

7.2 Support System Germany

Migrants often need a support system because of the traumatic events they experience during their flight. In Germany, the Federal Association of Psychosocial Centres for Refugees and Torture Victims (BafF) has organised 47 psychosocial centres that provide low-threshold services to those affected. These services include information on trauma and flight, as well as current political challenges (cf. Berg, 2023).

The services also include information on counselling centres, therapeutic approaches, legal basics and language courses (cf. BafF 2024). Those who need help can share their concerns and talk to other people (cf. Psychologische Beratung für Flüchtlinge und Migranten 2024).

In addition to the psychosocial centres, there is also a virtual contact point. The REFUGEEUM project enables people to learn about their mental health problems and learn self-help techniques in their own language. The project serves as a tool for promoting self-help and knowledge dissemination. Since 2017, the working group for the promotion of mental health in the Hamburg metropolitan region has provided a pool of translators to facilitate outpatient treatment by making professional translators more readily available and simplifying diagnosis (cf. Berg 2023).

8 Mental health services and how this affects the labour market

Unemployment is a significant risk factor for mental illness among refugees, along with social exclusion and language barriers (cf. Vikdahl et al. 2020).
This chapter compares the impact of mental health services on the labour market in Sweden and Germany.

8.1 Sweden

The Organisation for Economic Co-operation and Development (OECD) has recognised mental illness as a challenge for social and labour market policy in Sweden. The issue lies not only in the limited provision of care for those affected but also in the high costs for employers and the economy. Employment is decreasing while unemployment continues to rise, resulting in productivity losses. Therefore, the Swedish government has implemented several measures and strategies to mitigate the adverse effects of mental illness. However, there are still significant obstacles, such as a general absence of awareness, insufficient resources and a lack of tools to identify people with mental health problems in the first place and to help them in the next step (cf. OECD 2013, p. 13).

As with other countries, mental illness is not adequately treated in Sweden. Only a minority of individuals with mental illness receive treatment that facilitates early recovery and a prompt return to work. Nonetheless, the relationship between employment and mental health has improved in recent years. It is commendable that the mental health system is increasingly collaborating with health insurance and seeking rehabilitation measures. However, only a small proportion of individuals receiving mental health services are supported in achieving their employment objectives (cf. ORCD 2013, p. 128).
To address these issues, the OECD has developed a recommendation. Firstly, it is recommended to increase the resources of school health services. This will help in identifying pupils with mental health problems at an early stage and providing them with appropriate support. Additionally, it is recommended to offer appropriate assistance to students who have dropped out of school due to mental health issues, to ensure a smooth transition into higher education and the job market. It is important to provide support to smaller employers, particularly those who lack the financial resources, to enable them to retain employees with mental health problems. This can prevent the need for sick pay and facilitate the reintegration of sick employees.
Individuals receiving sickness benefits due to mental illness should be offered employment and healthcare services as early as possible to facilitate a prompt return to work. This

approach is known as employment-oriented mental health care, as defined by the OECD (cf. 2013, p. 13).
The national mental health action plan should also address employment, including jointly agreed goals and measures to ensure continuous follow-up. Modifying strategies is necessary if they prove ineffective, and an evaluation should be conducted at the end to achieve sustainable improvement (cf. OECD, 2013, p.129)

8.2 Germany

German and international studies indicate that a significant proportion of individuals with mental disorders who desire employment are often unemployed. The number of people in this group who are unemployed is therefore too high. Many affected individuals do not feel capable of working in the general labour market due to their illness, and instead opt to work in workshops for disabled people, also known as WfbM. Mentally ill persons are also welcome (cf. Gühne et al. 2020).
Throughout Germany, specialised programmes are offered in these workshops for individuals with mental illnesses. These workshops provide a favourable atmosphere, work content, and pay for people with mental illnesses. After a maximum 27-month vocational training phase financed by the employment agency or pension insurance provider, sheltered workshops offer permanent jobs in various areas of work, such as manual labour, services or production, depending on the individual's wishes and possibilities. The permanent jobs are subsidised by social welfare funds through care rates (cf. Werkstätten für behinderte Menschen WfbM 2023).
Some workshops offer in-house jobs in companies that are on the general labour market. These jobs still take into account the special needs of the person. Individuals who work in a sheltered workshop only receive a small wage in the form of pocket money. Therefore, they are dependent on social benefits (cf. Werkstätten für behinderte Menschen WfbM 2023).
There is a wealth of literature on mental illness among migrants and refugees, and there is a significant amount of research literature on mental illness in relation to the labour market. However, there is an absence of literature specifically focusing on refugees with mental illness and employment. This may be due to a sequential approach in which the treatment of mental health problems is prioritised before the search for employment.

9 Conclusion

The analysis shows that not enough attention is paid to mental illness within migration. It is important to note that mental health problems are just as significant as physical ailments and should be treated with equal importance.

In Sweden, initial tests for migrants in reception centres do include screening for mental illness, which is not a common practice in many other countries, including Germany. While this is promising, the reality does show lacks in this process. Studies have shown that these tests are not always comprehensive and that there is a lack of clear and uniform regulations. There should be an improvement in the screening done in Sweden and other countries should start screening. It is important to recognize and diagnose mental illnesses as early as possible to ensure effective treatment, which can have a significant impact on the lives, integration process and the employment of migrants.

To address the challenges of mental health such as tabu, stigmatisation, lack of resources, and others, it is essential that there is more sensitizing both to the migrants themselves and to organisations working in the area. The analysis shows that mental illness manifests itself in different ways in different cultures, people are not aware themselves that they suffer from mental illness and that social workers are lacking in training in the area.

Furthermore, it is important to provide social education and sensitisation on mental illness and trauma already from an early age through the school systems to successfully integrate nationals and migrants with mental health problems into the society.

While this analysis primarily focuses on post-traumatic stress disorder, it is evident that these considerations should extend to all trauma-related disorders. It is crucial to raise awareness on trauma and the negative consequences that can arise and need to be met.

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