

THE MIGRATORY DIAGNOSIS:  
HOW THE REFUGEE ROLE IS MAKING PEOPLE SICK

FARNOUSH MOZAFARI

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Department of Sociology  
York University  
Toronto, Ontario

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## ABSTRACT

The present-day refugee claimant is statistically at risk of encountering pre-peri-post migratory trauma (Hynie 2018) and is often pigeonholed as ‘traumatized’ by Global North countries (Summerfield 1999; Weine & Henderson 2005; Gass 2014; Pupavac 2001, 2008, 2012). In an effort to de-pathologize refugees, a psychosocial perspective has been offered by trauma critics to problematize the trauma-centric understanding of the refugee to highlight the refugee’s ‘resilience’ (Maier & Straub 2011; Silove et al. 1998, 2000; Summerfield 2001; Papadopoulos 2002). Despite this, disconcerting data shows that refugees are “highly vulnerable to mental disorders even years after resettling in a high-income country” (Henkelmann, de Best, Deckers, Jensen, Shahab, Elzinga & Molendijk 2020: 6). My work seeks to address this urgent call by closely examining the trauma-ridden “apolitical suffering body” (Ikanda 2018: 582) of the ascribed role, ‘the refugee’.

Through a retroactive analysis of clinical case notes from my clinical practice, which utilizes a resilience-based approach, I develop a therapeutic typology of refugeeness whereby I identify unaddressed, and potentially reinforced (through applied resilience models) tenets of refugeeness, where such a typology is not available. A central claim is explained through what I call the *migratory diagnosis*, which asserts that psychiatric and psychoanalytic approaches to refugee diagnosis and treatment reframes the refugee’s experiences around migration-induced loss and the (un)successful mourning of a pre-migratory self. The migratory diagnosis includes the psychosocial model of resilience, which espouses “strengths based approaches” (Hutchinson & Dorsett 2012: 66) to supplant the traditional trauma-labelling “deficits approach” (Betancourt & Khan 2008; Wessells 2009). Although well-intentioned, rewriting the script from ‘trauma’ to ‘resilience’ simply supplants a trauma ascription with a resilience one. Ascription-assignment is

the crux of the problem we are exploring, as it reinforces sickness. Herein lies the *trauma trap*. This trap reveals that trauma critics from the psychosocial perspective, alongside psychoanalysis, are isomorphic to the field of psychiatry which endorses the PTSD diagnosis. These seemingly diverse therapeutic approaches promote the internalization and reification of the refugee role for the migrant, creating a *migratory mind* that acts as a blueprint for ‘successful’ and ‘integrative’ behaviour in the exile country that actually causes negative conditions of refugeeness.

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To my patients

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*One must be a sea to receive a dirty stream without becoming unclean.* F.N.

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## **Chapter One: The Genesis and Development of the Refugee Role**

### **Background**

From 1648 to present, refugee reception in the West has undergone several societal shifts that are contingent upon binding international refugee laws. According to Phil Orchard's (2014) "four international regimes overseeing refugee protection", we are currently operating under the *non-entrée* regime whereby refugees face "restrictionism and discordance" through "policies of refugee deterrence, detention and extraterritorial processes" (2014: 17). Regimes generate "response scripts" that are couched in a "web of meaning" that furnish "behaviour guides for states; they provide a basis for cooperation and coherent responses to common problems" (Orchard 2014: 28). Response scripts are reserved for officials (i.e. law enforcement, legal professionals, medical professionals, educators, policy makers, politicians, journalists, and academics) in the host country. Officials "discursively construct" refugees through policy and any given refugee "program's objectives", resulting in behavior "shaped by hegemonic discourses about what 'refugeeness' should be" (Espinoza 2018: 234). When considering 'response scripts', one ought to gauge the socio-political-culture it is bred in. The contemporary refugee entering a Global North country, such as Canada, comes up against either arrests, detentions and removals, or one's refugee claim is accepted. Should you be accepted, one is introduced to varying resettlement programs that are overseen by a therapy culture (Rose 2018; Furedi 2003; Szasz 1998).

This culture informs response scripts pervaded by "a therapeutic discourse programming" (Sung 2017: 112) and an array of therapy applications of psychological interventions, arguably put into place to 'respond to common problems'. The prevailing understanding of a refugee is that they are statistically at risk of encountering pre-peri-post migratory trauma (Hynie 2018) and

are often pigeonholed as ‘traumatized’ (Summerfield 1999; Weine & Henderson 2005; Gass 2014; Pupavac 2001, 2008, 2012; Papadopoulos 2007). For this reason, the contemporary refugee is faced with role ascriptions that filter through ‘empowerment’ and ‘psychoeducational’ applications, to address their supposed “lack of knowledge” about how refugee trauma “affects [their] health” (Byrow, Pajak, McMahon, Rajouria & Nickerson 2019: 2). Put simply, guides for refugee reception are coloured by pathology. Ergo, the route to establish ‘cooperation’ between the refugee claimant and the host is, for example: to assess the refugee through mental health treatment screeners such as the RAS-MT screener (Nagy et al. 2023) or to implement cultural competence and consultation in training programs for clinicians who treat refugees (to apply methods like clinical ethnography and cultural identity exploration (Bhui 2022)) or impart empowerment and psychoeducation about the diagnosis of PTSD (Kinzie & Keepers 2020; Shannon et al. 2015). In a word, the regime is a referent point for the official’s response script, whereby instruments are deployed to pathologize the refugee.

The appropriate reception of refugees by the host, coupled with the refugees’ compliance, invariably engenders what sociologists call ‘scripts’. Scripts are expected behaviors associated with one’s social position, or as script theory contends, “guided by mutually shared conventions that help actors to enact...a situation interdependently” (Dworkin & O’Sullivan 2007: 105). Axiomatically, scripts function at a cultural (Goffman 1959), interpersonal, and intrapsychic level (Laumann, Gagnon, Michael & Michaels 1994). In our formulation, we refashion the conventional sociological ‘script’ known as “event schema” (Fiske & Taylor 1991) to better delineate the refugee role from others. What we will discover in this dissertation is that the refugee’s script, in addition to their existential and social worth, is *codependent*, rather than *interdependent*, on the perceptions of the host member in *any* social situation. Any

counter-dependent response to the host's ascription results in relational interferences that severely impact one's mental health outcomes. Thus, for the purposes of integration and assimilation, refugees must successfully internalize the 'refugee role', considered to be an ascribed role, in lieu of an achieved role (Linton 1936). The refugee role does not co-create or contribute to these scripts due to the codependency mentioned.

In this *non-entrée* era, refugee subjectivities are susceptible to the superimposition of "peculiar vulnerabilities" (Ikanda 2018: 581) that create "genuine subjects of compassion" (582) for host countries. The ingroup members of these developed host countries often interact with refugee identities through overlapping discourses. In addition to refugee pathology, other discourses include "law, nation, class, gender, race and the notion of membership of a mass group in flight, reception and resettlement" (Dobson 2004:17). The refugee's self-identity, confined by the refugee role, is therefore infantilized, depersonalized, and dehistoricized (Kaya & Nagel 2023; Seu 2003; Malkki 2012). Ascriptions manifesting in effeminisation and infantilization of refugees ensure that they do not "follow paths that were meaningful to them" but instead, they are subjected to "blindly following humanitarian policies that are disconnected from reality" (Ikanda 2018: 582). The refugee is then globalized through textual and photographic representations produced by academics, journalists, and humanitarian organizations. Denotations of "horror and powerlessness" or "productive, nurturing or virtuous activity" (Malkki 2012: 10) make up the 'refugee' for public consumption and transmittance purposes. These regimes and response scripts have ultimately permeated all sectors of the host country, from formal to informal settings, featured in both exoteric and esoteric teachings of the refugee.

In the section to follow, I outline how I evaluate the impacts of past and present refugee regimes and response scripts on individuals who have fled their country in fear of persecution. More specifically, my study traces the contemporary refugee regime and its materialization in a formal clinical setting, more specifically, when an intervention (i.e. instrumentalization of a response script) is applied. However, our data supports the claim that the refugee role's effects extend into the informal realms of a role carrier's life, well past asylum and resettlement (Daniel & Knudsen 2023), leading to protracted illness. The interventions employed and subsequently studied here are backed by current psychiatric evaluations and treatment(s) of refugees and therefore inclusive of humanitarian policies. Be that as it may, these interventions were practiced through a modality that considers the PTSD critique from social and cultural scientists over the last several decades (Silove et al. 2017; Summerfield 1999, 2004; Watters 2001; Rousseau & Measham 2007; Pupavac 2008). Extensive systematic reviews and meta-analyses of post-settlement psychosocial interventions have problematized our contemporary understanding of the refugee (Kinzie & Keepers 2020). However, despite casting aspersions on the conception of the 'trauma-imagined refugee', psychiatrists studying post-settlement psychosocial stressors continue to find that PTSD and depression are highly comorbid in refugee populations, and it remains unclear as to why.

## **Research**

In this dissertation, I look closely at the ascribed refugee role and what Dobson (2004) has described as the experience of "refugeeness" or "experience of otherness" (14). Amidst the experience of otherness is the hyper-pathologized, trauma-infused facet of the refugee. In addition to the prevalence of PTSD and it being markedly higher in refugees than the general population in Canada (Huminuik, Eslami, Sherrell & Friesen 2022), disconcerting data shows

that refugees are “highly vulnerable to mental disorders even years after resettling in a high-income country” (Henkelmann, de Best, Deckers, Jensen, Shahab, Elzinga & Molendijk 2020). The “urgent call for research and action in refugee mental health” (Saadi, Al-Rousan & AlHeresh 2021: 1) speaks to the paucity of effective approaches to a growing problem in global north countries, such as Canada. My work seeks to address this urgent call by closely examining the trauma-ridden “apolitical suffering body” (Ikanda 2018: 582) of the ascribed role, ‘the refugee’. To be clear, I do not intend to contest the existence and reality of PTSD and depression, but rather to propose a novel conception of the persistent and pervasive sickness in the refugee years after settlement. I do this by putting forth a psychosocial theory that postulates a ‘migratory framework’ that systematically deploys response scripts in clinical settings, leading to what I call a *migratory diagnosis*.

To preface, therapy cultivates ‘mind’ as migration-centered, or at least influenced by journeys of loss (Papadopoulos 2002; Leuzinger-Bohleber 2018; Akhtar 2011; Frost et al. 2019; Luci 2024). I assert and maintain that therapy is an apparatus that implements a response script, prompting the clinician to diagnose. It is at this point that a migratory diagnosis is in effect. The migratory diagnosis is a constellation of psychosocial and psychological models. These approaches to refugee mental health are intrinsically made up of ascriptions bound by stakeholders in the fields of psychoanalysis, psychiatry, and psychosocial studies. The therapy preserves and reinforces scripts and ascriptions upheld by the regime, which, depending on the model, can be said to induce what psychoanalyst Vamik Volkan (2017) has called “perennial mourning”, or as Professor Samina Salim (2024) put it “the burden of trauma in the life of a refugee” (1). Among the ascription-assigners is trauma critic and psychiatrist Derrick Silove (2017) who is a proponent of ‘resilience’, a social intervention that aims “to restore [the

refugee's] lost resources" (Silove, Ventevogel, Rees 2017: 133). A key discovery is that ascriptions are *prescriptions* that take the appearance of an antidote to suffering, but in actuality, reinforce sickness by creating a paradox I call the *trauma trap*. In other words, the migratory diagnosis, saturated with ascriptions informed by response scripts from the exile state, contributes to the validity of the traumatized refugee role.

I intend to extend the application of the concepts and heuristic devices mentioned thus far in a retrospective longitudinal multicase study of process notes and clinical documentation from my private clinical practice. After a painstaking review of clinical notes, I culled data that intimately interfaces with refugeeness and cultures of exile, or put simply, resistance. I delineate how it unfolds dynamically and symptomatically for the client. Findings illustrate how each individual, from three different regions of the world, all with idiosyncratic and unique characterological, social, and psychological locations, demonstrates negative conditions of refugeeness and trauma by means of internalizing a refugee role. Each individual signalled the internalized refugee role and its pernicious effect in the same way: by expressing uncertainty in self through rhetorical devices, in particular, rhetorical questions. Further analysis would reveal the source of this uncertainty as a fissure in the self. The refugee role revealed its lack of inclusivity of a pre-migratory self. A self that carries ascriptions from a past life. Thus, the refugee role jeopardizes certainty in narrations of self in the present. The following research questions were the starting point for my research:

1. How does an imposed or internalized refugee role impact the psyche?
2. How can an ascribed refugee role make an individual sick?
3. How can an ascribed refugee role be mistaken for a psychiatric condition or trauma/PTSD?

From these queries, my research uncovered a paradox: the very models intended to help the patients deal with their mental health issues were in fact found to be causing, or at least perpetuating, sickness. I discovered a trap: the trauma trap. This discovery led me to reimagine the prevailing wisdom. The formula I have constructed identifies the features and processes that make up a reenvisioned refugee experience. The regime and its response scripts, including therapy itself, reinforce a refugee role script that socially defines the refugee as sick. The refugee is constantly assigned these role ascriptions, and this leads to deeper and deeper penetration, sometimes to the point of full internalization of the role. I go on to show how the constant reinforcement of an internalized sick refugee role disrupts the psyche of the migrant and their pre-migratory constitution, creating a *migratory mind*. As the bearer of this mind, the refugee is not only assigned ascriptions but actively seeks them out. Under this regime, and in Western society, relationships and social acceptance for the refugee are only possible through illness. The more the internalization is resisted, the worse the social outcomes. In any case, the suffering persists. In this dissertation I propose a typology of refugeeness for therapeutic practice.

Despite trauma's very real presence in the lives of clients, I would be derelict in my analysis of the refugee role to not consider it as one of several pronounced discourses that eloquently capture the concept of refugeeness. Refugeeness entails "changing conceptions of self, boundary experiences and an active use of the flesh of the body, which sublimates into a different kind of flesh, the flesh of language and culture" (Dobson 2004: 24). Dobson explores how refugees "draw upon discourses as well upon other experiences and resources to form *cultures of exile* which are "signifiers of an oppositional power to the one enacted by those attempting to use discourses of law, nation to produce obedient and disciplined refugees" (17). I attempt to take a deeper look by proposing a *mind of exile*, coined the migratory mind.

Providing a backdrop to this venture is critical. The refugee role, recognized as an infantilized cultural object, has a history of its own, often not acknowledged. The subsequent parts of this introduction will outline the inception and establishment of the international refugee from the First World War to the present time. I outline how, why, and in what ways the refugee role mutated for its carrier and host countries in the global north. I explain the changes in the refugee role script as if it were analogous to childbirth, to pay homage to one of my patients (R.F.) who described their first interaction with post-settlement: “I became a baby when I arrived here. And, in some ways, still am”.

### **History of the International Refugee Role and its Script**

#### *Cervical effacement and dilation: Alien to Victim of War*

The ultimate decline of empires seen in the First World War made way for an international refugee regime – a regime that was responsible for fathering the categorical understanding of ‘the refugee’ by establishing “a set of legal rules, norms and agreements between sovereign states about refugees” and the states’ “responsibilities towards them” (Gatrell 2013: 5). The League of Nations, established by the Paris Peace Conference in 1920, was the first international organization founded post World War I. Preceding the United Nations, the League of Nations was a one of a kind intergovernmental organization that produced the ‘Covenant of the League of Nations’ with the sole aim of establishing “international peace and security by the obligations not to resort to war” and to respect “all treaty obligations in the dealings of organized people with one another” (The United Nations Office at Geneva, n.d.). The league facilitated and ensured the repatriation of refugees and developed a certificate of identity known as the ‘Nansen Passport’ for those seeking refuge, a distinct passport recognized by more

than 50 countries to alleviate obstacles for refugees and make way for travel, employment, and housing opportunities.

One of the primary objectives outlined by the Covenant was to provide conditions for membership as the influx of Russian refugees in Europe, and subsequently, Armenians, Assyrians, Assyro-Chaldeans, Ruthens, Montenegrins, Jews, Turks, and Hungarians required international protections and cooperation. The identity certificates did not offer specifics to what constitutes a 'refugee', but an essential tenet was seen in each person's case: they were "outside their country of origin and without the legal protection of their own state" (Venzke 2012: 91). Here we see the broad contours of the international refugee whose role script is largely understood by the boundaries of a state's system that intends to keep the individual out through the response script of repatriation and continued movement. The person is deemed an ephemeral. If the state can make use of, quite literally, this unidentifiable body, it will capture the refugee's labour by divesting the individual of their investments in themselves, including their identity. The refugee cannot be known beyond its alien objecthood. The refugee's script is dictated by host officials, states and systems, but remains largely unknown by the carrier who is inducted as 'alien'.

With respect to overseeing the treatment of these "aliens" anterior to the UN Charter in 1945, all international law was recognized as a "law of nations" in lieu of a "law of peoples" (Lillich 1984). In Lillich's infamous book on refugees titled *The Human Rights of Aliens in Contemporary International Law* he wrote: "In such a world the presence of 'objects' called human beings was an annoying problem, a perceived threat, one might say, to the logic of the system... If a State committed a wrong against an individual who was an alien, then that wrong, if unredressed, was translated into a wrong against the alien's State of nationality" (1). Put

simply, this object is but a small-scale simulacrum of its former state, often a state that did not want the individual.

At the time, Canada, the U.S. and in particular Europe were coming face-to-face with political, religious, and stateless refugees or “aliens” that were battling famine, disease, and repatriation. Up until this point, one could not criminalize or penalize a State for crimes against its own citizens. Matters of this kind were strictly handled domestically. The direct consequence of this poor mismanagement of people was reflected in post-war times when millions returned home with profound physiological and psychological conditions, none of which could be effectively addressed “internationally”. Rather, a “transnational” humanitarian movement was needed. Over time, refugees were being viewed as “victims of war” and legal scholars in the League of Nations were captivated by the humanitarian aid on the ground. The aid workers came to validate the essential and urgent need for humanitarian rights of victims, developing a much-needed humanitarian narrative (Cabanes 2014). The person who was once an ephemeral object and alien to a system, its logic, and the people dwelling “inside” of it, had morphed from object to a vulnerable, wounded flesh identifiable through its political passivity and need for rescue.

The genesis and subsequent formation of humanitarianism and its contribution towards developing the ‘victim of war’ script has a pre-origination stage that can be largely known by conducting archival research. For brevity, excerpts from a letter written by General Charles Harington and Sampson Aroutiounian have been selected to best illustrate what humanitarian aid workers on the ground may have experienced while encountering refugees. General Sir Charles Harington, a British Army officer, found himself in Constantinople where he encountered a flood of refugees who were deemed stateless persons, during a time where refugees had no legal status

and ultimately caused “disruptive effects on the labor force” of any state they fled to, giving rise to “shared concern for all nations in the West” (Cabanes 2014: 14). In his letter entitled “High Commissariat for Refugees: Appreciation of Refugee Situation in Constantinople” to Geneva dated July 14th, 1923, Harington details what he saw in November 1920 shortly after his arrival:

The collapse of General Wrangel’s Army took place, and within a few days we found ourselves confronted with 140,000 Russians who had arrived at Constantinople on some 75 ships in a starving condition. It was a sight I shall never forget. I went on board one of them to see the conditions. Though the responsibility for protection and maintenance fell on the French, it was a task which no one could stand aloof from. Our soldiers clamoured to help. They could not bear the sight of the ships on MODA Bay

He goes on to express his deep gratitude to the League of Nations, which intervened in a timely fashion. Harington reported that “since August, 1921, the League of Nations has evacuated 20,000 Russians and 8,000 Turks”. His appreciation is enclosed in the subsequent parts of the letter. Just a few years prior, Armenians were fleeing from the Ottoman Empire’s brutish force, and the president of the Armenian National Council of Tbilisi, Sampson Aroutiounian, assisted refugees in making their way to Echmiadzin. In his dispatches to the Armenian journal “Horizon”, Aroutiounian wrote of what he saw (Bryce & Toynbee 1916). He described the influx of refugees in the “hundreds of thousands...arriving at Etchmiadzin from Turkish Armenia. There seems no end to these solid columns moving forward in a cloud of dust”. He goes on to describe in detail what he witnessed and experienced on August 21st, 1915:

They are suffering terribly from dysentery. At the Etchmiadzin Secondary School, 3500 children who have lost their parents are huddled together. They sleep on the floor...in the big hall I counted 110 babies lying on the floor absolutely naked; some of them were sleeping, others were crying. The effect was so harrowing that one could not restrain one’s tears. The sight was too terrible for me to stand, and I fled from this hell. But in the courtyard an equally painful scene awaited me. Under the walls and in the corners there were refugees lying everywhere. One heard the cries of the sick; here and there one saw corpses.

The *inter*-national “refugee” is honed, fostered, and developed *in* states, *within* the closed-circuit logic of systems, and *in* the minds of officials. The experiences of these officials are severely circumscribed due to the predominant narrative that the refugee cannot be known because of its alien-being. As noted by Aroutiounian, sick, repellent refugees are suffering from *intestinal* parasite dysentery, among other illnesses. The interesting association here being the history of helminthology, better known as the study of parasitic worms, and the debate it brought with it in the Victorian era. The history of helminthology is marked by a debate between internalists and externalists, a debate that is interestingly germane to the locus of concern I wish to emphasize. Internalists argued that “helminths are spontaneously generated within the body of the host”. Conversely, externalists debated that helminths “enter the host from the external environment” (Orensanz 2019). It can be argued that the idea of “aliens” was generated *within* the body and mind of the host – the state, the system, the official, their minds, their testimonies.

This internalist view simply does not consider the migrant as having a life preceding their displacement. If one were to assume an externalist perspective, a migrant would be seen as ‘entering the host from an external environment’ and would necessarily *consider* the roles imbued within the individual in transit, such as parent, employee, friend, spouse, leader, etc. As stated, these roles, however, have largely gone unacknowledged by the prevailing internalist view. I wish to take this one step further in this dissertation: In addition to the loss of roles, the refugee role carrier loses insight capacities into the self, authentic relationality with host members, and personalized approaches to well-being. The reason being, host members of this time, and arguably today, see the psyche of the refugee as ‘alien’ with no pre-migratory constitution. Take Harington’s sights on the refugees that he “shall never forget” or Aroutiounian’s “harrowing” encounter with bodies that “one could not restrain tears” from.

Unequivocally, the ‘alien’ turned into a ‘victim of war’ was largely shaped by an internalist orientation that is mired in the disturbance brought on by sheer witnessing. In light of this, I take an externalist view towards my study of refugees that allows me to root out the *internalist* migratory framework that is covertly in effect today.

Turning our sights back to the interwar period, Orchard (2014) aptly titled the 1921-1939 mass migration epoch as the “Second Regime: Attempted Internationalization” where states collectively sought to manage the refugee influx via binding international law. The mass departure of approximately 2 million Russians, Armenians and others interacted with governments that were actively solidifying their economic and social life while taking measures to protect “critical entitlements for the benefit of their own citizens”. Such measures reified “boundaries between insiders and outsiders” limiting work and public housing to citizens (Hathaway 2021: 19). These early groups of refugees (only under half a million of them acquired Nansen passports) had to contend with border control, and if not, were prohibited from work and other sectors in society. These individuals could “at any moment prove to be temporary. They are men and women who often have no passports; who if they have money, cannot command it; who, though they have skills, are not allowed to use them” (Thompson 1939: 1). The exodus of people witnessed during and post WWI was seen as a “European problem” according to Canada and the United States. Canada, who was intimately tethered to Britain, and in lockstep with the United States, kept arm’s length from the refugee crisis. U.S. president Woodrow Wilson, too, regarded the British and their parliamentary system with respect but maintained, as he put it, an “impartiality in thought as well as in action” towards the post-war and all its concomitant worries (Powell 2005: 320).

Half a million Canadians immigrated to the United States between 1915 and 1932, pushing Canada to turn to refugee groups in Europe for economic recovery. Canada was in pursuit of “securing the right sort of citizen”, as advised by the president of the Canadian Manufacturers' Association, as “vacant acres” needed to be filled. Agriculturalists were invited to help build the prairies, but exclusionary policies remained nonetheless in fear of societal unrest (Powell 2005). Despite the global effort to keep individuals-in-transit alien, unidentifiable, and objectifiable, the impermanence inherent in the refugee’s role script would soon work against the prevailing regime that created it. An evolution in the refugee role script would accelerate effacement and dilation and allow for the birth of the “refugee”, a clearly defined category by the United Nations High Commissioner for Refugees (UNHCR). The rights and international standards of treatment for individuals who met its definition would exit through the canal of its host’s internalist womb.

### *Expulsion: The Refugee*

The League of Nations disbanded on April 18th, 1946, and transferred all its powers and assets to the UNHCR, who up until that point, had a minor part to play in international affairs concerning refugees. Before the commencement of the third regime in 1946, straight through to 1989, there was an interval of many years (1939-1945), known as the “interregnum” stage. This war-time period would convert an ‘attempted internationalization’ regime into the “Third Regime: Effective Internationalization”. In this epoch, (most) states were convinced that binding international law was imperative, and the UNHCR provided a compelling case for states to offer up help to persecuted persons fleeing their countries of origin (Orchard 2014). Ergo, the cord had been cut. Soon after the emergence of the 1951 Refugee Convention and its 1967 Protocol Relating to the Status of Refugees, refugee protection was globally acknowledged and

legitimized. The UNHCR played a crucial role in establishing an effective internationalization regime, as evidenced in its expansion in just a few years after the Second World War. Additionally, as the world witnessed an unprecedented refugee crisis compounded by the Cold War, worldwide expressions of sorrow and concern for refugees surfaced, making room for resettlement and integration programs. In parallel, much of the West witnessed and ultimately engaged in grassroots, international campaigning of NGOs, prompting social activism. This spurred a movement of support and commitment to solving the refugee crisis, and in doing so, concurrently boosted the UNHCR's reputation on the global stage (Loescher 2017).

On the other hand, several denunciatory commentaries of the 1951 Convention emerged. Critics have unanimously viewed the Convention as “The Eurocentric 1951 Convention” (Davies 2008) as refugee movements and crises occurred in the Middle East and South and East Asia, however “the Euro-centric orientation of the UNHCR reflected the foreign policy priorities of the United States, the hegemonic power within NATO and the Western alliance” (Loescher 2017: 78). The Convention's definition of refugees was “confined to those persons who had fled as a result of events occurring before January 1951” (Venzke 2012: 95). For further context, let us look at the Convention released on July 28th, 1951. The refugee was defined (according to para 6 (A) of the Statute and Art. 1 (A) of the Convention) as a person who:

Owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it.

The United States and Canada did not accept the 1951 Convention. In 1968, the United States however, did become a participant in the 1967 Protocol that eliminated the “temporal and geographic limitations of who is defined as a refugee” (FitzGerald 2019: 34) and Canada

followed suit in 1969. Interestingly, despite these late adopters bypassing the signage of the Convention, what was mostly agreed upon was repatriation, or rather, it being “a dirty word” (Gatrell 2013). Put differently, non-refoulement became the new norm.

While maintaining strict borders, Canada accepted 30,000 European refugees into the country between 1933 and 1944. However, there was a catch: refugees had to demonstrate “economic potential” and the goal was to “get the most highly skilled refugees before other countries of resettlement took them” (FitzGerald 2019: 37). František Braun and his wife, two refugees from Czechoslovakia arrived in Hamilton in 1949. Both found work as laborers and spoke of the treatment: “If you were honest and you did the work, then people treated you well” (Raska 2018: 1906). In and around this time, the U.S., Canada and Australia had very little incentive to admit non-white passing or adjacent refugees, such as the Chinese (FitzGerald 2019). It is worth noting that the refugee role script under this regime generated ascriptions that did not include illness. The regime prioritized white-adjacency, work ethic and economic productivity, and this was sufficient for social acceptance. In short, the refugee was able to maintain a firmer grasp on their pre-migratory self. However, in 1969, Canada started to resettle individuals fleeing third-world countries as it sought to be viewed as a champion of humanitarianism. Canada and the United States garnered noteworthy sympathy towards refugees and saw them as genuine people in need. The United States in particular had “commercialized its immigrant and refugee heritage” (Garcia 2017: 1) and also cemented its primacy over the Soviet Union through refugee admittance (Bon Tempo 2008). While Canada, in an effort to stay on trend, became more inclusive, further “[proving] Canada’s ideological superiority” (Reynolds & Hyndman 2021: 28).

The majority of refugees were coming from the Soviet Union, Vietnam and Cuba. Concurrent with upholding an ‘ideological superiority’, particularly over communist countries, interests were driven by foreign policy makers to make the point to non-aligned nations that democracy and capitalism as a political system and philosophy did in fact prevail over communist totalitarianism (Garcia 2017). Therefore, non-refoulement was in consonance with state interests as abandoning a communist informed economic system for one in the Global North, exposing the counter country’s weakness (McDuff 2019). In addition to the utilitarian value the U.S. mined from refugees, a notable number of knowledge-based workers were acquired, who had high social mobility in their own countries and were able to provide intelligence for the U.S. military. The eventual outcome for Americans was favorable: “refugees from the communist bloc became powerful ideological symbols of an innate human need to live in free societies [such as the United States]” (Garcia 2017: 6).

Let us unpack the symbolic interpretation of the refugee for our role-script generating purposes. The refugee symbolically shifted from alien, to victim of war, to a state-enhancing instrument, or rather an ‘ideological symbol’. We are left with a person’s functionality that solely represents a State’s dictum of ‘freedom’. Concomitantly, this freedom is emblematic of ‘an innate human need’. The refugee’s shape shifting is striking here: alien and feared, to a ‘victim of war’ through the experiential authority of humanitarian aid workers and officials, to becoming an inherent compartment of a state’s notion of freedom, such that repatriation would serve as a *deficit* to the symbolic order of the state and its peoples.

This last morphing stage renders the refugee an ‘essential’ and therefore an object that ensures the survival of a state’s democratic standing, while remaining undesirable as a person. The multiple renditions of defleshing (or one can say *de-roling*) carried out by governing bodies

reduces the refugee to just a symbol that seemingly cannot hold on to its own refugee role script history, let alone their ascribed roles, achieved roles (Linton 1936), general roles (Banton 1968), authority or leadership roles (Nadel 1969) they possessed pre-migration. They are more formally a symbol among many, subsumed under the symbolic system of a state. A symbol, as semiotician and philosopher Umberto Eco (1986) theorizes, is imbued with “a web of contrasting relationships”. One relationship is “from concrete to abstract (fox for cunning)”, another is “abstract to concrete (logical symbols)” (132).

The refugee’s relationship with the state that created it is bereft of any ‘social concreteness’. It has no roles or histories, and no self/other boundary that, interestingly in pre-Cold War times, was diminutively captured in the alienness of the refugee. Back then, the refugee’s political and religious affiliations informed host conjurings of who they were, and their passage into the host country was vehemently barred as a result. The role was permeable to the alien with no homologous features. The refugee’s refashioned symbolism during the Cold War reduced humans to a bare skeletal outline of an impermeable symbol. Eco (1986) explores the notion of symbols through “their vagueness, their openness, their fruitful ineffectiveness to express a ‘final’ meaning, so that with symbols and by symbols one indicates what is always beyond one’s reach” (130). The effort to keep the refugee in a liquified, amorphous, ‘beyond reach’ form (a symbol, an inescapable representative of *of-ness*) enhances the host’s perceived controllability over them, disallowing any trace of residual ‘concrete’ features to survive.

The notion of the symbol deserves some elucidation. In the social sciences, symbols are most effectively explained through three key approaches: 1. Symbols as motivated resembles (social psychology), 2. Symbols as displaced desire (psychoanalysis) and 3. Symbols as representations of the group (sociology) (Wagoner 2022). Although all three approaches can

further formulate an effective analysis for the shift(s) in the concept of the refugee, the third will be selected, as law begot the refugee and the role it generated in its midst. Womack (2005) provides an overview of Emile Durkheim's (1915) importance of symbolic forms on the subject of religion, deciphering Durkheim's conception of religion as a "social organization projected into the heavens" (51). Durkheim uses the totem as an example when he says it is "a symbol, a material expression of something else... it is the outward and visible form of...the totemic principle or god. But it is also the symbol of the determined society called the clan" (1915: 236).

Similarly, the refugee's materiality is only relevant insofar as it expresses the state's ideology and its adherents. Invariably, the totem, again much like the refugee, enforces "rules of conduct and thought which we have neither made nor desired, and which are sometimes even contrary to our most fundamental inclinations and instincts" (Durkheim 1915: 237). The refugee role's initial script was plagued by a foreign characterological makeup that hosts or ingroup members would perpetually disavow. Until the script evolved and could be 'retained' or more aptly *captured* by hosts, either through a 'sight one shall not forget' or a 'harrowing' encounter one could not expel from memory, there was a guttural reaction of repugnance towards people fleeing their countries of origin. The Cold War's global impact converted the refugee into an 'ideological symbol of an innate human need' for the U.S. and Canada, fortifying the rules, sanctions, and conduct of the Global North. The refugee's 'totemic effects' are inherently undesirable and contrary to 'fundamental instincts', but the role ultimately carried a state's desire by satiating a constructed need of 'freedom' that upholds 'rules of conduct and thought'.

Berger and Luckmann (1967) artfully spoke of some roles as having "no functions other than...symbolic representation of the institutional order as an integrated totality". They described these roles as "living symbols". These symbols "represent an order in its totality" as they

“represent not only this or that institution, but the integration of all institutions in a meaningful world... these roles help in maintaining such integration in the consciousness and conduct of the members of the society... the legitimating apparatus of the society” (1967: 93). Some roles can and do “die” and are “brought to life” through the “utilization of human conduct”. However, a living symbol, much like the refugee, must chronically and interminably live on to uphold their legitimacy to exist in the host country.

The symbol and its relation to the role is depicted in Post-Durkheimian Talcott Parsons (1951) monumental contributions preceding the eventual field of role theory. His structural-functional philosophy that spoke of a hierarchical order of the ‘social’ in his seminal book *The Social System* was heavily influenced by his intensive engagement with Freud’s works. Although Parsons’ work is riddled with contradictions and on the whole lacks “clarity and brevity” (Hamilton 1992: 119), it would be remiss to omit him from our analysis. In Parsonian sociology, the ‘social’ is made up of a personality system, a social system, and a cultural system. The cultural system consists of patterned and ordered symbols, in contrast to the other two levels of analysis. Parsons imagines ‘the situation’ as objects that assume an orientation under the classification of ‘social’, ‘physical’, and ‘cultural’ objects. The ‘social’ is in reference to actors, alters, and the collectivity. ‘Physical objects’ are ‘empirical entities’, they are simply conditions of actions. The ‘cultural objects’ that concern us here retain symbolic constituents such as “ideas or beliefs, expressive symbols or value patterns so far as they are treated as situational objects by ego and are not ‘internalized’ as constitutive elements of the structure of his personality” (2). The ‘refugee’ is fundamentally ideational and described as representative of an ‘inherent need’, a drive – a requirement. The refugee role, a symbol unto itself, can never quite be ‘internalized’ by any ego. Except, of course, *if it was ‘sick’*.

## **Methodology and Theoretical Underpinnings**

Before devoting ourselves to methodology in this section, it is important to briefly account for the theoretical framework and theory of mind I have chosen for analyzing the mechanisms behind the migratory mind. To preface, the refugee as a living ideological symbol of the Global North under the prevailing regime of its time, operationalized policies and sanctions to execute order as part of the macro infrastructure of society. The international refugee regime and Western society as a whole did not place credence or stock in the refugee's mind. Having said this, Parsons' structural functionalist approach to role-taking did apply. However, his role theory comes undone when we come to consider the refugee through psychiatric illness. Even his concept of the 'sick role' is ineffective for our analysis, as the sick role applied to non-refugees and was solely theorized as a form of deviant behaviour within society (Parsons 1951). Whereas its applicability to the refugee in the field of mental health and Global North countries at large is nonexistent. The reason for this is simple: sickness in the refugee is the consensual norm – afterall, it is an ascription.

If we look at Parsons' process of role-taking “where roles belonged to the social system and were explained through role expectations that were held by participants and supported by sanctions” (Biddle 1979: 1), it is limited in where we want to take our theory of the migratory mind. On the other hand, George Herbert Mead (1934) explains role-taking “as a process essential to socialization and a development of self” (Biddle 1979: 1). Although my clinical practice is guided by psychoanalytic theory and my understanding of self and personality is informed by psychoanalytic theories of mind, Mead's theory proves to be a worthy contributor to our analysis. The next paragraph explores this further.

I do not contest the invaluable contributions of psychoanalysis and its dynamic incorporation of the unconscious mind, its motivations, intrapsychic conflicts, and the potency and power behind such deliberations about the mind. However, we are evaluating a distinct aspect of the human experience here. Mead is useful as he does not invalidate or repudiate the unconscious but rather considers “the possibility of [an inhibited act’s] *progression* external to the subject towards a new potential action”, whereas Freud’s understanding of the inhibited act in response to stimulation is considered through “the possibilities of its *regression* within the subject, through the memory traces left by experience and the unavoidable search for pleasure (with its possible conflictual and traumatic issues)” (Côté 2023: 10). In the next section, I will speak about my practice, which exclusively analyzes ‘sickness’ through the psychoanalytic method.

### *The Practice*

From 2016 to present, I have been seeing and treating trauma patients in private practice as a registered social worker whilst undergoing training and supervision in an advanced psychoanalytic psychotherapy training program in the Toronto Psychoanalytic Society & Institute (TPS&I), affiliated with the University of Toronto’s Department of Psychiatry. The Toronto Psychoanalytic Society (TPS) is “a not-for-profit association of professional psychoanalysts engaged in the development and advancement of clinical psychoanalysis and psychoanalytic thought in Toronto [...] founded in 1965 as a branch of the Canadian Psychoanalytic Society (CPS), a component society of the International Psychoanalytic Association (IPA) founded by Sigmund Freud, with headquarters in London, England” ([psychoanalysis.ca/about-cps](https://psychoanalysis.ca/about-cps)). In this program, trainees acquire and develop expertise in case formulation, which reflects a clinical and conceptual understanding of the patient's problems

(e.g., symptoms; relationship, interests, or work difficulties), the patient's character, including developmental considerations, and the psychotherapy process. Through seminars, lectures, training cases and supervision, the operationalization of a psychoanalytic psychotherapeutic process is discussed and taught through different psychoanalytic schools of thought: object relational psychoanalysis, ego psychology, classical psychoanalysis, post-ego psychology and Lacanian psychoanalysis (as seen in ATPPP 2019-2021 Procedures and Guidelines For Case Reports and Supervision).

Working holistically, I integrate psychodynamic social work, psychoanalytic psychotherapy, and modalities used in cross-cultural therapies to address the psychological effects of trauma in patients. I follow a trauma recovery model informed by a feminist perspective (Herman 2015; Chodorow 1999; McWilliams 2011, 2015) that upholds multicultural principles (Gorman 2001; Ivey 1995), better known as “psychocultural mobility” (Gielen, Draguns & Fish 2008). It is in alignment with resilience-focused treatment programmes (De Jonghe et al. 1997; Southwick & Charney 2018; Laban et al. 2015; Calhoun & Tedeschi 2013) which seek to empower the patient by facilitating a shift from “traumatized victim self” to a “survivor self” (Gorman 2001: 448).

Although I consult the DSM-5, psychoanalytic psychotherapy has proffered another nosology whereby diagnostic labels are supplanted with “the dimensional, inferential, contextual, biopsychosocial diagnostic formulations characteristic of psychoanalytic and humanistic approaches” (Lingiardi & McWilliams 2015: 237). The atheoretical DSM-5 is often set aside and supplanted by the psychoanalytically supported Psychodynamic Diagnostic Manual (PDM), a diagnostic frame that is psychoanalytically driven and informed for the purposes of psychodynamic diagnosis and treatment (Wallerstein 2011). Additionally, it “is the product of an

effort to create a psychodynamics-oriented diagnostic system aiming to bridge the gap between the need for experimental and methodological validity, and the clinical complexity” (Kotan, Kotan & Bilgili 2018: 91-97). I will be outlining how I operationalized a psychoanalytic, trauma-supported model of therapy with clients in Chapter 3.

### *Case Study Research*

Concurrently, as part of my doctoral studies, I was studying trauma-informed models in psychiatry and psychoanalysis and how efficacious they were in treating refugee trauma. This led to the reexamination of clinical cases I had treated. Clinical cases contain informed consent documentation, intake information, assessment/evaluation information, treatment plans, progress notes, termination summary, and other client data. I retrospectively observed narrations of self in those who had fallen under the category of ‘migrant’. A series of “why” and “how” questions became apparent, questions that were not adequately addressed in sociology, refugee and forced migration studies, psychoanalysis, and/or psychiatry. The rich empirical data gleaned from clinical notes led to the development of theoretical propositions that ultimately guided design, selective/relevant data collection, and analysis (elaborated upon in Chapter 3). The “why” and “how” research questions, often suitable for case study research, revealed the distinctive need for case studies as I wanted to focus on concepts such as “explain, explore, describe, and understand” (Schoch 2020: 249). In order to fruitfully capture the complex social phenomena at hand, I needed a clear methodological path forward to compellingly identify and address the kernel of concern discovered in these psychoanalytic cases: the reproduction of refugeeeness in the clinical situation. Thus, an *explanatory* case study had proven to be an appropriate mode of inquiry for this undertaking (Yin 2017).

Case study research is ubiquitous among social science researchers and practicing professionals (Yin 2017) who are assuming a qualitative methodology approach. However, it remains a contested qualitative research strategy due to its contribution to theoretical pluralism in the field (Willemsen, Rosa & Kegerreis 2017), as well as its ill-defined structure, protocols, and parameters (Yazan 2015). As it pertains to clinical case studies in psychoanalytic and psychodynamic treatment, methodological improvements have been offered by Willemsen et al. (2017), who surveyed nearly half of the case study authors in the Single Case Archive (an online archive of published clinical and empirical case studies in the field of psychotherapy and psychoanalysis). Through this process, researchers of this study identified several concerns around the “reasoning style” of the case study authors included. Nine guidelines have been offered as a starting point for improvement: 1. Basic information to include, 2. Clarification of the motivation to select a particular patient, 3. Information about informed consent and disguise, 4. Patient background and context of referral or self-referral, 5. Patient’s narrative, therapist’s observations and interpretations, 6. Interpretative heuristics, 7. Reflexivity and counter-transference, 8. Leaving room for interpretation, and 9. Answering the research question and comparison with other cases (Willemsen et al. 2017). These improvements attend to the ‘data problem’ outlined by Widlöcher (1994) who believed published clinical case reports in psychoanalytic literature are “repeated and recurrent expression[s] of psychoanalysts’ own thoughts about their patients” and any other thoughts on the matter are “illusory”, or as he called it: “scientistic utopia of psychoanalysis” (1994: 1233).

Critiques on the anecdotal nature of clinical case studies, in particular the popular single case studies often found in psychoanalytic journals (Spence 2001), have resulted in advancements in the field. As Dattilio, Edwards, & Fishman (2010) state: “One observation or

one case offers only a small piece of evidence, but repeated observation [...] across a series of cases provides a way of constructing a database of evidence on which clinical theory can be built” (438). There is a general call for “more attention for a detailed description of the study, its methods, the patient and his or her therapeutic process” and the inclusion of “both instruments and methods developed within the field of psychoanalysis” (Meganck, Inslegers, Krivzov & Notaerts 2017). My research will demonstrate the aforementioned points of improvement through the application of a meta-study of psychoanalytic case studies “in which findings from cases are aggregated and more general patterns of psychotherapeutic processes are described” and is synonymous with “cross-case analysis of raw data, meta-analysis, meta-synthesis, case comparisons and review studies in general” (Willemsen 2017). The upshot is that there are clear, systematic, and demonstrable alterations that have been made to psychoanalytic empirical case studies that do not compromise the complex richness that is often uncovered in the psychotherapeutic process (Meganck et al. 2017). An additional aim of my methodology section will be to demonstrate the use of psychoanalytic concepts in a systematic way within sociological case study research.

Procedures for case selection will be elaborated and discussed in Chapter 3, however, it will be noted here that it was impossible to study all refugee cases from my private practice (estimated to be over 200 cases). It was therefore decided upon to carry out a pilot study on five cases and reserve the others for a follow-up project (Swanborn 2010). For the purposes of presentation, the instrumentality of the sets of strategies, guidelines and tools put forward by Yin is fitting for this dissertation. In the foreword to his book, written by Donald T. Campbell, Yin’s approach to case study research is argued as not presenting “hypothesis or evidence in the context-independent manner of positivistic confirmation”. Rather, his strategy includes “making

explicit other implications of the hypotheses for other available data” and “seeking out rival explanations of the focal evidence and examining their plausibility” (Yin 2017: xiii). Conversely, some have observed Yinian case study research to be in alignment with the positivist epistemological paradigm (Adams et al. 2022; Yazan 2015). As a direct response to this, Yin speaks to researchers who have diverse ontological and epistemological locations by stating the accommodative uniqueness that case study research possesses when one is theory-building. Whether one is a realist or relativist, or adheres to objectivism or subjectivism, the methodical and formulaic instrumentality in Yinian case study research can “excel in accommodating a relativist perspective— acknowledging multiple realities and having multiple meanings, with findings that are observer dependent” (2017: 16, elaborated in Chapter 2 of his book). How we come to acquire and create knowledge for a complex, ascribed role such as the refugee, requires utmost prudence and heedfulness.

In the chapters to come, I will build and develop my typology of refugeness in great detail. In Chapter 2, I will provide an extensive literature review that covers the genesis and development of the traumatized refugee before moving on to the trauma critique and contributions psychoanalysis and psychiatry have made to the field of refugee mental health. This chapter lays the groundwork for what we understand to be the “psychological birth of the refugee”. In Chapter 3, I will thoroughly discuss my methodology, ethical considerations, reflexivity, and the limitations of my research study. Additionally, I will detail the process behind case selection, the evolution of my research questions, data collection methods, and how I was led to identify a core theme. In Chapter 4, I define what is meant by ‘sickness’ and introduce Mead’s theory of mind with special focus on the “me” and the “generalized other”. Thereafter, I will begin my comprehensive analysis of the migratory framework where I introduce the

concepts of the migratory diagnosis, the migratory mind, and the trauma trap as highlighted by the cases of T.T. and M.K. In Chapter 5, I continue to apply the coined terms to R.S., R.F. and S.I. Prior to this, I provide a definition of uncertainty and its expression: the rhetorical device. I fully deploy Mead's theory of self by bringing his "I" together with the "me" and "generalized other". Finally, in Chapter 6, I provide a synopsis of our findings and speak of the refugee in the present day.

## **Chapter 2: The Refugees' Scripts and its Authors**

### **Introduction**

In this chapter, we will review the theme of trauma as it has acted as an established ascription for refugees under the current regime and is therefore of utmost importance. The patients selected for the study are in Canada due to a fear of and/or experience of persecution in their country of origin and are not unlikely to narrate uncertainty of self and identity confusion. These indicators are generally identified in the fields of psychoanalysis and psychiatry as dissociation, a prime mechanism featured under PTSD and dissociative identity disorder (DID), formerly known as multiple personality disorder. The topic of dissociation is paramount, as many patients both included here and in similar studies often present uncertainty in addition to a loss of semantic knowledge (previous knowledge about the world) and procedural knowledge (knowledge or memory of skills acquired and learned), all of which falls under dissociative amnesia (Sapp 2015).

The veracity of this diagnostic category is not in question, but addressing its manifestations within the parameters of refugeeness is. This can be proven by investigating patients who were once refugees but continue to exhibit dissociative markers well past resettlement in the host country. Although these markers are commonly regarded as a defence mechanism we are still left with a few questions: Are these effects simply generated by “postmigration factors that can add to the original symptoms” of a patient (Kinzie & Keepers 2020: 51) or is there a psychological phenomenon that can be crystallized under the consideration of a social consequence like refugeeness? What if the cluster of ‘symptoms’ we are observing, known as dissociative amnesia elsewhere, is a result of an ascribed refugee role that

conserves a script that is regressive (i.e. infantile) and holds no history of the agent (devoid of semantic, procedural knowledge) but only a history of itself (alien, victim of war, living ideological symbol)? This would make for a viable social determinant that asylum-seekers would experience trauma from, upon arriving in the host country.

The project involving the de-pathologization of refugees is well underway and very much germane to the paradigmatic shift we witnessed in the critical refugee research in mental health where the ‘sick, traumatized refugee’ morphed into a ‘resilient’ refugee. The subversion of the traumatized refugee narrative was and is bolstered by ‘the trauma critique’. The critique galvanized a movement towards a much-needed change (Maier & Straub 2011; Silove et al. 1998, 2000; Summerfield 2001). I argue in subsequent chapters that the resilience model(s) (or ‘resilience-oriented therapy and strategies’) deployed in therapeutic settings for refugees that are intended to counteract the Western psychopathology/deficits trauma models, although well-intentioned, actually reproduce negative conditions of refugeeness. Before ferreting out the details of this critique, we will trace how the modern ‘traumatized refugee’ came to be.

### **The Traumatized Refugee**

The Vietnam War presided over much of the Cold War conflicts in the 1960s and early 1970s, marking America’s brutish efforts to stifle Communist rule across Southeast Asia. As seen in our role script analysis thus far, the refugee has undergone several alterations from *alien* to *victim of war* to the Global North’s *living ideological symbol*. However, at this juncture, we would see the emergence –or *birth*– of the refugee’s psyche in the UNHCR, where the refugee’s abstract existence faced concretization, or, as other critical theorists would see it, as undergoing objectification (Summerfield 1999). Anterior to the 1970s, the psychology and mental health of individuals facing persecution from their country of origin was not considered. The first and only

of its kind was seen in Holocaust survivors who faced “concentration camp syndrome” (Etinger 1961) or “traumatic neuroses of war”, applied to both veterans and survivors (Kardiner & Spiegel 1947). The posttraumatic stress disorder diagnosis (PTSD) was first introduced in the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III), which began work in 1974 and was published in 1980. Before the diagnosis unfolded into what is considered to be refugee trauma today, it underwent a different route initially. The establishment of PTSD was a slow-moving development that was led by veterans who were grappling with acute combat stress reactions. Prior to this recognition, military personnel exhibiting symptoms both during and after battle were stigmatized as lacking moral fibre and a morally robust personality. By garnering traction from public health officials, veterans facilitated the establishment of the PTSD diagnosis and contributed to the field of traumatic stress studies (McFarlane 2015).

Additionally, and more germane to our analysis here, the PTSD inclusion would simultaneously “set the stage for the modern era of research in the refugee field” (Silove, Ventevogel & Rees 2017: 131) with the proliferation of studies and scientific publications releasing trauma-infused findings on South-east Asian refugees (Reyes, Elhai & Ford 2008). It's important to note that, similar to the second alteration of the refugee role script (the metamorphosis from alien to victim of war), the mere suggestion of the refugee as having any trace of an inner psychic world was introduced and guided by the psyches of combat veterans and officials who revealed their own anguish and torment concerning what they had experienced. This eerily echoes the role shift of refugees as ‘victims of war’ during a time when their suffering held no experiential authority. Instead, the experiences of humanitarian aid officials and/or authority figures were the reliable and validating markers for the assumed suffering of refugees. Returning to the originators of trauma, the PTSD diagnosis, which had been

synonymous to “shell shock” from WWI, “battle fatigue” from WWII and “post-Vietnam syndrome” (Reisman 2016), had affected 30.9% of veterans over the span of a lifetime. Authors of the study deduced that 15% of veterans exhibited symptoms in their initial psychiatric evaluations (Goldberg et al. 2015).

The field of psychoanalysis was not left untouched. Thomas S. Szasz, one of anti-psychiatry’s leaders, highlighted one of the intersectional roads by which psychoanalysis and dynamic psychiatry travel in unison. Both “obscure and disguise moral and political conflicts as mere personal problems” while disregarding the accurate datum that “the laws of psychology cannot be formulated independently of the laws of sociology”. Thus, we must adhere to “psychosocial laws” (Szasz 2011). Consequently, in psychoanalysis, analogous literature containing trauma concepts was referenced to describe the experiences of Holocaust survivor refugees, their children and grandchildren. Psychoanalytic-scientific concepts like extreme traumatization (Krystal 1968), sequential traumatization (Kielson 1979), and cumulative traumatization (Khan 1977) can be said to be demonstrative of their alignment with psychiatry’s trends (note the dates of publication). Not long after 1982, psychological outcomes of torture coloured public perception of refugees by attributing signs of suffering to symptoms classified under PTSD. The once fledgling field of refugee trauma had become “extensive and diffuse” by the 1990s as a result (Allodi 1998: 90). These are the preliminary etchings of a therapeutic migratory framework.

A key figure in the dissemination of refugee trauma data was and is Richard F. Mollica. He is famously known and widely sourced for trailblazing the medical field of refugee mental health as director of the Harvard Program in Refugee Trauma (HPRT). His wide-reaching, highly impactful publication “Dose-effect relationships of trauma to symptoms of depression and

post-traumatic stress disorder among Cambodian survivors of mass violence” (1998) involved surveying a community of Cambodian survivors who fled the Khmer Rouge regime. The survey, conducted in 1990, championed a dose-effect relationship whereby “cumulative trauma continued to affect psychiatric symptom levels a decade after the original trauma events”, offering further validity to the PTSD criteria (Mollica 1998: 482). Put simply, the conclusion maintains the idea that pronounced responses or reactions of an individual are contingent upon the exposure or “doses” of trauma one may have encountered (i.e. witnessed) or interacted with (i.e. directly experienced) in their life. This model swept the field and set into motion the constitutive elements of what would be the refugee’s psyche and how a researcher or clinician would likely approach a refugee’s brain and mind. This is a manifestation of a response script of its time. The overarching theme in the refugee’s grand narrative would bear resemblance to that of a traumatized person. However, a groundbreaking review would seek to problematize the reformulation of the refugee role as traumatized. We will review this critique and its impact on how we understand refugee trauma today prior to delving into the refugee trauma literature featured in psychiatry and psychoanalysis.

### **The Trauma Critique**

A major systematic review published in 2005 ferreted out 20 studies reported in 24 publications, most of which applied predominantly validated diagnostic methods. The studies yielded data for 6,743 adult refugees. When analyzing unselected refugee populations in “larger and more rigorous surveys” as well as “optimum designs”, the review revealed that the prevalence of PTSD ranged from 3% to 86% and major depression ranged from 3% to 80%. Overall, findings pointed towards a heterogeneity across larger and fuller studies that were carried out (Fazel, Wheeler & Danesh 2005). The findings of this study ultimately “provided a

corrective to the tendency to regard all refugees as traumatized and in need of counselling” (Silove et al. 2017: 131). Systematic reviews structured like the aforementioned study began to highlight incongruencies across refugee populations and the authors investigating them. What emanated from this discovery would subvert the refugee as a paragon of suffering and instead offer up a newly devised script informed by “the trauma critique”. Although known to have developed earlier, the trauma critique found its place in psychiatry for the first time.

Laurence J. Kirmayer (2007), a trauma critic, obliquely spoke to the manufactured script of the traumatized refugee. Time after time, the refugee’s narration of self drifts away from the host country’s “expectations for plausibility, intelligibility, order and coherence” rendering a “narrative as defective, indicating cognitive dysfunction or some other form of psychopathology” (363). The issue faced by the field of psychiatry was simple. Its preferred methods did not comply with the actual problem, as there was no unanimous or congruent result that could adequately point to the degree to which refugees appeared sick and symptomatic. The glaring inconsistencies had presented a very serious threat to the psychiatric franchise: the refugee’s psyche could not be bound or delimited by cultural authorities like the clinician. Furthermore, the variability in findings with respect to symptoms of PTSD and depression had been primarily linked to methodological factors, with researchers urging colleagues “to use more methodologically rigorous and valid survey designs when conducting mental health assessments in postconflict settings” (Steel, Chey, Silove, Marnane, Bryant & Ommeren 2009: 548).

The volatility across studies carried out by positivist methodologies on refugee suffering resulted in a much-needed epistemological upheaval to counter what was not working. A call for psychosocial data collection methods and subsequent interventions for refugee mental health emerged. In current times, there is global alignment that refugees suffer from poor mental health

due to post-migration social determinants in lieu of prior traumatic exposures. Determinants include but are not limited to: income, employment, housing, language skills and interpretation, the asylum-seeking process, social support and social isolation, and discrimination (Hynie 2018). This is evidenced by and through the UNHCR's Mental Health and Psychosocial Support Strategic Plan (MHPSS) that "addresses the urgent need for improved mental health services due to widespread psychological distress". Its "protection program" builds further "resilience" through "promotion and protection of psychosocial well-being and treating mental health problems" (UNHCR Mental Health and Psychosocial Support Update: January to June 2024). To better frame this psychosocial development in refugee mental health, let us explore the key contributors of the refugee trauma critique and the overturning of mass psychological trauma and PTSD in refugee mental health and its relation to refugeeness.

From a mental health and, equally as important, political and sociological standpoint, the notion of refugeeness is said to be in large part constructed under the current psychiatric approach to refugee trauma (Weine & Henderson 2005). Not so long ago, refugee trauma was understood through a 'trauma-focused model', also known as a 'direct effects model', rather than through a psychosocial perspective (Miller & Rasmussen 2010). To elucidate, the trauma-focused model imposes a Western modality of public health, which includes 'war-event checklists' and post-traumatic stress disorder criteria. This approach relies heavily, and arguably solely, on the DSM, whose prime mover is the American Psychiatric Association. It remains undisputed and uncontested that refugees overall have elevated and more pronounced psychological turmoil than the general public, in particular major depressive disorder and PTSD (Fazel et al. 2005; Porter & Haslam 2005). However, this does not address the "methodological concerns" such as "using different measures and diagnostic cut-offs in assessment of trauma and

other psychological symptoms; limitations of comparing across refugee cohorts; using culturally insensitive assessment instruments; cohort variations in levels of traumatic exposure; sampling bias; and sample sizes” (Murray, Davidson & Schweitzer 2013: 3). A question that has arisen from these monological findings from the field of psychiatry is: “How can a diagnosis address genocide, torture, or unjust immigration policy?” (Bhui & Warfa 2010: 67). The response to this question is evidently complex, but it speaks to the distressing conditions of everyday life for a refugee, such as communal strife and ruptures, displacement, as well as the dearth of social and material support. These variables have been said to resemble the noxious quality of pre-migration war exposure (Miller et al. 2010). The examination of such variables and their implications for health is known as the ‘psychosocial perspective’.

More sociologically inclined scholars like Summerfield (1999) are challenging the construction of the refugee’s symptomatology, or in our case, a prominent facet of refugeeeness, by highlighting the pernicious effects of Western psychological frameworks. As Summerfield has noted, these frameworks can objectify personal psychologies that do not conform to a system of Eurocentric practice and psychological thought (1999). Gozdzia (2004) speaks of how the medicalization of trauma has diminished “the capacity of human beings to deal with anxiety and suffering, deny their resilience, render them incapacitated by their trauma and indefinitely dependent on external actors for their psychosocial survival” (206). The move from trauma to resilience since the establishment and promulgation of the trauma critique has been substantial.

The shift to resilience was depicted through various avenues including the evolutionary standpoint that “the type symptom domains of PTSD (avoidance and arousal) that follow intrusions might be seen as potentially adaptive, coinciding with the infantile defensive reactions of flight and the readiness for fight” (Silove 2007: 248). ‘Survival learning’ is echoed in the

sentiments of Summerfield and Miller et al. as studies have shown that refugees generally exhibit “good social adjustment” and migrants are in “good mental health” despite premigratory traumas. Here, we see the evolution of the response script under the ‘resilience’ framework. Beiser et al. (1995) emphasizes and pushes for the adaptive, rather than the maladaptive, narrative that plagues the field of traumatology and undeniably contributes to the condition of refugeeness. He does this by discussing the importance of harnessing “self-esteem” and “self-concepts” that are pertinent to the “restoration of a secure ethnic identity”. When sustained and maintained over time, it has been statistically proven that the tenacious, hyper-functional refugee family is not reliant upon or made up of the psychopathology and mental health accounts presented in many research studies today (Beiser 1995: 70).

Albeit scholars in Refugee and Forced Migration Studies have recognized a turn from a ‘trauma’ orientation to a critical victimology, or rather ‘resilience’ stance (Hart 2014), the refugee’s agentic identity continues to be under duress by different disciplines like sociology, psychoanalysis, and psychiatry. Afterall, resilience is “the process of adapting well in the face of adversity, trauma, tragedy, threats or even significant sources of threat” (American Psychological Association, 2014, para. 4). Its ‘healthy’ functioning *in spite* of trauma continues to centralize and prioritize loss in a refugee role that appears one can never rid themselves of, even past the point of permanent residence acquisition. The primacy of loss and the implications that it has for the refugee role and refugeeness will be laid out in the paragraphs to come when we examine what can be called ‘the psychological birth of the refugee’.

### **Psychoanalysis and Psychiatry: The Psychological Birth of the Refugee**

Published in 1989, León Grinberg and Rebeca Grinberg’s *Psychoanalytic Perspectives on Migration and Exile* laid out what would be a “psychopathology of migration”, a seminal work

which served as the bedrock of future psychoanalytic works on the subject. Their frame of reference for migration would include myths of Eden, Babel and the Oedipus. The myth of Eden would show migration as “a symbol of birth”. It is “the first migration of human life, which brings about dissociation (knowledge of good and evil), emergence of the most primitive anxieties (paranoia and depression) caused by loss of the ideal object, and anxiety of the helpless ego left to fend for itself”. Migratory experiences therefore involve distancing oneself from the “original maternal object” (5).

The vulnerable psychic state brought on by this distancing/loss of the maternal object can result in a defective “psychic envelope” (Houzel 1987; 2005; 2012). This concept, based on Anzieu’s (1985) “skin-ego”, is most commonly used in the context of the infant’s body image, however, it has been applied to the refugee’s psyche. It has been described as “missing” from the refugee’s constitution (Leuzinger-Bohleber 2018; Papadopoulos 2002). As part of this image, identity formation is spoken of through group structures and how members of “the same family” entails “the complementarity of maternal and paternal parental roles, which guarantees the constitution of the basic identity” of each individual, leading to the feeling of “belonging” (Houzel 2005: 136). The migration process in the Grinbergian sense engenders a rift with the maternal object, and if its role is compromised, as Houzel points out, one’s very organizational structure is decentered, fractured.

In their chapter “Migration as Trauma and Crisis” Grinberg et al. moreover explicates migration as a fragmenting, traumatic experience that can be categorized under “cumulative traumas and tension traumas”. Its manifestations and effects are “not always expressed or visible” but “effects of such trauma run deep and last long” (1989: 12). To survive the “catastrophic birth” of migration one must possess “a stable, secure inner object” supporting

one's "sense of identity" (Grinberg et al. 1989: 57). Clinical psychology similarly supports the perspective that refugees are susceptible and vulnerable to mental disorders many years after resettlement, in particular in high-income countries like Canada and the United States. They also maintain that prevalence rates of depression and PTSD do not change over time (Henkelmann, de Best, Deckers, Jensen, Shahab, Elzinga & Molendijk 2020). From the diverse psychological modalities considered thus far, we can assert the position that migration's destructive toll on one's identity induces mental illness or latent maladaptive constructs that cannot be directly observed. Migration's 'catastrophic birth' takes with it the cardinal role of the 'maternal' in one's constitution and history, jeopardizing elemental bits of one's psyche, including its 'envelope', the identity contained within it, alongside one's sense of belonging and security.

In reference to our refugee role script, the compartments that legitimize, foster and solidify a role(s) that pre-existed migration, is fundamentally incapacitated when the refugee role is operative. In my analysis in Chapters 4 and 5 we will dive deeply into how exactly the pre-migratory self is incapacitated using Mead's theory of mind and self. An individual's roles and identity cannot withstand the force behind a refugee trauma diagnosis. Another consideration as we are piecing together the refugee's script, from a living ideological symbol to a 'traumatized' one, is that the role is growing organs, like a brain and skin. The role is moving into an infantile direction that is being contained and supported by a diagnostic membrane. The parts of a person who is labelled or beholden to this role is suffused with a diagnosis - a *migratory diagnosis* - that represents loss, inferring the role's poorly developed 'skin'. The refugee is then left with a defective, discontinuous envelope and a loss of primordially informed roles that ensure identity integration. Diagnostic classifications and treatment plans stand in as the container for the refugee, as these things are attached to the refugee role that has been

internalized, creating the so-called *migratory mind*. A refugee who has missing or inoperative primordial roles can only act and function in ways that are inimical to their identity formation and preservation.

Psychoanalysis and its concomitant interventions recognize, as seen in the Grinbergs' and Houzel analysis above, that the migratory experience of refugees is that of loss: "loss of family members and friends; loss of ancestors' burial grounds; loss of familiar language, songs, smells, food in one's environment; loss of country; loss of previous identity and its support system" (Volkan 2017: 3). It is through these instances of loss that we discover what has been called the 'experience of dislocation'. The exploration of this experience is conducted in therapy, by and through the assessment of a patient's "ability to mourn and/or resist the mourning process". As it pertains to identity, this is best described through Salman Akhtar's (2009) depiction of the dislocated person's individuation process.

Derived from Margaret Mahler's (1968) "separation-individuation" process, individuation first occurs in childhood, then in adolescence where the individual undergoes a "second individuation". Akhtar has added a "third individuation" depicting the migrant's experience of having to separate and ultimately individuate as a means to adapt to one's new circumstance and way of living in the host country. Mahler (1994) believed that the "psychological birth of the individual" took place under a separation-individuation process where one establishes separateness and relation to the objective world pertaining to their own body and 'primary love object', whom they would have attributed as an all-encompassing figure of the world and their reality. And just like any other intrapsychic process, "this one reverberates throughout the life cycle. It is never finished; it remains always active: new phases of the life cycle see new derivatives of the earliest process still at work" (3).

It is from this that Akhtar further develops his concept of “third individuation” as having “only a phenomenological resemblance and not a genetic equation with the infantile processes it is named after. Much psychic structuralization has ensued by the time the third individuation takes place. The term ‘third individuation’ therefore links an adult life reorganization of identity to a childhood phenomenon in a playful and metaphorical way. However, the potential of reworking earlier separation-individuation conflicts through this process cannot be ruled out” (Akhtar 2009: 286-287). A brief dissection of this concept is required at this time. The ‘third individuation’ that an adult refugee undergoes is ‘linked’ to a child phenomenon. As depicted here, the repetition of infantilization takes place, and we shall continue to see it as a recurring theme in refugeeness. Upon migrating, the refugee must bear a “psychosocial process” that lends itself to the “reorganization of identity” better known as a “hybrid identity”. Next, the individuation process, better known as a “psychostructural change” (Akhtar 2009), can only fully unfold once the individual has auspiciously untethered themselves from the Grinbergian “original maternal object” and has made adjustments in accordance with the host country’s expectations. Before going any further, it is important to cast an eye over Grinberg’s reference to the maternal object as it is a pivotal concept psychoanalysts often reference when theorizing migration.

The original maternal object stems from Klein’s object relations theory and the infant’s experience from birth onwards. The anxieties an infant may undergo as a result of the loss of self-parts as part of organic development may muddle the manner in which mourning is experienced. Failure to mourn adequately by virtue of forced dislocation, violence, and survival guilt can lead to “perennial mourning” (Volkan 2017). The refugee’s mind-based functions and traits are laid out before us, co-constructing a script in the process. So far, it has been determined

that the refugee mind is first and foremost distinct in that it is “playfully” separate from childhood phenomena, but of course, “cannot be ruled out” should it interact with it in some way, shape, or form. The insinuation here is that there is an inherent separateness between refugee mind/role functioning and the organic 2-phase separation-individuation-mind that is experienced by, say, a home-grown Canadian. This third psychological process of individualizing, exclusively unique to individuals who fled their country of origin, involves jettisoning roles and parts of oneself. Put differently, further loss of oneself is not only encouraged in treatment settings for refugees but regarded as the solution to combat neurosis.

Assimilation and ‘well-being’ is contingent upon this hidden layer of loss. Should there be a disinclination to accept this loss of self, the individual will be deemed ‘sick’ and in need of treatment supplied by the exile country. Therefore, they may act ‘as if’ they were a refugee, which comes with a host of symptoms (remains an introjected object and ego-alien). Mechanisms of internalizing the refugee role will be presented in Chapters 4 and 5, as well as what happens in the psyche of the person once the role is internalized, that is, how the *migratory mind* is created and its implications. We can say with some confidence that the psychoanalysts covered thus far are metaphorizing a phenomenon they are indisputably surveying in the refugee populations they are treating.

In the trauma critique, we see scientists discovering inconsistencies in positivist approaches to the phenomenon under question, such that the refugee mental health field has fully adopted the psychosocial perspective, conceding that social determinants are in fact affecting refugees and their mental health. However, neither psychoanalysis, the trauma critique, or psychiatry are exploring the embodied effects of the refugee role. They all maintain that cultural and social variables have an effect on the mind and brain, but the role as a social determinant is

absent. What's more, they have also assumed that individuals who cannot withstand the journey due to a dearth of internal resources and cumulative traumas are bound to experience protracted symptoms of trauma effects and depression for decades to come, post-settlement. This places the impairment and incapacities onto the individual in lieu of assigning it to the refugee role – a role that is ascribed once an individual enters, or more aptly, is *born into* the host country. It begs the question we inescapably return to many a time: what if the refugee role and the script in question is making people sick? More specifically, what if it is the chief contributor to an individual's enduring mental health issues? Let us continue to fine-comb the current literature in the fields mentioned and how they continue to shape the traumatized refugee script and, more importantly, the interminable ramifications it has placed on the mind and brain of this role incarnate.

Let us circle back to Akhtar as a significant point of departure for the analysis. Akhtar proclaims that there is no “genetic equation” that the third individuation has in contrast to infantile processes of individuation as seen in the conventional separation-individuation theory of Mahler. However, there is a “potential” that it can interact with pre-existing (one would presume pre-migratory) childhood conflicts. The ‘potential’ opens up a once ‘metaphorical and playful’ concept to a product of biological maturation found in the process of individuation. This would affirm the concepts and formulations produced in the mind and brain sciences alike as they pertain to trauma. As we shall soon see, these fields are unwittingly partaking in the production of a role script that is exteriorizing refugeeeness (despite their conscious efforts to avoid this). Put differently, one can say, in this stage of the evolution of the refugee role, we are beholding the ‘psychological birth of the refugee’. As illustrated in the diverse fields that study refugees, its psychology is defective, regressive, and infantile. It is sketched out in psychoanalysis but also in psychology and psychiatry as something ubiquitous, observable, and

testable; the infantilization of this role is demonstrative in the findings of many different methodological measures, even at an organic, cellular, molecular, and *genetic* level.

In a few words, at a physiological level, PTSD negatively affects brain functioning in the following areas: the hippocampus, amygdala, and prefrontal cortex, as well as the psychophysiological, structural, and functional spheres of the brain (Pitman et al. 2012). Psychiatrist Bessel Van Der Kolk (2006) is the leading scholar in neurobiological responses to trauma. He discusses the debilitating challenges that victims face when they are confronted with intense emotions, such as “confrontation and inhibition with anger, physical paralysis with fear, physical collapse in response to helplessness” and so forth (3). The literature stresses that the brain of the refugee is readily and unquestionably different from a ‘normal’ brain as it is solely marked by loss – loss of country, loss of roles, loss of self, and loss of physiological and perceived controllability. A concrete example of this was discovered in asylum-seeking children in Sweden in the early 2000s.

These were children who had faced persecution in their country of origin and had previous exposures to trauma. Upon receiving notification from the Migration Board in person or through the form of a rejection letter issued to them or their household, the child would fall into a coma. Their neurophysiological reactions were linked to “learned helplessness” or better described as catatonic states induced by acute fear seen in many mammals. Children with the syndrome would display staunch “refusal” to “acts of help in the early stage of resignation syndrome”. On July 1st, 2014 the diagnosis “resignation syndrome” was included in the Swedish version of ICD-10 (von Knorring & Hultcrantz 2019). As part of their treatment and recovery, a residency permit was regarded as “essential” for rehabilitation. It was discovered that the syndrome exclusively affected refugee children in Sweden, and what we know about the asylum

process in Sweden is its drawn-out waiting periods with respect to an individual's residence status (Sallin et al. 2021). Uncertain migration status is a strong predictor of PTSD in other studies as well (Chu, Keller & Rasmussen 2013; Laban et al. 2008).

The concept of “social death” plays an etiological role in resignation syndrome and has much to do with the “sharpened Swedish asylum laws and practice” (Elsrud 2020: 500) mentioned. The term ‘social death’ has been discussed in both psychoanalytic literature (Nadig 1986) and social work (Elsrud 2020) to describe ostracization and imperiled personhood and agency in refugees. Despite some theorists offering ‘metaphorical’ and ‘playful’ terms to the lived experiences and psychologies of refugees, resignation syndrome (RS) leaves no room for that. RS is a physical and psychological ailment affecting vital organs such as the brain, and in turn, overcomes the body, prompting non-responsiveness. The non-responsiveness of the body inevitably begins to affect other vital organs from functioning. Bodegård (2005) noted that patients presented as “totally passive, immobile, lacks tonus, withdrawn, mute, unable to eat and drink [often requiring feeding tubes], incontinent and not reacting to physical stimuli or pain”. These symptoms are largely driven by psychosocial ‘triggers’ that are treated pharmaceutically, medically, and lawfully (i.e. by means of granting residency). Without residency, one's legitimacy to exist is compromised as highlighted in the notion of a “social death”:

The concept ‘social death’ when describing the participants’ position in the Swedish margins, a segregating time-space where they must wait while having become ‘dehumanised’ and ‘un-grievable’ by Swedish authorities and racist discourse. The concept encompasses the condition where some young asylum-seekers have become devalued, in a ‘right-less’ position where authorities, including the social services, ignore, exclude and take away their opportunities for interaction, self-protection and self-control leaving them with severely restricted possibilities to master their situation (Elsrud 2020: 501)

Social death can therefore be applied to the state of refugeeness, a state of being that the refugee role is wholly subject to and operates through. The concept of social death and its relation to RS is a clear demonstration of the refugee role and, more importantly, the physical

facet it inhabits. A ‘role’ that is often relegated to the domain of sociology can lead to hospital admittance and medical intervention. This clearly shows the impositional power of the role upon the body; should it be further implemented and enrolled by governmental bodies onto an individual, directly threatening the parts of them that delineate their personhood through exclusion, third-party control, and uncertainty, we may see – and have seen– material death by a role. Social life, in contrast, involves pre-migratory role retention. To illustrate this point, let us consider *Michaelisdorf*, a refugee reception center in Germany. The interesting part of the “Step-By-Step” program is its commitment to the banality of humanhood and subjectivity. The not-so-interesting part is the “step-by-step” branding, where in pediatrics, the “Step-by-Step approach” is a popular method to treat febrile infants (Gomez et al. 2016). Besides this, the program is inspired by psychoanalytic and interdisciplinary trauma research, and was developed in the Sigmund-Freud-Institute which started early prevention projects between 2003 and 2015.

The program could be said to inadvertently recapitulate dimensions of refugeeness, but there was one component of the program that concentrated on individual characteristics. More specifically, their roles. The psychoanalytic perspective recognizes refugees “not as a homogenous group but rather as individuals having a specific trauma and live history” (Leuzinger-Bohleber 2018: 161). There was a system in place to dissuade “passivity” and the way of going about this involved “getting something” as well as “giving something back” for two hours a day. This included translating, gardening, painting rooms, helping others with activities, and so on. But, what was also seen in my own study, is that once researchers engaged with the individual characteristics of an individual, residents of Michaelisdorf “became highly diverse residents”. Researchers found residents like “an illiterate bricklayer from Syria as well as an expert of English literature and a pianist from Damascus, a car mechanic from Eritrea and a

hotel operator for the US army from Afghanistan” (Leuzinger-Bohleber 2018: 153). The efficacy of the program, with its consideration for psychosocial factors, was not insignificant. Its recognition of an individual’s pre-migratory roles alleviated the strangulating hold that the refugee role can have on ego-functioning and its strengths.

The inclusion of the trauma critique and its psychosocial perspective across all fields is undeniable and further proves that refugeeness and the role that encapsulates it has both an immaterial and material occupancy in our world. That it can engender social death, and if circumvented, can produce *social life*. The refugee role cannot be reduced to a fleeting administrative or political term that is simply discarded once residency is made available to the individual by the exile country. More studies have come to support this. One study (Frost et al. 2019) examined a sample of refugees and found complex PTSD (marked by relational traumas and cumulative traumatic exposure) and “simple” PTSD (situational traumatic experiences), confirming the dose-response effect paradigm in Mollica’s articulation. It also supported the study that refugees are more likely to experience symptoms than the host country population (Fazel et al. 2005).

Seen elsewhere, a nonclinical group of resettled refugees reported “decreased” symptoms over time, but a “substantial proportion of the group remained above the threshold scores after 23 years of resettlement”. The assessment tool used for this study evaluated “mental characteristics including impaired reality testing, disorganized cognitive processes, intrusion of trauma-related imagery, and destructive self and other mental representations”. The most notable unchanged facet over the course of the study in the refugee’s psychology was “relating to others was still difficult, and the way the participants perceived themselves and others was also still problematic”. Although exile life functioning was high and patients received psychotherapy

treatment that resulted in a decline in symptoms, “there is a need to address the high levels of depression and anxiety, as well as PTSD” (Opaas & Hartmann 2021: 869) that persists in these populations long after resettlement. In parallel, Jungian analyst Dr. Monica Luci (2024) characterizes this process in refugees as “losing a psychic skin”.

The adaptation of every single person (being functional or dysfunctional) can be looked at as a process in which the borders of the ego in relation to the self (intrapsychically) and the border of the self towards other selves (interpersonally), or the group(s) and the environment(s) can be disrupted and renegotiated, partially maintained, partially changed, and sometimes painfully or traumatically...refugees in their post-traumatic suffering, of whatever nature and extent, below or above the imaginary threshold of psychological disorders, the boundaries of the self seem to be in play and their nature, extent and organization are renegotiated (p. 771)

The perpetual and seemingly unending renegotiation process that one must abide by in exile gives “rise to different ways of Being” that “entails changing conceptions of self” and “boundary experiences” as defined in the concept of refugeeness (Dobson 2004: 23-24). Intertwined in refugeeness are experiences of “inclusive exclusion” whereby “boundaries between inclusion and exclusion become blurred” (Dobson 2004: 248). The refugee role’s permeability also allows, quite easily, for scripts to alter and meet the exile culture’s liking, leaving its carrier continuously on uneven ground. The term refugeeness understands the “refugee’s flesh of the body experience sublimated into signifiers of culture, such that they constitute a web of relations understood as a flesh of a shared history” (Dobson 2004: 161).

With its lack of psychic skin and inclusive exclusion standing in the world, refugees entering wealthier global north countries experience a culture that is suffused with what sociologist Frank Furedi (2004) would call a “therapy culture”. Touching upon the psychosocial perspective, Furedi claims the western culture has recast social problems as emotional ones, furnishing us with “a one-dimensional preoccupation with the self” leading to “overlooking the social and cultural foundations of individual identity” (25). This outlook makes way for one

principle, and it is that of emotional determinism. The refugee sublimated into signifiers of western culture, that being therapy culture, suggests that there is a possibility that the refugee role can and does interact with its own past (its past in this case would be the living ideological symbol, featured in our previous reading of the refugee role). As we continue to shape the refugee role's mind and script through psychosocial perspectives, another quality we can extend to the refugee role is dynamicism, for the role demonstrates a capacity to interact with its own past.

The incorporation of the psychosocial perspective has certainly expanded our understanding of the refugee role, but we must not forget that the role is defined by loss and how its effects permeate the lives of those affected. Psychotherapeutic approaches and tools for testing have been refined and reformatted since psychosocial determinants were considered. This has been instrumental in increasing assimilation and resilience among sufferers, however, we continue to be left with what remains as an inexplicable habituation among individuals who have been labelled "refugee". The impasse point arrived at each time suggests that individuals who are cast as refugees must negotiate refugeeness as it profoundly impacts their quality of life, irrespective of their functionality, resilience and adaptivity.

This dissertation seeks to explore and subsequently provide fitting approaches for the purposes of theoretical and clinical utility for practitioners and theoreticians alike when they encounter this phenomenon. To date, practitioners and researchers continue to test and probe into what is believed to be the prevailing contributing causal factor to a refugee's enduring maladies. An overview of refugee mental health studies (34 studies, 14 quantitative, 14 qualitative, and 6 mixed-methods) published in Global North countries between 2000 and 2021 found that qualitative studies most commonly studied depression, PTSD, anxiety and subjective well-being,

and quantitative studies applied the HTQ (Harvard Trauma Questionnaire), the Hopkins Symptom Checklist-25, and the World Health Organization Quality of Life scale. Qualitative studies examined the following themes and concepts: “refugee place making, healing and wellbeing practices through the concept of therapeutic landscapes; wellbeing as both subjective experience and an individual psychological condition; resiliency; experiences of psychosocial support and mental healthcare; some unpacked feelings of stress and insecurity, depression and psychological distress” (Ermansons, Kienzler, Asif & Schofield 2023: 4). Each of these studies simply captures a unifaceted, singular experience. Researchers tend to measure how the refugee either interacts with disturbance or how that disturbance ought to be treated. Arguably, this also demonstrates how ubiquitous response scripts are. Despite psychosocial indicators at play and resilience, as an effective trauma processor, the locus of existence for the refugee continues to be trauma. Herein lies the *trauma trap*. This concept will be developed and elaborated throughout my case study research, but it certainly applies here. Let us turn our analysis to the field of social work, whose attention to the psychosocial indicators of suffering is of prime importance when evaluating the chronic outcomes refugees suffer from.

### **Perspectives in Social Work**

In the field of social work, Patricia J. Shannon (2012) is best known through her contributions to the UN’s Sustainable Development Goals in 2015. She lays out 7 categories containing explanations as to why refugees found it difficult to engage and disclose within a mental health setting. These seven categories are: history of political repression, fear of community judgement, a belief that talking does not help, lack of knowledge about mental health and mental health treatment, posttraumatic avoidance symptoms, shame, and cultural values and belief (Shannon et al. 2012). Shannon and those of her ilk suggest empowerment and

psychoeducational tools to refugees who “did not share their trauma histories with their doctors for reasons that reflected their lack of knowledge about how trauma affects health” (53). To add to this, a recent key finding in barriers to seeking help also included “self-stigma”, a supposed PTSD effect found in those who “perceive the experience of their own PTSD symptoms as negative, embarrassing, or shameful... findings suggest that individuals with a refugee background were concerned about eliciting disapproval or being perceived negatively” (Byrow, Pajak, McMahon, Rajouria & Nickerson 2019: 9).

If we were to decipher the workings of this approach through our migratory framework, we would understand the ‘sharing of one’s trauma history’ as ‘empowerment’. ‘Naming the trauma’ would achieve this process and elevate an individual to a survivorship plane. Should an individual not share their ‘trauma’, which is demonstrative of a counter-dependence towards the script and arguably challenges the response script, the host official is taught to interpret this as sickness. The official will then call on the past of the refugee role, the traumatized refugee role, to aid in responding to this ‘problem’. Here we see that the refugee role’s past is the only referent to moving forward and no other option is viable or considered.

In an earlier study Shannon and her colleagues offered guidelines to physicians on how to interact with refugees who experienced resistance in disclosing, encouraging physicians to “inquire directly about the trauma histories of refugees and to provide education about the potential impact of that trauma on long-term health outcomes” (Shannon, O’Dougherty & Mehta 2012). Below in Table 2 responses for not sharing trauma histories with doctors were provided (see Shannon et al. 2012: 51).

**Table 2.**

Reasons given for not sharing trauma histories with doctors

Responses (n = 42)	Women	Men
1. The doctor did not raise the topic.	14	4
2. It was not the purpose of the clinic visit. The clinic visit was for medical/health concerns.	7	3
3. I don't want to talk about it/don't want to remember/I want to move on	3	3
4. Too little time in the doctor's schedule.	2	3
5. 'I feel they will not understand my English'	1	
6. 'Back home there wasn't that open communication with your doctor, so you hold things to yourself. I think it takes time.'		1
7. I feel like the patient needs to bring it up.	1	

Shannon's suggestion could be interpreted as not only a form of colluding with the refugee role and script, but more directly teaching a response script of empowerment to physicians. Solicitous questions from the physician are offered up as a solution for individuals who may not be well-versed in the refugee role script. The response "The doctor did not raise the topic" can denote the indisputable fact that the physician holds the script to the role and the response script, to which the refugee knows nothing about. The refugee attended the hospital visit for concerns regarding their health, concerns they have certitude on (see response 2). This was not a response the authors of the study would pay any heed to. In fact, response 2's content was reconfigured to fit a 'defensive trauma maneuver' in order to fit the 'traumatized refugee role' response script. This is reminiscent of the internalized view from the victim of war role that was fashioned off of a set of scenes which caused internal disturbance and guilt to its onlooker, designating that internal conflict as the principal descriptor to the experiences of those seeking refuge. Not much has changed today. On the flip side, should the refugee be conversant with the script, Byrow et

al. (2019) identified “self-stigma” as the barrier to their disclosing. In other words, should an individual internalize the traumatized refugee role, or reject it, the procrustean rulers of the regime will continue to execute response scripts where they see fit.

The operative word being “self” and the hyphenated ‘stigma’ thereafter, emblematic of a confined self that is solely belonging to a diagnostic classification. According to the Greek-English lexicon “stigma” is a Greek noun that translates to “a mark, dot, puncture” (Liddell & Scott 1843). The autonomous, agentic self that is subsumed under the refugee role is encased in a defective membrane akin to a psychic skin that is susceptible to puncturing. By now, we are no stranger to the trauma trap, whereby individuals who carry the imposed refugee role are either ignorant and dependent on the knowledge of perceived authority in the exile country, or they are cognizant of the role, however they reject it and must be treated for it to ‘assimilate’ effectively. Having reviewed the refugee mental health literature, we concretely and intimately familiarized ourselves with response scripts and how they are operationalized. Concurrently, we were able to firmly establish the traumatized refugee role and the resilient refugee role. We will now turn our attention to the methodology I have chosen to conduct research on this dimensionalized refugee role and its effects on the mind.

## Chapter 3: Methodology: Case Study Research

### Introduction

In the preceding Chapter a comprehensive overview of refugee mental health and refugee trauma was presented to further develop our concept of refugee role scripts and their lasting pernicious effects on the migrant's mind. The identification of harm induced through refugee role ascriptions offers up a psychic appendage to Dobson's (2004) term refugeeness. In this Chapter, I will walk the reader through my case study approach and methodology. As discussed and demonstrated in Chapter 1, an explanatory, retrospective, qualitative meta-study of psychoanalytic case studies has been proven to be the most effective research strategy to address our research question(s). Accordingly, a cross-case analysis of raw data has been executed across 5 clinical cases to demonstrate, explain and generate theory around the highly complex issue of refugeeness<sup>1</sup>. One's everyday exposure and interaction with refugee trauma and its operatives (i.e. clinicians, intervention models, policy, any given state's responses, expectations, and impositions) encapsulate the facet of refugeeness we are examining.

The complexity of our interpretive understanding of refugeeness presents us with a dilemma, or a quagmire: high-functioning, resilient, adaptive individuals who have fled from their country of origin, and are now years into resettling in the host country, are seeking treatment to address enduring mental health problems. Through our extensive literary review in the last chapter, we discovered unaccounted-for knowledge gaps. This study intends to highlight

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<sup>1</sup> As a reminder to the reader, our concept of refugee role scripts was spurred by Dobson's (2004) notion of "refugeeness" whereby "refugees in exile are the source of hybrid exile cultures, founded existentially, through ontologically valued choices, which give rise to different ways of Being" entailing "changing conceptions of self" and "boundary experience" (23-24). Mentioned elsewhere, Dobson coined the term to develop "theoretical tools capable of revealing the lived life of refugees" and to explore the "experiential and existential quality of the experience of refugees, as they make choices in the construction and living of their cultures of exile" (2004: 7). Dobson's concern is that of the "daily life of refugees" and how policies and reception have informed "cultures of exile". The theory of refugeeness therefore seeks to capture what the "prerequisites for self-recognition and survival" are for refugees (2004).

how these gaps are contributing to the relegation of mental health concerns, presented by this population, to their migratory experiences of loss. Or worse, should a patient not meet any criteria indicative of a psychiatric disorder or underlying psychobiological dysfunction, their suffering is deemed clinically insignificant (Stein, Palk, & Kendler 2021). On these grounds, a differential diagnosis is proposed (other potential condition or disorder) or care is denied. This is the making of a refugee role script. A script that is, often through humanitarian policies and psychoeducational means, explained to and experienced by a migrant.

To elucidate from this last point, the motivation behind the trauma critics, presented in Chapter 2, is to subvert the master narrative of ‘the traumatized refugee’ by recognizing the individual’s resilience and survivorship. In other words, they have converted the trauma ascription to an *adaptation to adversity* ascription known as resilience. The psychosocial perspective raised in refugee mental health studies known as the “contemporary trauma critique” challenges the “nosologic validity of [PTSD] when applied across cultures”. However, they also recognize that “there is a risk that if the critique of PTSD is mistaken, then survivors of trauma may be further disadvantaged by a failure to provide appropriate special care for their mental health needs” (Silove et al 2007: 319-320). This is the dilemmatic situation we are confronting. Although the well-intentioned approach has influenced and shaped policy across the refugee mental health field, it has not effectively attended to the problem of refugeeness as we understand it. In fact, I argue that it has unknowingly reproduced it, as seen across the cases I will be presenting in Chapters 4 and 5.

This reproduction had become patently clear to me as a practitioner who applied and implemented the psychosocial approach, in particular a resilience model, in sessions with patients who meet certain criteria (see Figure 2 under *Case Selection*). Clinically, the ‘trauma

critic' psychosocial approach regards refugees as possessing the capacity to call on survival strategies and competencies (Summerfield 1996) as well as resilience (Marlowe 2010) during their migratory experiences. They maintain that the over-diagnosing/medicalization of PTSD and depression superimposed on people who have faced forced displacement or fled their country in fear of persecution is, in large part, due to post-settlement social determinants and not solely centered on pre-migratory factors. Having built a practice oriented and motivated to problematize the Western "expert" and "victim-patient" (Summerfield 1996) polarity through the inclusion of survivorship rhetoric, I continued to notice the inefficacy of the approach. This inspired the reexamination of clinical cases I had treated under the survivorship/trauma critic *modus operandi*.

My multicase study hinges upon the conundrum presented in the aforementioned paragraph. Bearing this in mind, I seek to widen and contribute to the psychosocial approach and Dobson's theoretical tools by further dimensionalizing Dobson's theory of refugeeness and the experience of refugees post-settlement in Canada. In addition to the role scripts provided thus far, I propose a robust description of the refugee role's impact on the migrant's mind by revealing the intrapsychic mechanisms and workings of the facet of refugeeness that elicits sickness. This is made possible under the aegis of my case study research and analysis of 5 patients who sought therapy in my private practice, all of whom held, or arguably still hold and are confined by, an ascribed refugee role.

The refugee role, its script(s), response scripts, and the inclusion of my concepts, the *migratory mind* and the *trauma trap*, intend to better define and shape the experiential landscape of the refugee role and psyche, expounded upon more concretely in the chapters to follow (Chapters 4 and 5) where the reader can learn about my findings and analysis. In this chapter, I

will furnish the reader with my research design, which is guided by Yinian case study research methods. I followed a chronological order of actions that best reflect my research design or “blueprint” (Philliber, Schwab & Samsloss 1980). This blueprint clearly lays out “the logical sequence that connects the empirical data to a study’s initial research questions and, ultimately, to its conclusions” (Yin 2017: 25). To start, it is incumbent upon us to explore the ethical considerations prior to the inception and formation of protocols and how I administered them.

### **Ethical Considerations, Reflexivity & Limitations**

My ability to conduct a retrospective longitudinal study with the intention of carrying out a systematic meta-study of clinical records is in part due to my social work practice, which is regulated by The Ontario College of Social Workers and Social Service Workers (OCSWSSW). I am a licensed and registered social service worker and have been actively practicing psychotherapy, while in supervision, since 2015. During this time, I became and continue to be a trainee at the Toronto Psychoanalytic Society’s (TPS) Advanced Training Program for Psychoanalytic Psychotherapy, affiliated with the Department of Psychiatry at the University of Toronto. For the first two years in the program I was taught psychoanalytic concepts and theory and this subsequently informed my practice of psychotherapy with patients. Supervision and mentoring occurred in tandem with theoretical understandings and practice development by selected psychoanalysts who are affiliates of the International Psychoanalytic Association (IPA), which was founded by Freud and is the principal regulatory body for psychoanalysis. Supervision entails critical observation and examination of the trainee’s subject position(s), triggers and defences that may consciously or unconsciously unfold in the therapeutic encounter, partiality, and the active carrying out and practice of psychoanalytic theories and models. This is

meant to guide and assist the researcher or practitioner's 'honest gaze' (Frosh 2010); the cruciality of this must be referred back to in the midst of transcription procedures.

Additionally, differences in race, class, and gender are interrogated by the training analyst, in particular when cross-cultural therapy is conducted. Moreover, this will be useful as the reflexive stance I am assuming must examine how certain subject positions complicate or impact meaning-making activities I had undertaken during the research design phase of my research. In addition to following the code of ethics and standards of the TPS, overseen and monitored by the program and training analysts, I abide by the OCSWSSW standards of practice. As it relates to the research I am proposing to conduct here, the OCSWSSW standard and criteria for records is essential as it should reflect, as seen in Principle IV in the OCSWSSW handbook, "current, accurate, contain relevant information about clients and are managed in a manner that protects client privacy and in accordance with any applicable privacy and other legislation". In regards to disclosure of information from a record for research and educational purposes as outlined in 4.4.4 in the handbook, 'identifying information' must be removed and a clients' anonymity must be protected and subsequently maintained throughout or as section 5.6 states, "a disguise of identifying information" must occur should a client's consent be obtained. For disclosure of records a, consent form was reviewed and signed by each individual who has volunteered disclosure of their clinical records (see more details in the section *Case Selection*, where I go into more depth).

Clinical records will undergo review and analysis within a critical realism framework. The importance of our framing here would be useful to describe through critical realist Roy Bhaskar's (1975, 1986, 1989) analysis when he outlines two dimensions of science, the transitive and the intransitive dimensions. The former dimension speaks to the experiential component of

scientists with respect to their convictions and theories. The latter dimension speaks to the mind-independence of the world in which we live in. With the implementation of a reflexive stance, or rather, engaging with the transitive dimension of my research, one is confronted with two types of reflexivity outlined by Carla Willig (2013). The first, personal reflexivity, is marked by ways we reflect upon our experiences, interests and political commitments, in addition to our social identities and how they may shape our research. To further this, Davies & Gannon (2006) recommend researchers develop 'critical literacy' to recognize their own processes of subjectification whereby discursive and constitutive acts engaged in must be investigated by the researcher (88). The second, epistemological reflexivity, asks questions like: "How has the research question defined and limited what can be found? How have the design of the study and method of analysis constructed the data and the findings?" (Willig 2013: 10).

This seemingly subjectivist slant may appear limiting, but should not be assumed as being without objectivity, especially since we are working within a critical realism framework that does not completely reject mind-independent realities but acknowledges that social realities are constructed. To elucidate, I shall refer to Parker's (2002) description of traditional social psychological research under his concept of 'zero-sum equation'. Here he talks about the efforts exerted by the researcher to obtain an objective position while actively deferring a subjective interest in research. However, in order to do so, the researcher must "discard subjective involvement in favour of an objective attitude. In this process the researcher exchanges an affective engagement in the topic (an interest in the research and in a successful outcome) for the object status of the subjects". Of course what then happens is that subjects are debased, objectified and subsequently seen as subhuman and "the experimenter, when she understands her own role only in relation to an objective array of facts and data independent of her...suppresses

her nature as a human being investigating, and in relation to others” (192). This is not a true reflection of either researcher’s or subject’s day-to-day realities of phenomenological experiences.

In keeping with this, while engaging in a discursive reading of the clinical notes under critical realism, it is important to recognize that mind-independent realities exist. In other words, investigators may not have the “real thing” or event available to them but only the subject’s imitation as narratives provided are “event-centered—depicting human action— and they are experience-centered at several levels” (Riessman 2008: 22). In regards to my personal and epistemological reflexivity more specifically, it is crucial to examine my constitutive and discursive acts within the therapeutic frame as particular patients diverge in a multitude of ways from my social location; my countertransference must be examined contemporaneous with my standing in particular to notions of “survivorship” and trauma which are largely Western notions I was not acculturated into, nor were many to most of the patients being considered for this study.

The particular thematic functions and constructs of terms I am investigating or taking up were largely absent in my immediate milieu and the political commitments I hold require constant personal and academic exploration. To combat against reflexive blind spots, such as the one identified in the aforementioned sentence, I will look for ostensive material within the case notes that indicate clear disruptions or reproductions of a trauma narrative that may have occurred due to certain questions being asked and more importantly what happens after questions are presented, such as “how clients take up (or not)...presuppositions and how therapists respond to clients’ ‘resistant’ responses to questions observable, for instance, in clients’ non-answers” (Gaete et al. 2018: 124). Although reflexivity does not accept objectivism, it does not mean it

goes without validity, which is a scientific standard. Discourse analysis exercises or makes use of validity by evaluating political significance. In other words, research is evaluated from the standpoint in which “the researcher can judge her own and others’ research in terms of the role that the research plays in the maintenance of, or challenge to, power relations in society, that is, in relation to the ideological implications of the research” (Jorgensen & Phillips 2002: 117). In addition to these objective facets of reflexive work, a lot of the literature from this stance cannot account for complex unconscious processes that operate in conjunction with research production, formulation and execution (Frosh 2010), hence why it is key that I maintain and utilize a critical realist stance throughout my navigation of reflexivity. This was operative throughout, including for my case selection process.

### **Case Selection**

In keeping with the ethical guidelines it was important to assess potential risks this study may pose for participants and implement strategies to minimize these risks. Steps were taken to educate participants to address and reduce any potential harms. Their active and inactive status in treatment was considered during the case selection process. More importantly, the therapeutic alliance experienced by both parties during therapy was central to ensure consideration, transparency and sensitivity, all of which were in effect during this process. Clients considered for the study were emailed to gauge interest, and this was followed up by a phone call outlining details of the study, as seen in the Informed Consent Form below (see Figure 1). S.I. and R.F.’s cases concluded well before I initiated contact for the study, while the others were active patients of mine during that time. All clients agreed from the outset and signed the consent form. Both verbal and written consent were given. In addition to the ethical attention reviewed thus far, other considerations were taken into account for selection. I referred to Pauwels and Matthyssens

(2004) who speak of their principles entitled ‘Four Pillars and a Roof’, the first of which highlights the importance of selecting typical and atypical cases so one can bring to the fore contrasting and diverging results. Another helpful guide for case selection was Stake (2006), who stated as a matter of course three central laws for case selection: “1) Is the case relevant to the quintain [i.e. the phenomenon]?; 2) Do the cases provide diversity across contexts?; 3) Do the cases provide good opportunities to learn about complexity and contexts?” (23). How I tended to these laws is indicated below.

For starters, the five clients selected for this study all volitionally sought out therapy and determined suitability through a web search that directed them to my website. Other clients found me through Psychology Today. The latter is an online platform that provides articles and blogs on mental health in addition to offering resources, guidance and an extensive therapist directory of verified mental health clinicians and practitioners. My specialization and training is in trauma therapy, clearly indicated and specified on both platforms mentioned. Clients' reasoning for seeking out therapy is featured in Figure 2 below. Patients chosen for this study are demographically and socio-economically diverse with different psychological, structural and constitutional makeups. Individuals identify as male or female and originate from three different regions in the world (Southeast Asia, Sub-Saharan Africa, and the Middle East). They range between 23 and 37 years old. Patients all demonstrated profound suffering comparable to the refugee trauma discussed both psychoanalytically and from a psychiatric standpoint in Chapter 2. Their reasons, or the reasons provided by their caretakers, for leaving their country of origin range from religious persecution to displacement to adoption to human rights violations. As per the global trends, all the countries of origin included had faced mass displacement both internally and as refugees in the past several decades.

In regards to the legal title “refugee”, some may have been regarded as asylum seekers, then refugees, and *then* sponsored family members, while others have an elective migrant title by means of holding a student visa or international student title. Legal titles are important for states because Global North Countries such as Canada and the United States are expected to adhere to refugee protection acts and laws that promote international justice and security, in particular to those who are fleeing their country of origin from persecution. What we understand now however is that elective migrants, sponsored family members, economic migrants, and international students can also face ascriptions akin to the refugee. The old-hat prejudicial argument that *all* migrants or immigrants voluntarily leave their country of origin while an asylum-seeker or refugee flees or is forced to leave their country does not take into account 1. Both parties are not guaranteed protection from persecution; 2. Gender identity and precarious environmental factors that are not considered or met under the grounds of persecution; 3. “Age, gender, income, education, housing, employment, English language proficiency, race and ethnicity, social support” (Kemmak, Nargesi & Saniee 2021) are among other shared social determinants of mental health in immigrants and refugees.

From this premise, it is important to consider that refugee ascriptions are not strictly for the “refugee”. For example, S.I. was adopted by her Aunt and Uncle and taken from Uganda to the United States before settling in Canada. This was due to losing her mother to HIV/AIDS and having a negligent father who was by and large absent due to severe narcotic addiction. Ugandans have faced significant challenges with the HIV/AIDS epidemic and in 2004 the WHO stated that Uganda had the highest alcohol and substance abuse rate in the world (World Health Organization. Global status Report on Alcohol 2004). S.I. would face these precarious conditions alone, with no security or basic guarantee of shelter and food. Her paternal Aunt and Uncle

would eventually adopt her and bring her to the United States. Her legal title was not “refugee” but the precariousness embedded in her birthplace coupled with the post-settlement experiences and expectations she perceived to have been imposed on her by the host countries (the United States and then Canada), would suggest otherwise.

On the subject of post-settlement, among the selected cases, the number of years settled in the host country range between 2 and 27 to demonstrate diversity, variability, and allows for rival explanations, should the study and analysis present any. When I mention post-settlement, I am specifically referencing post-settlement in Canada, as some of these patients may have been in one or more transit countries for a significant period of time. Legally understood as a “country of transit”, it is not uncommon for migrants to pass through one or more countries to arrive at a place that is suitable for ‘home-making’ and integration into a new society. Post-settlement therefore means “a short period of mutual adaptation between the newcomers and the host society, during which the government provides support and services to newcomers. Integration is a two-way process that involves commitment on the part of immigrants to adapt to life in Canada and on the part of Canada to welcome and adapt to new peoples and cultures”

(<https://www.canada.ca/en/immigration-refugees-citizenship/corporate/transparency/program-terms-conditions/settlement.html#>). The variables considered thus far for the case selection process follow a logical guide presented by Yin. I used this and the importance of generalizability to guide me through my multiple case study.

From the aspect of a logical guide, Yin (2017) speaks of “replication logic” as a reference anchor for researchers pursuing multiple-case selection whereby cases selected either “a) predict similar results (a literal replication) or b) predict contrasting results for anticipatable reasons (a theoretical replication)” (55). It was found, and we shall later see in the next chapter, that

contrasting results were in fact seen across the cases but yielded a fruitful theoretical replication for our study. On the subject of replication, generalizability is often presented as an ‘issue’. Although it is commonplace for qualitative researchers to rebuff the notion of generalizability, growing interest has cropped up in the field of education, more specifically, evaluation research and basic research on educational issues. In our case, generalizability is not taken to promote “broadly applicable laws” or do without “thick descriptions”, rather it is strived for “to speak to or to help form a judgement about other situations” and make room for “similarities and differences between situations” (Schofield 1993: 97).

Often in multiple-case studies “generalizability is the goal, allowing the juxtaposition of an emerging theory and the extant literature, including competing theories” (Sarvimäki 2017: 903). Put differently, the work done here is akin to drawing “analytic generalizations” whereby one elaborates upon and generalizes theories instead of drawing “statistical generalizations” (Yin 2013). The primary objective behind multiple case studies is to have a better grasp of a phenomenon by selecting a “balance and variety” (Stake 2006) of cases that will lead to a working hypothesis (Schofield 2000) and “better understanding and perhaps better theorizing about a still larger collection of cases” (Stake 2005: 446). Multicase studies “sampling of attributes” should be further on the list than say “balance and variety” (Stake 2006). Gomm, Hammersley & Foster (2000) have spoken of the systematic selection of cases to manage the “problem of empirical generalization” and can include selecting cases that are “typical in relevant respects” in place of “convenient” (111). The cases we will explore in the next chapter clearly demonstrate the scrutiny and analysis of these methodologists, as the importance of heterogeneity and subverting conventional generalization is of utmost importance in the

production of knowledge in the field of refugee mental health. Let us now turn our attention to the phenomenon we are investigating and the evolution of our research question.

**Informed Consent Form Date:** \_\_\_\_\_

**Study name:** *The Trauma Trap: The Sociological Imagination of Refugeeess Understood through Traumatology and Feminism*

**Researcher:** *Farnoush Mozafari, Doctoral Candidate, Graduate Program in Sociology, York University.*

**Contact:** *Business no. (647) 991-9966*

**Purpose of the research:** *The impetus for this study will be to explore and engage with existing theoretical presuppositions pertaining to the refugee experience and the use of survivorship and trauma as a medical label in a therapeutic context with the intention of demystifying the experiential dimensions of the refugee. Furthermore, critical self-reflection in relation to psychoanalytical practice is a tried and tested approach that is encouraged as a core feature of the profession. Having said this, the trauma model utilized in session will be the primary object of study rather than your personal story. The cases will act as a vehicle to better understanding the efficacy of the refugee trauma narrative and trauma model.*

**What you will be asked to do in the research:** *You will be asked to provide consent to clinical records from our past sessions.*

**Risks and discomforts:** *There are minimal to no risks associated with your participation. In case you feel any discomfort at any point of the discussion you can withdraw consent from this study. A 45 minute meeting will be held in advance of accessing your file for research purposes. The meeting will outline the research, roles and responsibilities that I shall carry out as a principal investigator and therapist, the use of the anonymized data, the limits of confidentiality, and resources you can access should discomfort arise and you wish to address this beyond the dyadic relationship you share with me. At this point I will ask if you require additional time in considering whether or not you wish to participate in the study. If not, this informed consent will be offered and formalized by the both of us.*

**Benefits:** *As a racialised demographic who are often spoken about and mischaracterized in the social imagination of the West, providing information about one's migratory experience for knowledge production and advancement may contribute to strengthening your agency and contribution to the field of psychotherapy to better understanding and navigating cross-cultural therapies, in particular within the context of trauma.*

**Voluntary Participation:** *Your participation in this study is voluntary so should you wish to stop participating at any point you are welcome to do so. Your decision to withdraw consent will not influence the nature of your relationship with me, the practice, or York University either now or in the future. For added comfort, data extracted from your case file and used for the purposes of*

knowledge development in this project will be accessible to you prior and post final submission.

**Withdrawal from the Study:** You can withdraw from consent at any time, for any reason, if you so decide. Your decision to not be a part of the study will not affect your relationship with me, the practice, or York University. In the event that you exercise the decision to withdraw all associated data in relation to your case will be immediately destroyed wherever possible.

**Confidentiality:** Confidentiality will be provided to the fullest extent possible **by law**. Exceptions include the duty to report suspected child abuse or neglect. All information supplied during the research will be held in confidence, your name and specifics will not appear in any report or publication of the research. Data collected during this study will be securely stored for 7 years, after which it will be destroyed. Confidentiality will be provided to the fullest extent possible. In regards to disclosure of information from a record for research and educational purposes as outlined in 4.4.4 in the Ontario College of Social Workers and Social Service Workers (OCSWSSW) handbook, ‘identifying information’ must be removed and a clients’ anonymity must be protected and subsequently maintained throughout or as section 5.6 states, “a disguise of identifying information” must occur should a client’s consent be obtained.

Data will be collected through clinical notes that are generated within therapeutic confidential bounds and aligns with the ethical considerations outlined in the Ontario Social Workers and Social Service Workers code of ethics and standards of practice manual. During the re-transcription phase, identifiable data and personal identifiers will be removed, and discernible characteristics such as location, name, employment and other key identifiers of the patient will be altered or all together not mentioned should they yield no relevant connection to the thesis.

Data will be securely stored in a locked filing cabinet and access will be strictly limited to the principal investigator (Farnoush Mozafari).

**Date by which the data from this research will be destroyed (mm/dd/yyyy):** 02/01/2028

### **Questions about the Research?**

If you have any questions or require further information about this study, please contact the researcher, Farnoush Mozafari, Graduate Program in Sociology; or the supervisor, Dr. Christopher Kyriakides, Associate Professor, Department of Sociology, York University, [ckyriak@yorku.ca](mailto:ckyriak@yorku.ca), phone: (416) 736-2100 Ext: 60305; or the Graduate Program Director in Sociology, Professor Luin Goldring, [socigpd@yorku.ca](mailto:socigpd@yorku.ca), phone: (416) 736-2100 Ext: 33913.

This research has been reviewed and approved by the Human Participants Review Sub-Committee, York University’s Ethics Review Board and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines. If you have any questions about this process, or about your rights as a participant in the study, you may contact the senior Manager and Policy Advisory for the Office of Research Ethics, 5th Floor, York Research Tower, York University, telephone (416) 736-5914 or e-mail [ore@yorku.ca](mailto:ore@yorku.ca)

### **Legal Rights and Signatures:**

I \_\_\_\_\_, consent to participate in the above-mentioned re  
[participant's name]

-search study conducted by Farnoush Mozafari. I have understood the nature of this project and wish to participate. I am not waiving any of my legal rights by signing this form. My signature below indicates my consent.

Signature: \_\_\_\_\_

[Participant]

Signature: \_\_\_\_\_ [Principal investigator, Farnoush Mozafari]

Date: \_\_\_\_\_

**Figure 1. Consent Form**

Pseudonym	Age at start of treatment	Gender	Country of Origin	Reason for Migration	Legal Status History	Years Post-Settlement	Exposure to prior therapy Y/N	Duration of therapy	Chief complaint/presenting issue for seeking out therapy
R.S.	27	F	Iraq	Religious persecution and displacement	Refugee; Sponsor-ed family member	9 years	Y	4 years	Lack of affect, isolation, experiences with racism
S.I.	23	F	Uganda	Adopted at age 10 due to unstable economic and political conditions	Sponsor-ed family member	13 years	Y	3 months	Apathy, relational challenges, hopeless
M.K.	29	M	Bangladesh	Human rights issues; unstable economic and political conditions	Refugee; Sponsor-ed family member	23 years	N	5 years	Addiction
T.T.	37	M	Sri Lanka	Religious persecution; war	Refugee; Sponsor-ed family member	27 years	Y	4 years	Health fears characterized as "health anxiety"
R.F.	29	M	Iran	Human rights issues; unstable economic and political conditions; fear of political persecution	Student visa	2-3 years	N	2 years	"Depressive symptoms", apathy, flatness, relational issues

**Figure 2. Case Selection Chart**

## **The Phenomenon and the Evolution of a Research Question**

What we shall see in this section is how I developed questions to address what was reflected in the literature and ultimately my clinical cases. Through “direct observation of the events being studied and interviews of the persons who may still be involved in those events” (Yin 2017: 12), I found repeated observations across a series of cases on which theory can be built. The general observation is quite simple and clear: irregardless of the patient’s registration of reality – understood psychoanalytically and psychiatrically to be dependent on their type of character organization, defensive processes, developmental levels of organization and symptomatology – patients who fled their country of origin in fear of persecution would convey uneasiness and dissatisfaction in their lives that would manifest as uncertainty in their narrations of self in the present. Oftentimes, within the context of refugees and migration, this lack of continuity, knowledge, and understanding in the self can and has been misconstrued as refugee trauma, PTSD, dissociative symptoms, and/or a well-known psychological factor of PTSD known as “intolerance for uncertainty” (Oglesby et al. 2016). An example of the latter is best demonstrated in the concept “resignation syndrome” (see Chapter 2) and holders of insecure visas (Liddell et al. 2023). The incongruity and peculiarity found here is straightforward: individuals who have successfully resettled are still sick, and we do not know why. The sheer paucity of studies on this matter is alarming and demands attention, a demand that I took upon myself to pursue. In the paragraphs to come, I will walk the reader through my preliminary working questions, propositions, and research questions.

The pattern of uncertainty in narrations of self in the present across the clinical cases I will be presenting in this study took place in a therapeutic setting encompassing a dyadic relationship between myself (fulfilling the role of therapist) and the client (fulfilling the role of patient). This relationship is regulated and overseen by a ‘system’ and ‘programme’ in my

private practice, namely, psychotrauma treatment guided strictly by psychoanalytic psychotherapy. Given this, I began building my preliminary questions around the modality of care implemented in these cases. The modality of care I offer extends beyond a strict set of trauma-focused models by considering complex psychosocial models that are imbued with adaptivity (Garmezy 1991; Masten 1989; Werner 1995; Werner & Smith 1992), self-efficacy within a multicultural perspective (Castanos-Cervantes, Garcia & Reitz-Kruger 2024), functionality (O’Leary & Ickovics 1995) and resilience. My approach towards trauma has ideologically and practically taken into account the importance of resilience and survivorship. The popularization of these concepts, most notably seen in the 1980s, emphasizes the individual’s proclivity for adaptation (Ayalon 2005) and the need for the “survivor” to reconstruct the “totality of their life history” (Ornstein 1985). With this in mind, it was imperative to seek an understanding of the outcomes of adaptivity and survival in the context of trauma and refugeeness through a series of “how” questions (Yin 2017):

1. What impact does survivorship have on the recovery of traumatized refugees?
2. How do survivorship or resilience frameworks challenge the condition of refugeeness?
3. How might survivorship and refugeeness overlap?
4. To what extent can therapeutic interventions enable refugees to move beyond refugeeness?
5. How might therapeutic practices/interventions reinforce refugeeness?
6. What are the potential benefits of trauma-based interventions for refugees?
7. What are the potential limitations of trauma-based interventions for refugees?
8. In what ways could therapeutic practices be improved so as to take account of the impact and influence of refugeeness within the therapeutic relationship?

The observations and raw verbatim data reviewed over the course of my cross-case analysis were guided by the preliminary questions seen above. The review, in conjunction with what was revealed in the refugee mental health and trauma literature, supported the questions enough to “bound the case”. Put another way, the questions helped to identify the case by

“tighten[ing] the connection between the case, the research questions and propositions” (Yin 2017: 31). In the review of clinical notes and data, propositions or “potential answers” to the questions posed were in mind throughout to help focus and guide the collection and analysis of data. However, as themes and subthemes were being developed, rival theories or competing explanations and questions emerged (see Chapters 4 and 5). This is conventional as “concluding with new questions” (Yin 2017) or “dropping” questions or allowing them to “evolve” in order to “understand the quintain better” (Stake 2006: 14) is necessary for theory and research building purposes. The study pivoted from a theory-led project to a theory-generating one. The evolved research questions, tasked to reformulate what is commonly viewed as PTSD symptomatology and its redrafted substitute, resilience and survivorship, are:

1. How does an imposed or internalized refugee role impact the psyche?
2. How can an ascribed refugee role make an individual sick?
3. How can an ascribed refugee role be mistaken for a psychiatric condition or trauma/PTSD?

The evolution of the research questions above licensed us with greater access to the quintain as demonstrated in Chapters 4 and 5 where the analysis and findings from the chosen cases are developed and presented. In the section to come, I describe how data was collected, or rather how I operationally carry out the practice of survivorship in my clinic.

### **Data Collection Methods: The Operationalization of the Ethos of Survivorship in the Clinical Situation**

As mentioned elsewhere, I am conducting a retrospective study on data that has been collected prior to the commencement of this study. The process of collection, although acquired prior to the research design process, is important to be familiar with as the preliminary questions of this study surrounded the notion of survivorship and its accompanying concepts (resilience,

adaptivity, functionality) propounded by the psychosocial perspective. The redrafting and reformulation of trauma understood by the psychosocial perspective was carried out with the patients who were selected for this case study research. As discussed in some detail in Chapter 1, in my clinical practice with patients I follow a trauma recovery model informed by a feminist perspective (Herman 2015; Chodorow 1999) that upholds multicultural principles (Gorman 2001; Ivey 1995), better known as “psychocultural mobility” (Gielen, Draguns & Fish 2008). This mobility model rejects monocultural orientations that trauma interventions conventionally adhere to. Instead, it is in alignment with resilience-focused treatment programmes (De Jonghe et al. 1997; Southwick et al 2023; Laban et al. 2015; Calhoun & Tedeschi 2013) which seek to empower the patient by facilitating a shift from “traumatized victim self” to a “survivor self” (Gorman 2001: 448). This entails a therapeutic regime that is akin to a feminist psychoanalytic approach.

What is meant by the psychoanalytic approach is the ‘contemporary psychoanalytic approach’, best described by Nancy McWilliams as “an open-ended effort to understand all of one’s central unconscious thoughts, wishes, fears, conflicts, defenses, and identifications” (2004: 17). Bearing this in mind, I have referred to psychoanalyst Judith Herman’s (2015) three stages of trauma recovery in my practice, which one can confidently say, effectively captures the ethos of survivorship. The stages are: 1. safety, 2. remembrance and mourning, 3. reconnection and ordinary life. In the midst of this three-tiered staged scheme, clinicians have to ‘name the problem’ by conducting an informed diagnostic evaluation. Although I consult the DSM-5, psychoanalytic psychotherapy has proffered another nosology whereby diagnostic labels are supplanted with “the dimensional, inferential, contextual, biopsychosocial diagnostic

formulations characteristic of psychoanalytic and humanistic approaches” (Lingiardi & McWilliams 2015: 237).

The ‘naming’ of the trauma under the ‘psychoanalytic diagnosis’ (McWilliams 2011) framework helps clinicians develop a dynamic case formulation to guide and inform them on treatment decisions that can then be shared with the patient. The tenets of psychotherapeutic practice mentioned here must operate through a deep understanding of the patient’s developmental level of personality organization that is informed by the individual’s characteristic defensive style. At this juncture, it is important to note that throughout this dissertation I will be critiquing the very model that I apply in my own clinical practice. As well-intentioned as I and other practitioners are, what will be surfaced is highly critical of the approach. The theory I will develop involves a migratory framework that comes to bear in therapeutic settings wherein psychosocial approaches, in particular resilience models, generate refugee role ascriptions that ultimately make and/or keep people sick. It is truly a situation where the cure is worse than the disease.

The first three to five sessions of therapeutic engagement involve conducting an assessment in order to decipher what stage of psychological growth or pathology the patient is in. Following this, the clinician seeks to identify the patient’s type of character and then assesses any early childhood developmental obstruction that may inform the clinician on how they ought to proceed, as to not leave the patient vulnerable to threat (i.e. triggers).<sup>2</sup> Progressing through this preliminary understanding of the patient’s psyche, the clinician is expected to proceed through a treatment modality that is best suited for the client. This can include ‘exploratory’ or ‘uncovering’ work that has been deemed insight-oriented or ‘expressive’ treatment, or a

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<sup>2</sup> It is important to note, that this is the training I underwent, and we shall explore in the next chapter how this has contributed to the reproduction of refugeeness in its own unique way.

‘supportive’-based approach (McWilliams 2011). This phase of therapy, for the purposes of our study, is critical as the roles of the individual will be expanded upon here. In accordance with the literature and our analysis thus far, the refugee role’s eclipsing effects can take center stage at this interval of therapy, in tandem with the establishment of ‘safety’.

As part of Herman’s first stage of recovery under ‘safety’, a psychoeducational approach is included. This tenet is geared towards enhancing transparency while diminishing power differentials in the hopes of developing a positive therapeutic alliance, also known as a positive transference. Strategies of safety are designed to ‘restore control’, as victims are robbed of their agency and the perceived controllability they can often experience in situations where they have encountered trauma. Thus, it becomes the clinician’s commitment to recovery “to restore power and control to the survivor” (Herman 2015: 159) by addressing control of one’s body. This is illustrated in Salman Akhtar’s (2011) work on immigration and acculturation where he speaks of “allowing the patient a greater amount of physical settling in the office” to connect to a physical space that acts as “a tangible glue to their internally destabilized perceptual world” (41). As an extension to concrete connections, exploring existent or potential social supports while establishing stability in lieu of exploratory work is important to execute at this point in time. A sense of rudimentary safety in the environment has to be achieved for this stage of the recovery process to be complete.

Herein lies again the importance of the therapeutic relationship and understanding of one’s countertransference. To strengthen the dyadic rapport “clarifications about boundaries, clients rights and therapeutic goals and the character, interests, and role of the therapist” is key “with refugees whom psychotherapy is culturally unfamiliar”. To sustain and maintain this approach, the patient “determines when and how to proceed” to assist the therapist, as the latter

can “inadvertently trigger fears of intrusion and danger, recapitulating the earlier duress of interrogation and compromising or even terminating the treatment” (Gorman 2001: 447). At this point, it is safe to take preliminary steps towards examining the patient’s attachments from both the past and present in order to determine how one can support the empowerment principle for the survivor. More specifically, attachments are framed in the literature and the mind of the clinician within the context of loss for the refugee, including the loss of oneself. We will see in the next chapter how this can pose a problem for both parties, again, inadvertently.

The second stage of trauma recovery is remembrance and mourning. The survivor engages in a work of ‘reconstruction’ where the traumatic memory coalesces with the survivor’s life story (Herman 2015: 175). As we will see later in this paragraph and in my analysis, when viewed through the lens of the migratory framework and its focus on reframing past experiences through ‘loss’, much of the therapeutic work, in an almost inescapable way, play a role in creating and keeping both clinician and patient in the trauma trap. What is understood about trauma is that it ‘shatters’ an individual’s sensorimotor and cognitive functions. The ‘traumatic scene’ could not be retained in one’s memory bank (Leys 2000). Trauma’s effects on victims leave them feeling “altered” or “other” and “nothing more than a series of heterogeneous and dissociated roles” (Roustang 1988).

Forgetting is a primary symptom of trauma, and reflectivity of trauma means conjoining the past and the present under two particular mental faculties: representations and imagination (Caruth 1995). Steps towards “reconstructing the trauma story” are taken by reviewing the patient’s life prior to the trauma. The outcome involves the patient’s developing capacity to excavate the appropriate details and historical context that the fragmented, partially repressed traumatic content belongs to. The patient’s ability to verbalize traumatic content in and around

this time of reconstruction can be a challenge for patients, as the content has historically presented itself through nonverbal methods such as psychosomatic reactions, abreactions, repetition compulsion, and the like. On the subject of mourning, some patients are plagued by “established pathological mourning” or what Volkan (2017) calls “perennial mourning” (17). The effort here is to examine all forms of loss, such as one’s country of origin, familiar objects, security, and honour. Reactions to these losses marked by forced migration are said to be linked to other traumas that ought to be explored and integrated in the reconstructed narrative (Volkan 2017).

The clinician of the refugee is expected to engage in “conducting developmental work in regard to the changed physical reality” of the individual. This involves “helping the patient find words for new external and internal experiences, maintaining hope over long periods of time, correcting culturally emanating misunderstandings of social reality and genuinely believing that development is a life-long process and ego-mastery does not end with one or the other developmental epoch” (Akhtar 2011: 45). It can be said that the therapist is acting as the ‘container’ for the patient who has lost the “containing membrane of home” (Stubley 2021; Papadopoulous 2002) through the narrative developing process. The practicalities of operationalizing this stage are comprised of containing dysregulated affect through “modulated emotional reworking of the trauma” accompanied by “cognitive restructuring” (Gorman 2001: 447) of the content one is attempting to actually ‘remember’ in order to effectively mourn as opposed to reliving a trauma that has not been successfully converted into memory that can be situated in a history that is appropriate.

The treatment of once or current displaced and dislocated persons often takes shape in this way. However, this second phase does not take into account that the refugee role, now taking

precedence in the sessions, demands within itself the jettisoning of roles that can leave one feeling 'altered' or 'other'. Another consideration may be that the trauma story starts with refugee ascriptions, arguably ascriptions that are unknowingly being recapitulated in the very 'remembrance and mourning' this stage promotes for 'well-being'. The final stage of recovery emanates something similar, but more specifically, the uncritical push towards the internalization of the refugee role. This point cannot be stressed enough: the resilience approach generates refugee role ascriptions, and these are the output of the migratory diagnosis that comes from practicing, albeit unknowingly, through a migratory framework, together all of which create the trauma trap and perpetuate illness in refugees.

The third and last stage of recovery is reconnection and ordinary life. The survivor now "faces the task of creating a future" by successfully mourning "the old self that the trauma destroyed" (Herman 2015: 196). Herman specifically alludes to refugees and immigrants in her elucidation of this stage, stating that survivors who have altered personalities in large part due to the trauma "often feel at this stage of recovery as though they are refugees entering a new county [...] battered women or survivors of childhood abuse, the psychological experience can only be compared to immigration" (2015: 196). This stage entails recognition that one was victimized prior to the establishment of safety and the process of reconstructing a cohesive, integrated narrative that regards the trauma as part of one's life story. Now, the individual is prepared to be empowered to acquire the capacity for reconnection. This stage bears witness to the 'once victim now survivor' patient who has interrogated maladaptive social reactions and has increased control over bodily and emotional responses that have manifested the power they once lost due to the trauma (Herman 2015).

With little to no guidance from the clinician, the patient recognizes maladaptive defences versus healthy ones and they can identify what is a normal affect state versus a trigger response or symptom. “Desire and initiative” is encouraged (202) and modelled by the survivor in sessions. These improvements are manifested within the therapeutic dynamic and are lived through the transference. The patient comprehends reconnection through the experience of integrating their pre-traumatic selves with “a more resilient and enabling sense of identity” (Gorman 2001: 448). I argue in the next chapter that this stage, controversially, is where the patient is confronted with either adopting a refugee script that has now become apparent through the stages of recovery or is deemed ‘repressed’, ‘defensive’, or a different type of ‘sick’ in consequence. Let us now review how I procedurally went through the data collected.

### **Conducting a Retrospective Multicase Study: A Look into Procedure**

In this segment, I will provide an overview of my research design and analysis. I followed three distinct steps in my process: 1. Discursive reading of the entire interview text; 2. Identified core narratives and themes; 3. Re-transcribed the core narratives and conducted a fine-grained analysis. The multiple case study research strategy is vital here as it closes “the gap between the objective of the study and the object of the study” allowing us to capture “the subjectivity that is embedded in the object” (Pauwels & Matthyssens 2004: 3). This allows us to take a deep dive into the psyche of a refugee and the role reifying it. My research begins with a discursive reading of the entire interview text. To preface, discursive psychology (DP hereafter) specializes in the use of “naturalistic materials” which includes “records of what people actually do” such as therapy, counselling, everyday phone calls, neighbour mediation and the like (Wiggins & Potter 2008: 78). Its ultimate interest is in how objects of psychological enquiry are

worked through discursively (Gibson 2018), hence why retrieving data from clinical records under DP yielded the most fruitful results.

Discursive reading was limited to 5 clinical records from 5 different patients who have been treated for trauma and identified themselves as having been forced to leave or flee their country of origin. The progress notes reviewed include session details (date and time), client information (identifiers and demographics), chief presenting issues, medical history, the assessment, psychoanalytic case formulations, the client's general response to my interventions (prompts, probing, guidance and interpretations), my observations of the client (including my countertransference) and the treatment plan. Throughout the discursive reading and verbatim data review, I kept the following questions in mind: What can be defined as disruption or reproduction of refugeeness? Who is acting the disruption or reproduction? Through a close discursive reading of "available words, metaphors, and broad patterns of description available to language users" (Gibson 2018: 7), I mined for core themes and narratives that were integral to evaluating refugee trauma treatment in practice. As we shall see in the next section, when moving through the clinical notes segment-by-segment, the data revealed codes and factual, thematic and analytic categories where properties, dimensions and subcategories were derived (Kuckartz 2014).

This moves us into the second phase of identifying core narratives and themes. After discursively reading through the clinical records with a fine comb and ferreting out material for analysis, I referred to my research questions and several guiding questions that stem from DP's functionalism to identify "implicit constructions" (MacNaghten 1993) from any given extract (i.e. explanations/example dialogues). The prime mover behind these questions situates itself within a critical realist social constructionism orientation, as the functional facet of DP asks

‘What is this discourse doing?’ rather than ‘What do participants’ responses tell us about their attitudes, beliefs or thoughts?’ (Willig 2013: 119). In other words, we see the accessibility to reality beyond discourse in action, while simultaneously being forced to then re-engage with that reality discursively. For the purposes of my study, I will identify themes through explicit and implicit constructions of my own responses to patients (more specifically a response to their symptoms, the transference and countertransference, and their narrative) in-session coupled with the conscious (material, manifest) and unconscious (immaterial, tacit) responses provided by the patients. What these responses *do* can emerge through and/or affect social psychological factors tethered to the treatment or outside of it and/or intrapsychic phenomena both at a conscious and unconscious level.

The ongoing challenge during this time was to strike a balance between tacit, unconscious content, indigenous concepts of stress and what Yinian case study methodology calls for the researcher to do, as case study research is quite distinct from psychoanalytic research. The latter involves unearthing unconscious processes by means of developing a ‘third ear’ (Reik 1983) in order to arrive at a deeper understanding of the client’s intrapsychic defenses and fantasies. The ‘listening’ I carried out in my case study research involved bracketing and suspending the inclination to root out a hidden meaning of my client’s words. This suspension was maintained from the open coding process straight through to the selective coding procedures. An example of this could be during the open coding process, where I had to conceptualize the data and identify categories along with their sub-categories. The category mentioned elsewhere thus far as “uncertainty” in the narrations of self in the present was not reduced to a symptom, defense or an unconscious spectacle. Therefore, I was looking at what the responses were *doing*, *not* how the analytical situation would have interpreted it. These

reductions seen in psychiatric and psychoanalytic practices today have arguably given rise to what I coin elsewhere as the *migratory mind*. Therefore, in accordance with DP and ongoing guidance of Yinian case study research methodology, I captured core themes and narratives through social and intrapsychic phenomena by specifically seeing how refugeeness surfaces in ‘ideological dilemmas’.

The concept of ideological dilemmas was developed by Billig et al. (1988) who drew the distinction between ‘intellectual’ ideologies and ‘lived’ ideologies. Billig et al. argues that the ideology of a society or epoch is analogous to its culture and “concepts of culture and lived ideology are similar because both seek to describe the social patterning of everyday thinking”. Furthermore, individuals “partake of the general cultural patterns of that society, and their thinking is shaped by these patterns. The word ‘culture’ could easily be substituted by ‘ideology’” (1988: 28). Lived ideologies are known to be inconsistent, fractured, and contradictory, where contradictory maxims can exist side by side and are consequently subsumed under common sense. These ‘dilemmatic’ facets of our lived ideology generally go unseen or overlooked (Edley 2001).

When evaluating the germination and subsequent treatment of trauma from a theoretical standpoint, we have been able to schematically sketch out many inconsistencies that stand in direct contradistinction to its consistent and pervasive messaging. This is concerning insofar as practitioners and patients enter the therapeutic frame with a pre-transference or counter-transference that can sully and ultimately thwart the agentic objectives and motives drawn out by insight-oriented therapies. Themes centered around refugeeness’ reproduction or disruption in the therapeutic encounter can be gleaned by what language does and how it is operationalized under a lived ideology carried out by both the patient and me. This section will

require me to code my data along the lines of disruption and reproduction of refugeeness by outlining themes that influence the development of ‘subject positions’

Through the re-transcription of core narratives and fine-grained analysis, I consider Louis Althusser’s paper on ideology in 1971 where “subject positions” appeared. As a result of what he called ‘interpellation’, individuals recognize and ultimately place themselves in subject positions in systems of power with the guidance of ideology, gradually enabling their own domination within that power structure. Derived from Althusser’s philosophy, DP understands subject positions as “locations within a conversation” that “can change both within and between conversations (i.e. as different discourses or interpretative repertoires are employed) so too do the identities of the speakers” (Edley 2001). This is critical as we pull out elements of the discourse that represent the way in which disruption and reproduction emerge in the therapeutic encounter. Drawing out how they may emerge in sessions will entail reviewing codes, code descriptions and their relevant themes closely, for the identification of subject positions in my study will further solidify inconsistencies like how survivorship may overlap with refugeeness, or how refugeeness may impact the therapeutic alliance/relationship, and how subject positions unfold or acclimate in light of refugeeness being interrogated by myself, the patient or by us both.

This section of the research design is captured quite nicely in Potter and Wetherell’s (1987) summary of the principle tenet of discourse analysis as “function involv[ing] construction of versions, and is demonstrated by language variation” (33). Viewing discourse as variable will be key in analysis as it ties everything together. The constructive nature implanted in discourse is reliant upon the function being carried out. The function is context-dependent and therefore the analysis should reflect the variability of this discourse (Gibson 2018). The notion of subject

positions is critical for how we have come to conceptualize role scripts and the refugee role's function in the sessions. As part of my analysis, it was important to examine "pattern matching" and carry out "explanation building" (Yin 2017) around raw data and the case study research methodology, as opposed to inadvertently calling forth the migratory mind through exercising my default psychoanalytic and diagnostic practices (practices include excessive 'interpreting' or 'decoding' or 'offering' up psychoeducational tools to clients, which can unknowingly turn into offering or superimposing a role script onto one's client). By simply categorizing and coding without any excess processing, aggregating or psychoanalytic interpretation of the data we can come by "behaviors, strategies, states, conditions, [and] consequences" (Simmons 2017) more honestly. It was important that the analytical techniques deployed here, coupled with the cross-case synthesis did not lend themselves to what may be happening clinically.

### *Theme Identification*

Clinical progress notes from the first 6 months of therapy, at a frequency of once a week (50 minutes in duration) with each patient, was reviewed. I opted for a theoretical orientation for my case study analysis due to the abundance of data and content I had at my disposal. As reiterated elsewhere, this meant I used theoretical propositions derived from refugee mental health literature and what I had observed in my practice in lieu of working my data from the "ground up". The primary theoretical proposition I formulated was simple: refugees who have settled and "successfully integrated" in Canada for many years present enduring mental health challenges in relation to their settlement. The challenges peripherally manifest as uncertainty in narrations of self in therapy. This suggests that the survivorship and resilience paradigm may be reproducing refugeeeness, as highlighted in the clinical situation. This helped to organize the analysis by "pointing to relevant contextual conditions to be described as well as explanations to

be examined” (Yin 2013: 168). Figure 3 below illustrates how I organized my content and textual data alongside the rhetorical devices for each patient.

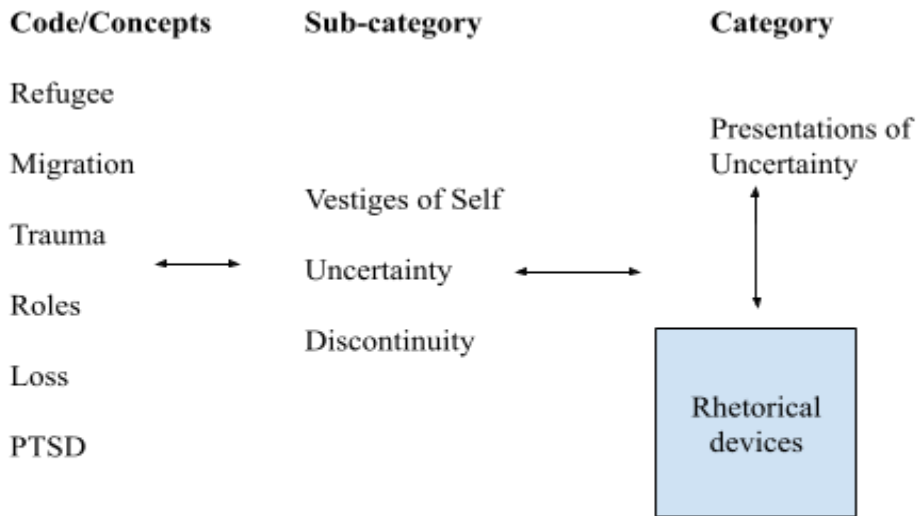
Excerpt of Uncertainty	Therapeutic Stage of Expression of Uncertainty	Interactive therapeutic context of Uncertainty	Clinical interpretation (defense, symptom, pathology)	Excerpt of Certainty	Therapeutic Stage of Expression of Certainty	Interactive therapeutic context of Certainty
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**Figure 3.**

During a close line-by-line discursive read of the clinical progress notes of all five patients, I inductively and deductively arrived at what Stake (2006) calls the “quintain”. At this open coding juncture, I familiarized myself with the data corpus to ferret out core themes and categories that solicit query. Abigail Lock and Kristy Budds’ (2020) application of critical discursive psychology suggests coding from an interpretive and descriptive standpoint. Procedurally, one “assigns various kinds of codes to the data, each code representing a concept or abstraction of potential interest” (Yin 2013: 169).

The descriptive concepts of potential interest from the qualitative data sources, guided by textual analysis practices (Kuckartz 2014) and the coding imparted by DP, included ‘refugee’, ‘migration’, ‘trauma’, ‘roles’, ‘loss’, and ‘PTSD’. Through the identification of these themes, I further developed sub-categories by way of axial coding, the intermediary procedure between open coding and selective coding (Kuckartz 2014). The sub-categories, gleaned from excerpts containing the overarching descriptive themes mentioned, revealed ‘vestiges of self’, ‘uncertainty and certainty’, and ‘discontinuity’. Once I had put these excerpts and quotes together, I arrived at presentations of uncertainty. Presentations of this type were exclusively manifested by dint of rhetorical devices and textual features (see Figure 4) across all the

participants in their narrations of self in the present. On the subject of self, as mentioned in Chapter 1, we will be referring to Mead's self-system to organize our understanding of uncertainty and the self in the chapters to come.



**Figure 4**

## Chapter 4: The Migratory Diagnosis

### Introduction

In the anterior methodology Chapter, I provide an abridgement of my psychoanalytic practice tenets regarding trauma rehabilitation of refugees and migrants under the section “Data collection methods”. In the section mentioned, one would have read my adoption and implementation of psychoanalytic theories on trauma and refugees and the heralded ‘three stages of trauma recovery’ as outlined by psychiatrist Judith Herman (2015). It is a three-tiered approach comprising safety and stabilization, remembrance and mourning, and reconnection and ordinary life. Furthermore, it is substantiated by other psychodynamic practitioners and operationalises a survivorship ethos while strongly interfacing with resilience-based treatment programmes. I strive to challenge this approach in the chapters to follow vehemently. One integral argument that I am posing in this dissertation is that the adoption of the refugee therapeutic model, outlined by refugee trauma critics and traumatologists in the fields of psychoanalysis and psychiatry, does not adequately counter the negative conditions of refugeeness that induce suffering. These conditions include ascription-assignment, imposed role scripts, and dehistoricization that leads to infantilization. Illuminated in the data to come, such therapeutic models demonstrably recapitulate a refugee trauma script despite pursuing the inverse. I call this the *trauma trap*.

In an attempt to circumvent this trap, I propose a typology of refugeeness for the purposes of therapeutic practice. It is a model that is substantiated by input from my data and work with clients. As a preamble, Chapter 2 set out to thoroughly explore refugee mental health literature, supporting the notion that *exile is at the core of the refugee’s experience*. We have

come to understand this as refugeeness (Dobson 2004). From this, one could contend that the therapeutic encounter with an individual who is subject to the refugee role and its ascriptions more often than not operates through a ‘migratory framework’, a framework that prioritizes *loss*, trauma, and recovery by means of diagnosing or analysis. It is a framework that relegates the past and the pre-migratory self and mind to an object-in-morning, a symptom, or a defense. I argue that this framework has given rise to what I call a *migratory diagnosis*. I devote this chapter to unpacking the migratory framework and the migratory diagnosis it generates. By way of clinical progress notes and cross-case analysis, in this chapter and the next, I intend to show how the *migratory mind* is part of a therapeutic construction that promotes the reductive conditions of refugeeness. Let us now address how this relates back to our research questions: How does a refugee role impact the psyche? How can an ascribed refugee role make an individual sick?

In Chapter 1, the refugee role in Parsonian terms is a “symbol unto itself” that “can never quite be internalized by any ego”. I concluded the history of the refugee role script section by theorizing that the Parsonian ‘internalization’ of a role, such as the one we are investigating, can in fact occur if an individual has a defective, sick ego. In Chapter 2, the refugee mental health and trauma literature states that individuals who have undergone pre-peri-post migration, coupled with having to contend with the impact of post-migration social determinants (Hynie 2018), will inevitably be confronted with a form of migratory trauma. With psychiatry’s endorsement, psychoanalysis highlights the infant structure that emerges from loss precipitated by migration. This is unique to the refugee and immigrant. So much so, Akhtar (2009) has called the process of becoming and resettling as a refugee a ‘third individuation’. Taken from infant psychology, psychoanalysts in the field have referenced the newcomer’s “protective shield”

(Freud 1926), also viewed as one's "skin-ego" (Anzieu 1987), or "psychic skin" (Bick 1968) as *sustaining a loss* (Luci 2017; Papadopoulos 2002; Elton et al. 2022). If we were to use Daniel Stern's (1992) "pre-narrative envelope", a term analogous to the aforementioned concepts for one's early years of development, we would see that such a loss would entail the impoverishment of a newcomer's early, formative experiences of life. In other words, their pre-migratory life.

The newcomer's pre-migratory self that consisted of "autobiographical narrative acts of meaning" does not survive the migration and resettlement process, resulting in us losing a path to "the origins of the patient's representational world" (314). Therefore, the migrant is "born again" once they seek refuge - a newborn, with no history and no self. The newcomer is thus imagined to be disjointed, fragmented, and circularly dwelling in an infantilized state, but only once and if they 'successfully mourn' and accept the refugee role. Just as one would see with an infant, the refugee becomes a repository for host country ascriptions. Later, we will critique this interpretation by applying the migratory framework to reveal the migratory diagnosis and the ascriptions, like the above, that generate it. Through the critique, we will uncover yet another wrinkle: that the underlying root cause of this loss of pre-migratory self is by way of a rupture between Mead's "I" and 'me' in the psyche of the refugee due to the internalization of the sick, traumatized refugee role.

Psychoanalysts and psychiatrists who adhere to refugee mental health models alike agree that refugees are afflicted by a defective ego that has lost psychic envelopment as a result of migration, while trauma critics normalize experiences of PTSD and trauma (Silove, Steel & Bauman 2007). However, I argue that the affliction stems from the ascriptions that are superimposed on an individual by dint of the refugee role and other social systems that uphold this role, such as therapeutic spaces and models. The literature has shown, in addition to the

clinical cases I will present in the next three chapters, that refugees are “highly susceptible to mental disorders and conditions *years* after resettlement in high-income countries” (Henkelmann, de Best, Deckers, Jensen, Shahab, Elzinga & Molendijk 2020) and there remains an “urgent call for research and action in refugee mental health” (Saadi, Al-Rousan & AlHeresh 2021: 1).

The participants of this study meet these criteria. We see resilient, adaptive, and functional individuals who continue to suffer with ‘symptoms’ for years after resettlement – and it has not been determined why. From a psychiatry standpoint, we are observing persistent and pervasive ‘symptoms’ consistent with the findings of de Best et al. and Saadi et al. (2020). From another perspective, we are in a trauma trap: it’s not the symptoms of a ‘disorder’ that are the problem. This is not what is making people ‘sick’, it’s the ascription-assignment that is making people sick. In contemporary times, ascriptions can be resilience, survivorship, adaptability and functionality. Not too long ago, PTSD and depression were prescribed to patients. Prior to the ‘traumatized’ refugee ascription, there were ascriptions from the Global North’s *living ideological symbol* script and before that the *victim of war* script, all the way back to its original iteration as *alien*. Now, prescriptions of a different kind are being presented: *ascriptions of survivorship and resiliency*. In other words, the survivorship ethos is reinforcing the sick, traumatized refugee role script.

To reiterate, although the depathologizing movement among trauma critics has been instrumental in some ways (e.g. contesting the over-medicalization of refugee experiences and normalizing ostensive suffering), they recapitulate refugeeness by offering up the new prescription: ascriptions of resilience, functionality and assimilation. Regardless, if you are a survivor, resilient or traumatized, the role ensnares one in a migratory framework, rendering a

migratory diagnosis. Before delving into the fundamentals that make up the migratory framework (imagined to be the substructure of the refugee role and its script), I will briefly indicate in theoretical form what the migratory diagnosis is. The framework and its heuristic tools and devices will be vindicated by clinical documentation later. The next section is meant to provide the reader with a theoretical base for the empirical, observable clinical data to come in the latter part of this chapter and in Chapter 5.

The migratory diagnosis begins in therapy when the migratory journey and what was lost is centered. The aim here is to facilitate memory of migration-induced loss and its successful mourning. Accordingly, the locus of patient-therapist concern is lodged in the mind that has undergone migration and resettlement. Early childhood experiences are subsumed within a *pre-migratory* chronological designation that emerges to inform the therapists' view that what is being articulated is the narrative of a *pre-migratory self*. This alerts us that the patients' entire biography is classified under a "migratory journey" over time and space, from pre- to post-migration. The 'remembrance and mourning' stage preceding 'reconnection' and its successful shift into a survivorship narrative elicits a paradoxical response where patients rapaciously seek answers and deploy rhetorical devices (the appearance of uncertainty) while exhibiting combativeness towards the instigated metamorphosis that is meant to actualize their survivorship. There is a perceived push against interpretive analyses informed by the migratory framework. The therapeutic intervention threatens to undermine their previously displayed self-certainty (evidenced by accounts and narrations of self, pre-migration). The restructuring of memory, and the retrieval project it is indebted to for the purposes of reframing the trauma, has the mind undergo a filtration process focused on what has been lost. This is supported by

illustrating the patient's successful acquisition and mobilization of innumerable intrinsic and extrinsic resources they already had or have built.

The problem is that during this time, the pre-migratory mind is subject to a migratory diagnosis, and a form of mourning is called upon, shifting the mind to a 'subverted psyche'. The pre-migratory mind is thus redefined through the migratory framework to support the migratory diagnosis. It can be argued that their personal psychology, developed pre-migration, is no longer considered, as is generally the case in refugee studies and refugee mental health. This mind is only relevant as a frame of reference to further inform the migratory diagnosis. The self, or rather this dynamic migratory mind, that emerges from a resilience narrative seems diametrically opposed to what the therapeutic environment and relationship is meant to achieve: a sense of self-possession and self-actualization that undergirds demonstrable resiliency. The sense that a continued psychology (the continuity of self over time) is possible is compromised at this stage. The migratory diagnosis makes it so that the resilience approach 'recovers' only remnants of what may have 'possibly' existed before. Resilience is marked by what the mind survived or managed during the migratory journey. Here again, we are faced with the trauma trap.

The indicated is the anchor through which 'the refugee patient' is differentiated from 'patients in general'. This entails that from here on in the therapeutic co-creation, in attending to what the models outline as specific to 'migrants/refugees', and implementing the tenets of those models, we run the risk of reproducing negative conditions of refugeeness. In the next two chapters, I will unpack the refugee role through its history of scripts and ancillary subterranean currents that can be described in as much detail as the manifest character of a psychodynamic self. I offer not a culture of exile, but a *mind of exile* that I have called the *migratory mind*. This is not a genetic term, or a psychological one per se, but a sociological and cultural term that

explains the becoming and subsequent inculcation of what it is to *be* a refugee in Canada. Leading up to the data that will corroborate the migratory mind, as well as the heuristic tools accompanying it, I will be using George Herbert Mead's (1934) understanding of the 'self' to aid in organizing the essential constituents of this mind. After this, 'sickness' and its nomenclature will be defined to equip the reader with what is meant when I reference key terms in the data portion of this chapter and the next.

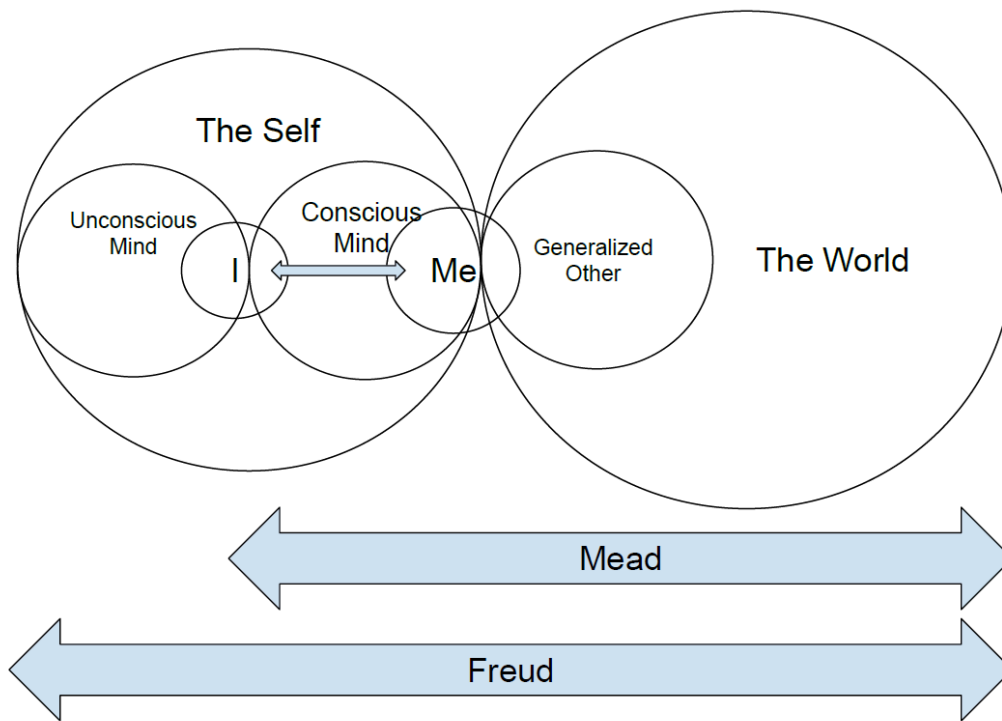
### **The Self**

Dobson's (2004) ontological exploration into the "embodied refugee self" implies an assemblage of practices and activities that emerge from its being, to construct a "culture of exile". This monumental contribution is the "starting point for understanding the consciousness for the transnational self" and refugee self (Soong 2015: 13). Refugeeeness is therefore conceptualized as "a different kind of otherness" (Dobson 2004: 15). As a matter of course, the individual who is fleeing their country of origin in fear of persecution possesses a self that will encounter having to "become a refugee". However, it has been argued that the venture into becoming a refugee "is not a psychological phenomenon *per se*; rather, it is exclusively a socio-political and legal one, with psychological implications" (Papadopoulos 2007: 301). I take this one step further. I am making the shift from mind to role as part of a de-pathologization undertaking. I do this by outlining a self that clearly demonstrates the effectuation of social roles, such as the refugee role and its script.

Our entry point into this project entails a practical approach to synergizing three self-concepts popularly made in social psychology and sociology: the individual self (comprised of experiences, behaviors, traits and is relatively independent of dyadic relationships or group memberships), the relational self (consists of attributes shared in interpersonal attachments where

defined roles among partnerships, peers, friends and family unfold) and the individual's collective self-identity (features shared among ingroup members in contrast to outgroups). Different fields assert the primacy of a particular self. However, it has been illustrated that the three selves co-exist (Sedikides, Gaertner & O'Mara 2011). The amalgamation of these selves is important as they imbricate one over the other in the clinical cases considered in this study. We can clearly see this when considering the data. Each given datum accentuates the intra- and inter-dimensions of an individual, the refugee role, and how every patient contends with these dimensions in the host country and within therapy. To illustrate a fuller picture of the three-tier self-system referenced in our analysis of the cases, I will briefly outline George Herbert Mead's notion of self. Mead expanded the works of William James to develop "Me", "I" and "the Generalized Other" and presented the self as a product of what is now known as symbolic interaction.

Mead's "strong insistence on recognizing the interrelatedness (and irreducibility) of "mind", "self" and "society" (Prus 1996: 52), coupled with his interaction with psychoanalysis best illustrated by Swanson (1961) as signifying "incompatibility and convergence" with Freud (319), helps us organize and localize the inner workings of the refugee role and its impact on the individual. Mead's articulation of the "social foundations of the self" has what he calls an "I" which is "aware of the social "me" (Mead 1934: 173). The "I" will be expounded upon in Chapter 5 as we intend to strictly concern ourselves with the "me" and the "generalized other" here. Below is a diagram illustrating how Freud and Mead converge and diverge when we are considering Migratory Mind through Mead's theory of self (see Figure 1. The Migratory Mind below).



**Figure 1. The Migratory Mind**

In the excerpts to come, the “me”, understood as the relational self, is organized around the ‘attitudes of others’ and therefore is most reflective of the refugee role-in-action and its script. After all, the “me” dimension fosters and corrals roles. Participants in this study have all had to “become a refugee” by endorsing the refugee role and its auxiliary ascriptions. The ‘organized set of attitudes’ germane to the refugee role is ‘assumed’ by its carrier for, one would think, integration and assimilation purposes. Assimilation is often possible when one successfully ‘mourns’ their losses and can triumphantly close the “cultural distance” (Alisic & Kartal 2019) between their country of origin and the exile country. Put another way, success is marked by the ability to close the gap between the pre-migratory and the migratory mind. In our analysis, we will see those who resist the internalization of the role and the aftermath, in contrast to those who

more readily accept it. The “me” ‘part’ of the self functions by closely following the refugee trauma script as the “I” rejects any premise that endorses the diagnostic endeavour and recovery/survivorship-centric diction. As we move from the relational into the collective, we find the role of mental health and therapy, otherwise called the “generalized other”, in our analysis.

The “generalized other”, feasibly looked upon as the collective self-identity, has been linked to Freud’s concept of the superego, while Mead’s “I” has been associated with the “id” (Miller 1973). In keeping with this consideration, Mead has taken the generalized other as “the organized community or social group that gives the individual his unity of self” and holds within itself “the attitude of the whole community”. The example Mead provided was that of a baseball team. The team “is the generalized other in so far as it enters – in an organized process or social activity– into the experiences of any of the individual members of it” (Mead 1934: 154). He went on to include the attitude of the generalized other and the criticality of “taking” it “toward” oneself through an organized process. Taking on such attitudes is the only way one “can think at all; for only thus can thinking or the internalized conversation of gestures which constitutes thinking – occur” (1934: 156).

In therapy, the organized process, which we have named the migratory framework, arguably ‘enters into the experience’ of the participants involved, and ‘thinking’ can only occur through this framework. Often, clients would seek guidance, in or outside of the clinic, on the refugee role. As we have understood it thus far, this esoteric role possesses a script that has historically and to present been constructed and directed solely by the exile country. Let us dissect this further. Global North countries – regarded as the exile country for the participants in this study – are governed by a therapy culture (Furedi 2004), which has bred what Maurice North (1972) has called “secular priests”. Having supplanted religious authority, “the psychological

society” necessitates a “psychological expert who claims there is a *new scientific standard of behavior*” (Gross 1978: 4). The authority of psychotherapy “rests on its ability to give meaning to experience in a world strongly wedded to a therapeutic ethos”. Moreover, “therapeutic intervention is not simply confined to the relationship of the therapist and the client” but can come to characterize “all contemporary organizations and institutions” (Furedi 2004: 10).

The generalized other is thus an ideology facilitated by a therapeutic ethos that ‘enters into the experiences of’ the patient. It can be argued that society plays this out while therapy and its operatives authenticate and endorse experiences for individuals. Home-grown Canadians contend with this already, but are arguably acculturated into the psycho-generalized other, while the refugee has to grapple with this alien layer they are *not meant to know about* (hence why psychoeducation plays a crucial role in the migratory framework and the development of the migratory mind). The ideology here encompasses the social imagination of refugeeness and the migratory framework that clinicians practice within when working with their refugee clients. Thus, clinicians and clients bearing or opposing the role, both engage in the migratory framework through psychoeducational and migratory discourse such as migratory experiences of loss, the normality behind the induction of illness as a result of migration (i.e. interpersonal losses and role transitions), trauma, acclimation to the host country, race, notions of belonging and the like. From a Meadean perspective, this co-created field intended to ‘give the individual his unity of self’, as we will see, reiterates the negative conditions of refugeeness. As therapy is such a vital part of this analysis, it would be remiss not to walk the reader through competing explanations and frameworks of suffering that operate within biomedical and psychodynamic paradigms before jumping into the case studies.

## Sickness

The synchronization of the three self-concepts discussed above allow for the development of a new classification and taxonomic group for refugeeness by closely evaluating the psyche's personal and social intercourse with refugeeness and the refugee role in a clinical setting. In this section, I will discuss what the clinical situation supports, demands and expects for the migratory framework to 'work'. Let us start with the patient. A patient is described in the *Publication Manual of the American Psychological Association* (2010) as "a person affected by the disorder or illness and receiving a doctor's care" (72). Successful admission into psychoanalytic psychotherapy as a patient entails meeting particular 'suitability criteria' including "desired traits" in order "to participate fully in and benefit greatly from this mode of therapy" (Rueve & Correll 2006: 45). Desired traits include: motivation, positive therapeutic alliance, psychological mindedness, acknowledgement of maladaptive patterns, positive response to trial interventions, modifiable defenses, and positive response to transference intervention (Truant 1999). This criterion makes for a "good patient" and allows for membership in a 'social activity' that is supported by classifications such as 'symptoms', 'psychoanalytic character diagnoses', 'developmental levels of personality organization' and the like. The patient's experience is organized under this rubric, in addition to the migratory framework. This will be explored further in our cross-case analysis when we see how clients maneuver this framework in an attempt to synthesize parts of a very schismatic self-system, rudimentarily held up by an infantile structure, for the sole purpose of ending their suffering.

In psychiatric terminology, suffering is codified and classified under 'signs' and 'symptoms' of mental disorder. A sign is an "objective observation of the client by the clinician" while a symptom is a clients' "subjective experience" (Bernstein & Kaplan 2022). The subjective

nature of a symptom was introduced in the nineteenth century when “inner experience”, “contents of consciousness” and “introspection” were deemed sanctionable in descriptive psychopathology. In addition to this, a symptom is “first of all an *index for diagnosis* used by clinicians to establish that the person who shows that symptom is sick and that he or she is affected by a particular illness or disease”. This is largely a “device” that is predicated on “causality” (Stanghellini & Mancini 2017: 18-19). In the process of therapy and treatment, one is exposed to a cluster of both signs and symptoms, often operating concurrently, signifying mental disorders understood as syndromes (Sadock & Sadock 2010). Interestingly, this device does not have a steady read on roles and the deployment of their effects on the self, mind, society and within the therapy itself. The psychodynamic paradigm attempts to mitigate these effects by addressing the ‘why’ in lieu of the ‘what’.

The psychodynamic paradigm searches for the *meaning* of the symptom. Freud (1936 [1961]) stated that “a symptom arises from an instinctual impulse which has been detrimentally affected by repression” (8). Psychoanalytic thought looks at conscious and unconscious conflicts and trauma to decipher symptom formation in the client. Put simply, psychoanalysis often searches for the meaning of the symptom by asking: “What does that symptom *mean*?” (Stanghellini & Mancini 2017: 21). Kellerman (2008) aptly captures the psychoanalytic approach to the symptom by saying there “is no need for logic in the symptom. In this sense, the symptom has a certain kinship with, and is more similar to the latent dream - that amalgam, in the unconscious, of amorphous bombardment of stimuli, reflecting conflicts, fixations and hungers” (10). Even Post-Freudians like Jacques Lacan, who is known to clash with IPA psychoanalysts, refers to ‘classical diagnoses’ such as paranoia, schizophrenia, and perversion (Soler 2003: 94).

In the cases I will be presenting here, the psychodynamic paradigm of symptom ‘evaluation’ was most used with clients in consultation with the DSM-5 (which appeals to the biomedical paradigm). Be that as it may, I argue that both modalities of ‘evaluation’ and ‘diagnosing’ failed to effectively capture and treat the suffering induced by refugeeness. I will clearly lay out their limitations by way of verbatim data and excerpts of sessions between myself and patients. In this chapter, I only reference M.K. and T.T.’s cases. These cases are sequestered from the others because I wanted to give primacy to both patients who have more thoroughly ‘internalized’ and at times identified with the refugee role. The next chapter features the three others who actively opposed the role’s internalization, while M.K. and T.T.’s opposition is less obvious or at times, seemingly absent. In the excerpts that follow, I was seeking to establish rapport, gather initial information, symptoms, and chief complaints, alongside reflecting upon the pre-transference, transference, and countertransference activity. We shall start with M.K.’s case.

### **The Case of M.K.**

Born in Bangladesh, a 4-year-old M.K. travelled in the cabin below deck of a Greek cargo ship en route to New York with a woman he was directed to call his mother. He was chosen among all his siblings (4 sisters) to embark on the arduous journey to “reunite” with his father. After arriving in New York, the woman and M.K. took a van into Canada, arriving at their eventual destination, Toronto. The migratory journey was a total of three weeks. Halfway through the voyage, they ran out of food and arrived emaciated. Not too long after, M.K. was separated from the woman he had travelled with, and his father left M.K. with an Uncle who would come to molest him.

*F.M.: Tell me a little bit about why you have chosen to seek out therapy? And more specifically this type of therapy?*

*M.K.: Well, to start, I started my own brokerage, as I left the company I worked for before. Got sued. Had to fight this court case, and all that resulted in a lot of helplessness. I could feel my family who needed me – as I send money back home – in Bangladesh and the failure took over. Cocaine then took over.*

...

*F.M.: Do you mind speaking to the helplessness?*

*M.K.: There were a lot of complications I faced immigrating to Canada. I wasn't permitted to talk to my family. It stuck with me that I had no connection with them. I had nobody. I saw my family twice: once at 14 and another time at age 29. Both times I'd return to Canada and the connection was lost. I would go back to drinking, shame, drugs... I wanted to contact them but had fear of shame from them.*

*F.M.: The connection was lost?*

*M.K.: Yeah it was this thing that I would come back, felt lost for a very long time, but when I drank with friends I felt socially "more"... I felt people liked me! Outside of those times I don't know how to orient things around me. My family is my outlet. Here, I am alone. And I need an outlet – in these friends and drugs.*

*F.M.: I'm hearing you say that a connection to yourself and others is dependent upon drug use...*

*M.K.: Not when I'm going to see my family. It's when I come back to Canada. In Bangladesh I don't fit in entirely either, with the exception of being with my family. It's like, who the fuck am I? I belong in my success. My ventures and my responsibilities. All of that gives me reassurance. I'm doing exceptionally well in my work actually.*

If we were to operate within the psychoanalytic and psychiatric scope of interpretation and formulation, the appearance of symptom or sign here and elsewhere would move us towards “substance use disorder”, frequently co-occurring with PTSD. It was found that alcohol and substance abuse in refugee youth who “displayed significant symptoms of PTSD” are faced with “the burden of migration” and are therefore prone “to substance use, as a consequence of scarce coping resources and the stress of adjusting” (Vasic, Grujicic, Toskovic & Milovancevic 2021: 1). Psychoanalytic configurations of migration, mourning and adaptation, interpret the

uninterrupted commitment to work and needing to send money back in fear of ‘shame’ as “work addiction” (Krueger 1986) propelled by “defense against unconscious remorse...compounded by preexisting feelings of guilt regarding oedipal and separation issues” (Akhtar 2011: 73). Formulations of this kind were considered for M.K. during his treatment. Such conceptualisations denote a prelude to an impervious migratory diagnosis that draws out not only the negative conditions of refugeeness but the contours of the refugee role, and inevitably, the migratory mind.

He mentions how his “sickness” or symptoms of substance dependency ‘takes over’ once he ‘comes back to Canada’. Upon his return, ‘connection is lost’ but interestingly, a particular *type* of connection is “found” with friends and the accompaniment of substance use as his Canadian friends act as an ‘outlet’, supplanting the ‘outlet’ his family provides. If we were to understand “outlet” as a means of expressing or an “opening through which something is let out” (Merriam-Webster Dictionary), it can be said his family facilitates a ‘means’ or ‘opening’ to a self that is unencumbered by illness, while a ‘sick self’ is supported and authenticated in the host country among friends and arguably, his therapy. Sickness appears to function as an ability to generate and sustain relationships, while meeting the criteria for therapy in the exile country. The migratory diagnosis featured in our aforementioned paragraph offers an apparatus that the migratory mind can operate through. This mind draws bridges and connections to the host country and its members, making sickness an outlet of its own, permitting one the authorization to socially exist. Our migratory matrix so far decrypts the dominant psychoanalytic and psychiatric approaches to migration. It does this by removing the psycho-interventionist layers that pathologize the effects of the pre-migratory. The unmortgaged pre-migratory mind, that is ‘asymptomatic’ and experienced in shared spaces with family ‘back home’, is encouraged to be

mourned to promote resiliency and ‘wellness’ in a recognizable way to the therapy and the social situations it pilots. This is a primary feature of the trauma trap. Therefore, the effort here is to bring to light an internal contradiction of the therapeutic project and the refugee role it endorses. Let us examine another excerpt that illustrates M.K.’s commitment to the refugee role whilst negating refugeeness.

*MK: All my friends here, 90% of them have been through various traumas. They’ve gone through a lot of the same stuff I have – all this ‘stuff’ happened after I immigrated.*

*FM: I wonder if, by having these friends, you are finding a way to keep something that is lost undead... I sense that you want to move on but at the same time you have people around you that carry tragedy*

*MK: Yeah, well we have a lot of commonality. I actually love it. I feel my friends and I can speak in unfiltered ways... there’s never this thing of, how will they react? I can keep relations, they’re just not conducive to my health. Toxicity inspires me to think and not be as close... I don’t know. How can attachment exist without toxicity?*

My intervention at the time was supported by the works of Volkan (2017) and his special concentration on the refugee mourner who “is torn between a strong yearning for the restored presence of the lost person (or thing) and an equal wish that the lost item become futureless” (18). However, the localized nature of sickness is quite interesting in that it persists under exile relationality while jeopardizing the more structured, less insufferable pre-migratory self and mind. Attachment for M.K., strictly in the host country, cannot be imagined outside of illness or what he calls ‘toxicity’. The compelling insight here is the refugee role’s capacity for intersubjective attunement with other self-acclaimed ‘sick’ and ‘traumatized’ members of the host country. This also further emphasizes the importance *refugee role mirroring* plays for an individual who has enlisted in the framework, as well as the diagnosis it bears and the mind it produces. What we will see in the next chapter are three clients who have resisted the inductive

effects of the migratory diagnosis and therefore the mind it promotes. But before doing so, let us turn our attention to T.T. to further sketch out this phenomenon and the contours of the refugee role.

### **The Case of T.T.**

T.T. was “under duress till the age of 9” in his birthplace Sri Lanka. He describes the relentless “tension and stress” from the war outside and the “fighting and screaming” from the war inside his Aunt’s home. T.T. and his family were members of the marginalized Tamil community during the time of civil war and unrest in Sri Lanka. T.T. describes the systematic discrimination he faced as a child and the direct effects it had on him as a result of being barred from accessing education, his language and culture. His mother, a refugee claimant in Canada, had been separated from T.T. for 2 years before they were reunited.

*F.M.: I understand that you have sought out therapy before? Can we explore what some of your concerns were there and why you are looking to resume elsewhere?*

*T.T.: I’m constantly checking things on my skin. This can be everyday for multiple hours. Like bumps or infections. Or I have a fear of getting sick. I have a really hard time managing this. When I’m at work or with my girlfriend, I don’t think of it at all. My symptoms aren’t bad with her. They’re muted in fact. She is always there for me to reassure me and validate my pain. It’s only during my personal time, when I have a lot of time to think or reflect on interactions I’ve had with people, or even in certain friendships and relationships... I can open up to some of my friends and they are super understanding and there for me when I’m experiencing symptoms.*

Before submitting our analysis on the migratory framework, I would first like to offer the framework and the migratory diagnosis I operated under while treating this patient. Descriptions provided by T.T. corroborate his obsessional-compulsive disorder (OCD) diagnosis, formally diagnosed by a psychiatrist outside my private practice. The psychiatrist, who is committed to a biomedical paradigm, has advised medication and cognitive behavioral therapy (CBT). However,

there is a dilemma. T.T. appears vulnerable to his illness outside of work, but is impervious to it while in his role as a teacher. Behavioral therapists and social workers Terri Laterza, Kalie Pierce and Robert Hudak (2011) maintain that the OCD's "psychosocial functioning is not always directly correlated to the severity of symptoms... OCD is unusual in that patients can have marked differences in their level of impairment in different facets of their lives. It is common for patients to report that they function at work reasonably well, but 'save up' their rituals for when they go home at night" (186).

As it relates to migrants and their migratory experiences and the social determinants they face in the exile country, a comprehensive review (Bustamante, Cerqueira, Leclerc & Brietzke 2017) found that migrants and the prevalence of PTSD and stress-related disorders like OCD were found at a significantly high rate of 47%. Psychoanalytically, I was collaborating with T.T. to unearth unconscious fantasy and desire behind his obsessional neurosis to get closer to the "distorted private religion" (Freud 1953) believed to be instituted in his psyche. These rival explanations, more often than not, neatly explain away a deficit discovered in the patient who is chronicling their 'symptoms'. Whether it is a problem that needs to be diagnosed or an unconscious manifestation that ought to be uncovered, we are still left with the problem of refugeeness and the refugee role that ought to be 'managed' continuously through illness or therapy vernacular. I will now postulate outside the framework I have been challenging, as to outmaneuver the trauma trap and reproductions of refugeeness.

In the excerpt, sickness arises in private when 'thinking on interactions' or in the company of friends. The "me" in this case, often organized around the attitudes of the host country, is made up of ascriptions belonging to the refugee role's script. Similar to M.K., the commitment to the refugee role and its script allows for intersubjective fields of meaning and

sharedness with host country members. When reflecting upon the ‘thinking’ piece of T.T. 's statement, it might be helpful to reference Mead’s ‘generalized other’. In his articulation, the dialogical nature of thinking and its relation to any given individual’s membership and experience is highlighted. What is understood so far is that the refugee role is governed by sickness and therefore only knows how to think through ailment or rather ‘symptom’, which is based on one’s ‘subjective’ and ‘inner’ life. It can be argued that T.T. has ‘internalized’ and ‘identified’ with the refugee role quite intimately, such that his subjective thoughts are that of ‘symptom’ and within clear bounds of the migration framework. It can be argued that this is quite revealing of an individual’s adherence to the refugee role and its script. However, when a different socially authorized role is called upon – for T.T. and M.K. it is a vocational role – both clients are ‘asymptomatic’.

The vocational role is clearly outlined and structured with a socially approved script that both clients closely follow and concede to. This temporary ‘relief’ seems to suggest that the structure and certainty of these preauthorized roles allow the client’s “I” and “me” to function normally. Sickness returns when the refugee role is reactivated in one’s private relational life. Let us explore this through T.T.’s partner, whereby symptoms are described by the client as ‘muted’ with her. To contextualize further, T.T. is engaged in a romantic relationship with a homegrown Canadian caucasian woman who has taken on ‘reassuring and validating’ his pain. Symptoms are rendered dormant when she ‘assures’ or consoles his sickness. My theorization is that the refugee role script is in some way being ‘read back’ to him through the act of validating, which puts him at ease, but only momentarily. Something similarly occurs in another session between T.T. and I. When I resort to the script, embedded in the migration framework, he is momentarily moved:

*F.M.: You have talked about checking your skin – you mentioned in a session some time ago about bumps and infections. This concern around insides coming out, increasing visibility, and the fear of the outside making its way in... I wonder about this. The crossing of borders has been a prominent theme in your life – I wonder how much migration, trauma and having to acculturate has played a role in this*

*T.T.: I never thought of it that way. Wow. I'm getting quite emotional hearing you say that. I have never acknowledged my trauma. You know, I'm racialized here... I hate white supremacy. I don't trust myself and I'm sad I don't have that. But I want to say that I am happiest at my job. It is my best self experience! I'm so confident. So... who am I? Well I'm different when I'm alone. I don't know, I'm just overwhelmed by my obsessions during that time. My friends describe me as fairly shy, kind, easy going, easy to get along with and intelligent. My girlfriend sees me as supportive, nice, respectful, I treat her in a way that makes me feel belonged. And she sees me as a great person. But I don't feel the same, so I have a lot of guilt. I hope that can go away.*

*F.M.: What can go away?*

*T.T.: With my relationships I have deep doubts. Am I doing it correctly? But when I'm with her [reference to girlfriend] these doubts are washed away. I want affirmation that I am doing things right and she provides that. Constantly. When I start to obsess she's there, always talking to me and it's very validating.*

T.T. first speaks of compulsively “checking things on the skin” and the terror behind potentially discovering bumps and infection. However, when he is at work as a teacher, he has the ‘best self experience’ instead of, arguably, a ‘sick self experience’. The excerpt starts with a migratory interpretation and diagnosis, largely informed by what the reader would have encountered in the literature reviewed in Chapter 2. Again here, similar to his partner, I am reading a script on the refugee’s psyche and how it develops a defective “psychic envelope” (Houzel 1987; 2005; 2012), a term derived from Didier Anzieu’s (1985) “skin-ego”. T.T. is deeply moved but remains seemingly confused. A rhetorical question of “So... who am I?” separates how he sees himself vocationally – i.e. his ‘best self’ and ‘confident’ – versus how everyone else in the migration framework, including myself, sees him. What people see in his personal life (docility and sickness are integral to the refugee script) is what they can connect to, yet there is something in

him that feels ‘guilt’ for knowing he does not truly possess the traits that make relationality possible with ‘him’, or from a Meadean standpoint, “I”.

### **The “I”**

If we were to pursue the premise presented here, host country members cannot connect to the “I”, for its functions are performed outside of a migration framework and script. When connection is possible, the “I” is hijacked by illness as seen below:

*T.T.: I get obsessed over my body after being overly empathetic and connecting with people*

M.K. eerily responds similarly. When returning to Canada, he must abandon a pre-migratory self or “I”:

*F.M.: I’m hearing you say that a connection to yourself and others is dependent upon drug use...*

*M.K.: Not when I’m going to see my family. It’s when I come back to Canada. In Bangladesh I don’t fit in entirely either, with the exception of being with my family. It’s like, who the fuck am I? I belong in my success. My ventures and my responsibilities. All of that gives me reassurance. I’m doing exceptionally well in my work actually.*

In both cases, the Meadean “I” is no longer receptive to the corrupted input of the sick “me”. In Chapter 5, I theorize that the “I” is a pre-migratory residue that is reacting spontaneously to a clearly defined “me”. However, this “I” largely remains unknown by the operative refugee role, the clinician and oftentimes this unknowing is reflected in the narrations of clients in the present. Oftentimes, should the “I” emerge in the migration framework, it is subject to pathologization or alerts us to something worth ‘exploring’ as it denotes resistance, or something that is “alien” (note the first refugee role script post-WWI). In *The Psychoanalysis of Symptoms* Henry Kellerman (2008) writes that “a symptom is an *ego-alien reaction*. This means that the symptom reaction feels different from anything else in the personality, as though it has been produced by a force outside of the personality—the person feels possessed” (11). It can pose a potential

hindrance to the therapy and treatment if the “I” is not addressed as a symptom through an intervention like an analytic migratory interpretation, or ‘treatment’. However, the “me” we *do* know is clearly defined by both parties, as both clients are known to concede to large parts of the refugee script (hence why they are relatively popular, social and highly functional and adaptive in Canada). The “me” reflects back a docility and agreeability, arguably an enactment of infantilization known to be a critical ascription ingrained in the refugee role. We see it here with M.K.:

*F.M.: So how do you see yourself here [in Canada]?*

*M.K.: I see myself differently here than there [in Bangladesh]. I'm a docile cat here - shy, very agreeable. I'm not like this in Bangladesh.*

To reinforce this point, it may be revealing to provide the reader with examples of instances where T.T. and M.K. have made rare remarks on the “I” that is operative outside the refugee role. Shared in a separate session, while free associating, T.T. talks about feeling ‘really crazy’ well before experiencing ‘health anxiety’ (i.e. conventional ‘symptoms’):

*T.T.: I often feel really alone. Makes me feel really crazy and the odd man out. It makes me feel guilty. I am led to believe I am the weirdo. That stress leads to health anxiety.*

This signals that T.T. can feel a ‘different kind of crazy’ when disconnected from others. In the state of feeling ‘alone’ (outside of a social relational platform) he feels ‘guilty’ when he goes “off script”. This leads to ‘health anxiety’ – put differently, the refugee role is initialized as to avoid feeling ‘alone’, ‘odd’ or ‘weird’ (i.e. pre-migratory mind-based experiences). M.K. has also reflected on connection in similar ways as it involves ‘hiding’ who he is:

*M.K.: Connections to my friends or others involve hiding who I am. I look at things and they appear really fucked up.*

*F: Connection feels... threatening?*

*M.K: \*Laughing\* Wow. I must be crazy then. Right?*

M.K. relies on the concealment of “I” to engender connection in Canada. We explore this “I” in the next chapter, but within the context of sickness and illness, he has deduced that this “I” sees things differently than others. It sees things outside of a script, leading things to look ‘really fucked up’. This “I” is not the “me” that holds the attitudes of others. It clearly operates outside and beyond the migratory mind.

The rhetorical device of “Who the fuck am I?” similar to T.T.’s “So... who am I?”, is centered around the appearance of lack in the knowledge of self and is deposited between the narratives of a ‘sick self experience’ and a self that is experienced as ‘exceptionally well’ or ‘confident’ in the vocational spheres of M.K. and T.T.’s lives. The veneer of uncertainty in the rhetorical question creates a wedge between these two selves that do not seemingly coalesce or converge at any significant point. The effort here is to synchronize the “I”, “Me” and “Generalized other” to negate future proliferation of refugeeness. The sick experience that M.K.’s friends connect to and T.T.’s girlfriend and friends are amenable to is an experience that the clinician equally connects to, as I did. This makes for a ‘positive transference’. In the next chapter, we further problematize the migration framework and diagnosis by focusing our attention on the “I” and the ‘uncertainty’ it emits to its perceiver.

## Chapter 5: Uncertainty: I, the Rhetorical and the Reversed Answer

### Introduction

At the tail end of Chapter 4, a thumbnail sketch of Mead's "I" was introduced to highlight a facet of the self that the migratory framework often overlooks: the pre-migratory self. This chapter analyzes the "I", a "historical figure" (Mead 1934: 174), that is actively encroached on by the 'migratory framework' to ensure the 'successful mourning' of a pre-migratory constitution. For a deeper understanding of this, I not only call attention to the *primacy of loss* that the migratory framework fosters, but *what has been lost* along with its expressions and subsequent prescriptions. As a reminder to the reader, the migratory framework comes to bear in a therapeutic setting. It is a schema informed by the *non-entree* international refugee regime, imbued with host country response scripts (Orchard 2014) that shape its institutions and ingroup behaviours, including refugee mental health approaches upheld by biomedical and psychodynamic paradigms. The polarizing paradigms that operate in this migratory framework conventionally address psychological suffering in vastly different ways; however both generate what we have called a 'migratory diagnosis'. This 'diagnosis' is a play on words; a metaphorical conception that does not identify a condition or disease in a patient, but localizes a problematic output informed by the framework mentioned. Our goal is to demystify the 'migratory diagnosis' and demonstrate that it is a cluster of ascriptions derived from the refugee role script, itself a reinforcer of sickness. The identification of illness is not in the patient; rather, we have discovered it to be part of the treatment itself. This centers a mind in loss, leading to the erection of a migratory mind. Our intention for this chapter is to demonstrate the migratory diagnosis-in-action as it thwarts a critical facet of the self.

My aim then is to postulate a *phylogeny of the migratory mind or mind of exile* and its social materialization: the refugee role. To understand how and why high-functioning individuals are sick when classified under a refugee role and its script, we are tracing the evolution of the refugee role script over time through previous Regimes. We have learned that regardless of one's ontogenic uniqueness or individual history and microgenesis, the refugee role inhibits certain pre-migratory parts of a self. Not only this, the refugee role has a past of its own: alien, victim of war, refugee as living ideological symbol of the West. We will see that in spite of an individual's unique makeup, my clients' interaction with the refugee role yields consistent results across all five cases featured in this study, for example, how social relations are made possible. The refugee role is unique in that once it interacts with host country members through the "me", known to be shaped by the internalized therapy culture or "generalized other" (Mead 1934), relations are possible. Although its interceptive powers can sequester pre-migratory facets of a self, a therapeutic method like psychoanalysis can draw out disruption through its free associative method and process whereby a patient freely speaks of dreams, fantasies, events of daily life, history and resort to "regressive ego functions" for "uncovering" purposes (Greenson 2018: 1904). But this free association is informative if it remains outside the migratory framework.

As mentioned, one of our central claims is explained through the migratory diagnosis and reads as follows: psychiatric and psychoanalytic approaches to refugee diagnosis and treatment reframe the refugee's experiences (affect, suffering, reminiscences, relational perceptions and the like) around migration-induced loss and the (un)successful mourning of a pre-migratory self. Trauma critics have attempted to problematize the trauma-centric understanding of the refugee through their psychosocial model of 'resilience'. The resilience model espouses "strengths-based

approaches” (Hutchinson & Dorsett 2012: 66) to supplant the traditional trauma-labelling “deficits approach” (Betancourt & Khan 2008; Wessells 2009). Although well-intentioned, rewriting the script from ‘trauma’ to ‘resilience’ simply supplants a trauma ascription with a resilience one. Ascription-assignment is the crux of the problem we are exploring, as it reproduces negative conditions of refugeeness. Herein lies the ‘trauma trap’. This trap reveals that trauma critics from the psychosocial perspective, alongside psychoanalysis, are isomorphic to the field of psychiatry, which endorses the PTSD diagnosis.

These seemingly diverse therapeutic approaches support and promote the internalization of, and thus reify, the refugee role for the migrant. What emerges from this is what I call the migratory mind, a blueprint for ‘successful’ and ‘integrative’ behaviour and thinking in the exile country. The problem is that the migratory mind produces negative conditions of refugeeness, as evidenced in the cases of M.K. and T.T.. Both appeared to internalize the refugee role and its script such that they displayed classical sick, psychiatric ‘symptoms’, as one would *expect* from a refugee. This was displayed to the clinician (myself) and to host country members who validate their social legitimacy to exist through ascriptions. M.K. and T.T., along with the three other clients featured in this study, would appear, *years* after settlement, to emanate tenacity, social plasticity, and vocational success, while suffering from a deep lack of resolve that would manifest as uncertainty in narrations of self in the present. Uncertainty would often manifest through linguistic devices such as rhetorical questions that were absorbed by the migratory matrix and rationalized or ‘symptomized’ away. Our typology of refugeeness brings to light the facet of a self that is obliged to partake in its own loss for ‘wellness’ and integrative purposes while advocating for itself through presentations of uncertainty and rhetorical devices. As there

is no direct bridge to this facet, we rely on Mead's "I" to create a full picture of how clients interact with the migratory diagnosis.

To break this down further, Mead's "I" is "responding to a social situation which is within the experience of the individual" (177) and "gives the sense of freedom" while the "me" "represents a definite organization of the community" (178). By taking on certain attitudes "we have introduced the "me" while "we react to it as an "I" (174). The "I" is "not directly given in experience" but is "the response of the organism to the attitudes of the others" with the concomitant appearance of the "me" as an "organized set of attitudes of others which one himself assumes. The attitudes of the others constitute the organized "me" (175). As the data will reveal, the "I" declares itself through rhetorical devices, often while the individual is 'free associating', or as I have theorized, as a response to the migratory framework. From appearances alone, the expressions of the "I" could be seen as an irrational intrusion or simply a symptom. This irrationality emerges more often than not as a rhetorical question. In the data, this device is buried between narrations of a thriving self and a 'sick' self shrouded by self-doubt that evokes suffrage. The "I's 'freedom' and response that is never 'directly given in experience' may display irrationally. More precisely, it exudes uncertainty and confusion, or it can be interpreted as something that requires the unearthing or uncovering of a fantasy, or be depicted as a primary defensive process of splitting sickness and 'healthier' facets of experience to modulate painful internal processes. I argue something different here. Based on the data, the rhetorical device is, in fact, a "reversed answer" and signals opposition. But opposition to what exactly? I maintain that it is an unconstrained response to the "me" – the leading apostle of the migratory framework, with a therapeutic frame supporting its 'sick' composition. Before examining this any further, it is imperative to look at the concept of 'uncertainty' and what it means in our analysis.

## **Definition of Uncertainty**

As part of the analytical examination of our data, and more specifically the “I”, it is important to establish a useful working definition of the term “uncertainty”, for this concept served as the fulcrum of our thematic and sub-categorical analysis. As we will see, presentations of uncertainty centered around the self were pervasive in all the cases included in this study. In this section, I will share the steps I took to hone the concept of uncertainty for the purpose of coding and data cataloguing. The need for precision in shaping this concept was required to achieve literal and theoretical replication of the findings, making way for theory development and testing, validity and credibility. Avoiding tautology was a priority, as most studies on uncertainty often fall into unnecessary repetition (e.g. ‘Uncertainty is the state of being uncertain’). The circumventive measures taken involved being concise and clear in the use of the term and when experiencing uncertainty, as it has no fixed referent. In a psychoanalytically informed clinical practice, uncertainty is context-dependent and often leads to fruitful analyses, which I argue facilitated important queries and findings in this dissertation. However, it can sometimes get entangled in the migratory framework. Let us consider this below.

As far as referents go, uncertainty in the clinical context was observed and analyzed indexically, as one would expect. In the psychoanalytic tradition, “uncertainty is discussed in the context of participation and suggests that appreciation of the value of uncertainty in practice goes hand in hand with appreciation of the intersubjective nature of the psychoanalytic process” (Hoffman 1987). A considerable amount of attention has been given to uncertainty in psychoanalysis concerning the Socratic premise that although we may know or ‘see’, we still do not truly know and are blind to what is being seen (Lear 2012). As it relates to trauma, psychoanalyst Philip Bromberg (1998) notes that the process of uncertainty is always somewhat

dissociative and is therefore a normal mind/brain function to help us manage stress, or can be viewed as a protective mechanism from what may be too much to bear. In my clinical practice, uncertainty is assessed against a backdrop of developmental, personality and characterological structures, and functioning and transference, as understood and recognized by psychoanalytic diagnosis and theory. As we saw in Chapter 2, the migrant from a psychoanalytic perspective undergoes loss that is foreign to host country members and may exhibit “uncertainty about the future” and self, as a result of “loss of social and occupational status” and “deprivation of social support networks” (Luci 2017: 2001). Once we move towards such categories and considerations, we will inevitably interact with a migratory framework that begets a migratory diagnosis – just as I did in my private practice. Having said this, for our sociological study and analysis, it was important to investigate uncertainty in a sociogenic process and evaluate the relationship it has with psychogenic processes, as done by others in the field of sociology<sup>3</sup>. In keeping with our sociological engagement with the topic and how it unfolds clinically, I reviewed an array of studies on uncertainty and found that they either poorly defined and described the term or the experience of it, and the concept was reduced to the field of pathology. A review is provided in the forthcoming paragraph.

The qualitative scoping review conducted by Hanna Kienzler et al. (2025) in Global North contexts further demonstrates my aforementioned point. The authors scrutinized 47 studies under the keywords “uncertainty and mental health”. The review revealed 25 of 47 studies provided “no definition of the term ‘uncertainty’” while 22 studies gave “various definitions or descriptions of the concept”. Other studies were broadly referring to uncertainty as “unpredictability, insecurity and ambiguity”. Groups investigated under the concept of

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<sup>3</sup> In Norbert Elias’s ([1978-82] 2000) *The Civilizing Process*, one of his arguments concerning the course of civilizing processes was that societies became “more tightly organized and also more separate from one another; inner dynamics cannot be distinguished from political patterns in the relations between states” (Mennell 2010: 400).

uncertainty included: “patients suffering from physical health conditions, caregivers, refugees and asylum seekers, people with mental illness, healthcare professionals and disaster survivors” (Kienzler et al. 2025: 7). The appearance of “refugee” and “asylum seekers” in the cluster group bolsters our observations and their centrality in the construction of the refugee role, as researchers in the field have linked the ‘refugee’ with illness and the pathologized notion of uncertainty. This is something we are expounding upon and ultimately wish to challenge to contribute to the de-pathologization of the refugee and its latent self-parts. Another point of interest is the inclusion criteria for the review, which, among several, were publications and studies between the years 2000 and 2018. What we know is that in 2015, the world witnessed a “migrant crisis” where Europe and Canada received an influx of migrants, primarily from the Middle East (Peters et al. 2023). During this time, psychosocial programs and approaches, as reviewed and discussed in Chapter 2, were in place to aid migrants in their resettlement journeys. Special heed to this matter of uncertainty and the refugee role is required more than ever, for although participants of this study arrived in Canada before 2015, it does not preclude them from experiencing persistent prejudicial effects and ascriptions known to newly settled refugees.

The conclusive findings of the review above lay the groundwork for the data to come, as it is revealing of two things: 1) our observation of uncertainty in narrations of self in the present by clients who bear the label ‘refugee’ is confirmed by these studies. But similar to what the migratory framework does, presentations of uncertainty are reduced to sickness, and 2) uncertainty and sickness, as it pertains to the refugee, is found in the collective. Let me refine this second point further: one of the findings of this review highlighted that “uncertainty is not experienced solely in people’s minds, but rather in community and, in many cases, it is linked to macro-political challenges especially in cases related to war and displacement” (Kienzler et al.

2025: 7). With these two points in mind, it was important to look at uncertainty outside of the migratory matrix. With respect to point number one, a blatant contrivance to note is the pervasiveness of the hearer's perspective on observed uncertainty in the studies (Holtgraves 2014; Deloitte 2020, 2022; Basu 2022; Furr & Furr 2022).

In an effort to sidestep the migratory framework and thus mitigate negative conditions of refugeeness within our own study, it was important to *not* center observed uncertainty of the client around my experience (also known as countertransference in practice), as this would call on the internalist-problem seen in the ancestral scripts of refugees reviewed in Chapter 1. In lieu of centering the refugee role in my mind (as previous authors of the many scripts before the refugee trauma script have done), I wanted to capture the role within the confines of a therapeutic dynamic. This is where the refugee role is most active. This brings us to point two. Disentangling our perception of the refugee from its script (in this case as an uncertain individual in need of rescue or help) requires us to lay bare the collective, generalized other and the refugee role it sustains. Uncertainty, as it concerns displacement and mental health, is both *inside the mind* and *within the collective*. Where the refugee role is concerned, we understand that an individual who encounters it is enraptured by its script, as one's social self-worth rests on its internalization. One can argue that the 'free', unencumbered "I" that is drenched in historicity can be affected by its associated parts that are condemned to sickness in the host country. The "I" across all 5 cases exudes manifest enigmatic features like uncertainty that evinces rhetorical questions, fugaciousness, and vicissitudes of self. It is inviting but negating. Compositionally consistent, but spontaneous and mercurial in its presentation. Let us now turn our attention to the data to circumscribe the properties and hallmarks of the "I" and its interactions with myself and the other self-parts in the case of R.S.

## **The Case of R.S.**

R.S. is a Chaldean Christian who was born in northern Iraq and ultimately fled alongside select family members at the age of 6 to Jordan. At the time, her family was escaping sectarian violence and religious persecution. Jordan is known to be a significant destination for Chaldean refugees and therefore became ‘home’ for R.S. and her family before she migrated to Windsor at age 13 and attended high school there. Shortly after high school, she moved to work for her brother in San Diego where he resided. Her stay lasted for 5 years, at which point she moved to London, Ontario and eventually, Toronto. Her post-Jordan experiences marked the shift from being regarded as “human” to a disembodied “gender and ethnicity” category, keenly felt in London, ON.

Upon commencing therapy and in the months following, R.S. would on occasion reference her previous therapy. When R.S. first moved to the United States shortly after emigrating to Canada, she pursued therapy because of what she would describe as “going between anxiety and depression”. Over the course of several sessions (sessions are divided up by an ellipsis), she would go on to describe her therapy as previewed below:

*FM: Tell me a bit about yourself.*

*R.S.: I’m originally from Iraq. I was raised in Jordan and did schooling there. I lived in the States for 5 years and went through therapy there. I can go between anxiety and depression, but not formally diagnosed. In the therapy I was in, I liked the therapist and I developed self-awareness. I recognized patterns and there were confidence building exercises that we did.*

...

*FM.: What can you tell me about it? [inquiring about R.S.’s previous therapy]*

*My previous therapist was very helpful. Extremely helpful. Her name was M. She pushed me to get away from them— my family. When I started therapy in the U.S. I went twice a week for 5*

*months. I have nothing negative to say about her. She wanted me to be an individual and take responsibility.*

...

[R.S. free associating, unprompted]

*R.S.: Here [in Canada], I don't feel I have much of a personality...*

*F.M.: There appears to have been considerable loss. The loss of your family, a Chaldean community that you had in Jordan and also some in the U.S... Forced migration can interfere with how we connect to ourselves even. But you have had considerable success with your walking group and your roommate appears to confide, considerably, in you*

*R.S.: Migration was never discussed in the household. That's something people talk about here. Questions I get asked about here are not normal. I'm actually a very easy going person... but it hurts. There are rules here, consequences here. There are no rules in the Middle East.*

*FM: What is positioned behind the anger, do you think?*

*R.S: You're told, 'you do this because you are Iraqi' I am in a culture of labelling. You know, one time as a joke someone said I don't have a personality. My previous therapist said "I'm too nice". Maybe that's what I am, just nice and nothing else. I don't know how people view me. Can you tell me how I appear to you? I don't know. Why improve yourself when someone will put you in a box?*

Let us unpack the vignettes above. R.S.'s previous therapy proffered her tools to help develop 'self awareness'. In this case, the self we are referring to is the "me". To contextualize further, R.S. speaks of her therapeutic work with M., who happens to be a Christian female from the Middle East. From the five months of therapy, R.S. concluded that it would be best to leave her family's radical conservatism in San Diego to develop and hone her autonomy in Toronto. More precisely, M. 'pushes' R.S. into leaving her family to discover 'be[ing] an individual' who 'takes responsibility'. An 'individual' in Herman's trauma recovery template is the survivor "fac[ing] the task of creating a future" by successfully mourning "the old self that the trauma destroyed" (Herman 2015: 196). Grinberg et al. (1989) characterized this as a 'catastrophic birth'

that forces the migrant to individuate as a means to adapt to one's new circumstance and way of living in the host country and undergo what Akhtar (2009) calls the 'third individuation'. Debatably, the kernel of future creation solely relies upon one's resilience and the destruction and subsequent mourning of 'the old self'. This is what it is to 'be an individual' in the host country. Should one deny the resilient route and the migratory diagnosis it filtrates through, one's legitimacy to exist is threatened, and they are confronted with the possibility of enduring a 'social death' (Elsrud 2020).

A sure way to eschew a social death is to exhibit and conserve one's resilience, or put differently, perform it. M's psychotherapeutic approach arguably stays close to the resilience model as behavioural 'pattern' recognition and 'confidence building' exercises were administered during therapy to practicalize resiliency. Although she and I operate through different therapeutic modalities (M. appears to practice cognitive behavioural therapy, and I operate within psychoanalytic psychotherapy), we both maintain a resilience-based philosophy. In the domain of resilience, therapy must move towards a prosocial objective through an anti-oppressive attitude, furthered by cultural competency and anti-discriminatory practice (Hutchinson et al. 2012). M.'s practice conceivably meets the competency requirement by way of her own social and ethnic location, making cross-cultural therapy unchallenging as she intersects with R.S.'s Iraqi heritage. Another criterion that she seemingly meets is recovering R.S.'s existent ego-strengths by noting R.S.'s excessive 'niceness', which, viewed differently, denotes agreeability and an aptness to question or resist less. In other words, the 'survived strength' identified and supposedly worth saving from R.S.'s migratory journey, is akin to the trait of an acquiescent infant. This is fitting and convenient for what is expected of the refugee role, as laid out by its script. Other resilience-based tenets include identifying internal and external resources

in the client to facilitate empowerment through an agentic-oriented modality. M. ‘pushing’ R.S. to leave and ‘survive’ her family by ‘taking responsibility’ and ‘be[ing] an individual’, which R.S. ultimately carries out, involves possessing ‘proactive and prosocial’ tendencies. However, the aftermath of this supposed proactivity is often not noted in studies conducted on the refugee. In a session that transpired months later, in free-associative fashion, R.S. responds to being asked ‘how she was’. What appears to be anger, confusion and uncertainty was, contestably, a reactive “I”:

*R.S.: After work and weekends I have no energy to go out. But I do anyway. Things started to not make sense as I was thinking. Why did I move to the States? Why did I move here? Why did I do that? You start looking back... didn't make sense to me. It's easy to blame people you can't blame. At the end of the day, you don't know people. Are they with you or against you? What is their intention? Is this small talk? Why are people talking to me?*

Here, R.S. is reacting to a set of decisions made within a resilience-based therapy. In other words, reacting to a “me” that was groomed by a migratory framework and diagnosis. Masten (1995) has defined resilience more specifically as “patterns of desirable behaviour in situations where adaptive functioning or development have been significantly threatened by adverse experiences” (283); more specific to asylum seekers and refugees, Laban (2015) has defined resilience as “the capacity to maintain or regain health and function ability despite past experiences and to endure stressors of the asylum procedure and all daily living hassles (post migration living problems)” (192). As the U.S. is part of R.S.'s migratory journey to her now settled life in Toronto, we see a plethora of reactive rhetorical questions in response to a set of ‘desirable’ and ‘adaptive’ past decisions. The “I” reaction is structurally similar to the reception she displayed apropos of my resilience-informed intervention from earlier. The resilient criteria mentioned stem from a model called ‘resilience-oriented therapy and strategies’ (ROTS) (Laban

et al. 2015) developed from the works of De Jonghe et al (1997) who describes vulnerability, personal strengths and social support as tenets of resilience. However, what we see here is M. prescribing a set of ascriptions for R.S. to “become a healthy person” as it applies to resilience principles (Laban et al. 2015: 194). The ‘healthy person’ must maintain a “dynamic equilibrium between these [personal strength and social support] factors”. This model assumes a patient-centric attitude whereby concentration is placed on the patient’s “healing ability” in lieu of focusing on stressors. Resources of resilience are further unearthed by involving “the patient in his or her own healing and/or surviving process” (194). When ‘prescribing’ the ascription of resilience, which I later do in the excerpts provided above, we are, just as M. was, confronted by the “I”: ‘Can you tell me how I appear to you? I don’t know. Why improve yourself when someone will put you in a box?’

Operating outside the migratory framework, one can say R.S.'s *actual* strengths are located in her possession of insight, which grants her access to what we have called the migratory framework and its output, the migratory diagnosis. When I provided or ‘prescribed’ a migratory diagnosis and a refugee script to go along with it, she pushed back by bringing forth ‘the discussion of migration’ that is held by host country members and their representatives (i.e. me). She goes on to mention ‘questions and rules’ that only the exile country has, while comfortably segueing into how she sees herself: as ‘easy-going’. In my personal notes, I document what I perceive to be anger, and ultimately share my perception of her anger with her. This is where the social legitimacy of R.S.’s “me” is contested. I reflect back to her something that is essentially off script, deduced to be an ailing “me”. This fits a traumatized refugee script, but immediately thereafter, R.S. devolves into uncertainty and negation of self. Her response references the host country’s proclivity for ‘labelling’ – the very thing I implement. I interpret

the anger, at the time, within a migratory diagnosis configuration by which anger is understood as commonplace among individuals who have faced either/or pre-peri-post migratory trauma (Spiller et al. 2016). This reflects Amelie Harbisch's (2025) 'Useful Labor Script' of the refugee whereby the refugee is in a "double bind" as they are "expected to work, but also suspected to take citizens' jobs" and "such contradictions define refugees' experience with labor market access today" (2025: 5.1) -- and apparently in the realm of mental health. The ubiquitousness of the migratory therapeutic framework extends beyond therapy, however. In one of a myriad of sessions, R.S. explains the banality of encountering labelling and ascriptions (even in spaces where she does exhibit the utmost certainty), for its source is nestled deeply and comfortably in response scripts:

*R.S.: A guy from work was trying to explain things to me for an hour. He was also throwing in jokes during the time but I was furious. I know exactly what I'm doing with work. I can explain to you clearly what my job involves and how to do it. I'm not sure what role he is playing but he is all over the place. He needs to stop. I found that he was labelling my feelings. Like, what the hell? Why is he labelling my feelings? I didn't get it, so I said nothing.*

The example above demonstrates her 'fury' in the face of ascriptions. I had quite rightly observed this fury earlier, however, for erroneous reasons. In connection with our migratory formula, the anger I interpreted was not indicative of a trauma effect, but was an ascription-assignment effect under a framework that prioritizes the dissolution of a pre-migratory constitution. In every attempt at mourning the pre-migratory constitution, the "I" appears. In the original vignette, she brings up an observation made by a host country member who says she has 'no personality'. R.S. relies on her therapist M., and to some degree, me, to tell her 'who she is'. Or one could say, to inform her of a refugee script that she visibly cannot negotiate. M. tells her she is 'too nice' and R.S. accepts, albeit questionably, that she may just be that and 'nothing

else'. In the host country, she experiences a "me" that is 'nothing else' but a script that ascribes 'labels'. Paradoxically, she rhetorically ponders the purpose of knowing who she is or how she appears as she finds the activity futile. After all, one just ends up in 'a box'. An example is found in another session, 6 months into our therapy:

*F.M.: How did you feel after our last session?*

*R.S.: What are you supposed to feel? I don't know how I felt post-session. I don't know who I am.*

*F.M.: Are you interested in knowing who you are?*

*R.S.: Helps to not feel it... I think of my 5 sisters and 2 brothers. I wonder if it is me or them at times. Did you know I made the honor roll in grade 11 and 12... I used to be so focused and determined. Now school requires more focus, I think...I could be mistaken... Where am I going? Where am I getting at? What is the point to any of this? The vibe I get from people is that I am an exotic creature, but all you want to do is blend in. Long story short, I don't know what to expect from people. And it shows on me. With this whole work thing, what should I do? How should I feel? What is wrong with me? I don't understand people. What are you trying to do? What do you want?*

## **The Rhetorical**

The excerpt above is laden with rhetorical questions that must be addressed. Before moving to the cases of R.F. and S.I., let us explore the function of rhetorical questions, as oftentimes they are deemed "formal, but not functional questions" (Borge 2013: 415). From sheer appearances, these questions exude spontaneity, irrationality and uncertainty of self in the present, in particular within the cases we are reviewing, as the self is at the core of the rhetorical device: *M.K.: Who the fuck am I? T.T.: Am I doing it [relationships] correctly? R.S.: What are you supposed to feel?* But is it simply uncertainty? In the qualitative scoping review conducted by Kienzler et al. (2025) in Global North contexts, uncertainty was largely undefinable but a chief characteristic of

the refugee. I seek to reformulate this uncertainty through which it is expressed: by means of the rhetorical device.

Rhetorical questions have been explored extensively in the field of linguistics and such questions “look like questions but don’t really behave like questions” as they do not seek what “Wh-questions” are after (Valli & Lucas 2000: 142). An interesting matter to note is that the rhetorical device under examination ‘does not behave’ “genuinely” or like a “normal” question (Borge (2013) distinguishes “genuine questions” from the ‘nonfunctional’ rhetorical question). What we have established and wish to extend here, is that the rhetorical device deployed by clients is the expression of the “I”. It is because of the “I” that we say that we are never fully aware of what we are, that we surprise ourselves by our own actions” (Mead 1934: 174). The “I”, similar to the rhetorical question, is ‘not functional’ in a socially meaningful way, nor does it ‘behave’ unless subsumed under a symbolic order of meaning under the direction of the “me”. The “me” converts the “I” into a socially functional self-part, making its experience ‘normal’ and translatable through intersubjectivity. In other words, the “I” “comes in as a historical figure. It is what you were a second ago that is the “I” of the “me”. It is another “me” that has to take that role... The “I” is in a certain sense that with which we do identify ourselves. The getting of it into experience constitutes one of the problems of our conscious experience; it is not directly given in experience” (174-175). The problem here is that once the refugee role is internalized, it is expected to be deficient. The role is expected to manage sickness through its ‘resilience’, infantilization, its trauma, and its ahistoricity. This poses a dilemma between the “I” and the “me”.

To elucidate, upon arriving in the exile country, the refugee is expected to undergo a “catastrophic birth” (Grinberg et al. 1989) that involves the construction of a new self, or as

Gorman (2001: 448) puts it: “a more resilient and enabling sense of identity”. In other words, the “me” undergoes a catastrophic set of changes by way of a set of expectations to eradicate significant parts of itself; the pre-migratory self. Quite rightly, the pre-migratory self is expected to be grieved, mourned and restrained by the migratory diagnosis as it does not ‘behave’ as the “me” now expects it to in the host country. I argue that upon internalizing the refugee role and accepting its ascriptions, the “I” is severed from the “me” and no longer ‘constitutes *the* personality’ as imagined by Mead. The “I” which preserves remnants of the pre-migratory self, reacts rhetorically and definitely against a “me” that is trying to establish its social worth in the exile country. In the excerpt below, Mead’s “I” and “me” only work side by side, in *particular* lived experiences of individuals who operate within a “certain” circumscribed social world. I have italicized Mead’s mention of ‘certain’ in the excerpt below:

The “me” and the “I” lie in the process of thinking and they indicate the give-and-take which characterizes it. There would not be an “I” in the sense in which we use that term if there were not a “me”; there would not be a “me” without a response in the form of the “I”. These two, as they appear in our experience, constitute the personality. We are individuals born into a *certain* nationality, located at a *certain* spot geographically, with such and such family relations, and such and such political relations. All of these represent a *certain* situation which constitutes the “me”; but this necessarily involves a continued action of the organism toward the “me” in the process within which that lies. The self is not something that exists first and then enters into relationship with others, but it is, so to speak, an eddy in the social current and so still a part of the current. It is a process in which the individual is continually adjusting himself in advance to the situation to which he belongs, and reacting back on it. So that the “I” and the “me”, this thinking, this conscious adjustment, become then a part of the whole social process and makes a much more highly organized society possible.

In other words, Mead’s notion of “I” and “me” that makes up ‘the personality’ only operates synchronously under *certain* criteria, which include: born into a certain nationality, at a certain spot geographically, together which make up a certain situation. This is not inclusive of the refugee. The refugee has an *uncertain* nationality as they are forced to flee their country due

to fear of persecution, or find themselves stateless with a contested nationality that can evoke nothing else but uncertainty. They are often in *uncertain* spots geographically and therefore find themselves in perpetual *uncertain* situations. Thus, Mead's 'personality' is ruptured in a migratory mind system, a mind that arises amidst the internalization of the refugee role. The refugee role that operates through the "me" may very well meet and perform the expectations laid out for it by response scripts, but the "I" expresses the residue of a pre-migratory constitution through the appearance of uncertainty and rhetorical devices. After all, that which is "uncertain constitutes the "I" (Mead 1934: 175). Rhetorical questions are understood as "emotive interrogatives", meaning they function as "self-addressed expressions of doubt" and seek "no information-providing answers" (Maynard 2002: 251) as they "force us to interpret them in the form of reversed answers to impossible-to-answer questions" and a "non-literal interpretation" is sought (256). One never quite reaches the reversed answer, as reactions of the "I", expressed through rhetorical questions, are 'symptomized' away in the migratory framework, perhaps because it poses a threat to the logic of the state that circulates response scripts.

To curb the threat of the premigratory self that has been historically seen as 'alien' in its unassimilated, unrieved and unadaptive form, involves oversight from the migratory framework. Stifling the pre-migratory self's reaction involves the reframing of the "I" to 'sickness' or an object of inquiry or 'exploration' as an attempt to organize its 'disorder'. This may be leading us to observe uncertainty in mental health settings involving clients that fit a 'migratory profile', rendering them 'sick'. As seen in the cases of T.T. and M.K., it is conceivable that the "me" carries out sickness for social adaptivity and integrative purposes, keeping the refugee an "apolitical, suffering body, in order to be deemed a worthy recipient of humanitarian rewards" (Ikanda 2018: 582). Albeit their cases are more 'diagnosable' and

therefore migratory-framework-approved, the tension arguably resultant from a ruptured “I” and “me” is visible. Cornelia Ilie (1994) sees rhetorical questions as “challenging statements” that wish to “convey the addresser’s commitment to its implicit answer, in order to induce the addressee’s mental recognition of its obviousness and the acceptance, verbalized or non-verbalized of its validity” while its “main discursive functions” are to “induce, reinforce, or alter assumptions, beliefs, or ideas, in the addressee’s mind” (128). Psychoanalysis ultimately seeks to draw out the unconscious mind’s contents, so it comes as no surprise that the premigratory self comes through, albeit in a skewed fashion, in a preverbal and reactionary “I”. We will be turning to the cases of R.F. and S.I. to further illustrate the “I” in conjunction with its other parts.

As a preamble to some of the vignettes I will be sharing of R.F. and soon after, S.I., it is important to note that the duration of therapy with both was significantly shorter than the others. The length of therapy with R.F. was only two years including periods of interruption, while S.I.’s therapy only lasted for three months. Another distinction to mention is that both cases terminated therapy. S.I. terminated due to economic hardship and R.F. because he received a formal diagnosis followed by pharmaceuticals elsewhere. It is important to note that limited therapy provides less opportunity for psychoanalytic interpretations/intervention. Needless to say, it does leave enough room for a migratory diagnosis to take shape. Psychoeducational approaches, a significant facet of the migratory diagnosis, had taken full effect in both cases mentioned. Francesc Colom (2011) defined psychoeducation “as a patient’s empowering training targeted at promoting awareness and proactivity, providing tools to manage, cope and live with a chronic condition... and changing behaviors and attitudes related to the condition” (339). Culture-sensitive psychoeducation interventions like the “tea garden” are advised to ‘promote

awareness' (an [self-] awareness we arguably observed in the case of R.S). The intervention's name, the 'tea garden' is meant to be a "familiar concept for many migrants from different regions of origin and is often associated with a positive situation...to avoid difficult names or labels [like psychotherapy]" (Mewes, Giesebrecht, Weise & Grupp 2021: 3). Psychoeducation is a critical component of immigrant and refugee mental health, and in turn was implemented with R.F. and S.I.. In addition to this, early stages of therapy rely on free association work post-assessment, so we will be looking at this in the cases to come. The cases of R.F. and S.I. were included because they yielded contributory data that will aid in enriching concepts we have systematized thus far.

### **The Case of R.F.**

Born in Isfahan, Iran, R.F. had been settled in Canada for only 2 years when we met. At the time, he was granted a student visa after he received an acceptance letter from a doctoral program. At the time of applying, social and political unrest in Iran was nationwide and R.F. had fears of "being thrown into jail" for having counter-governmental views that could lead to being charged with "enmity against God" or "corruption on earth", a sentence not uncommon among university students in Iran.

*F.M.: Where would you like to begin?*

*R.F.: I have bonding issues. I don't really know how to do it. I cannot consciously make friends. Not knowing what to do is the problem. What do I say after hello? I can't come up with anything to say. Most of the time I have no interest in getting to know them. It's a logical decision as to whether or not I ought to get to know someone. I don't really care for people. But I also don't really care for myself either. I watch movies, smoke a lot, kill time. I just exist. My worth is made through producing material. I'm passive towards my feelings. I'm absolutely not curious about anyone.*

...

*F.M.: Can you tell me a little bit about your experience coming here?*

*R.F.: When I came here I thought something was wrong with me. Something in me said I ought to change!*

*F.M.: \*Provides psychoeducation on experiences of migration – emphasis on resilience\**

*R.F.: I don't think I've solved a single problem in my life. It seems like I have not learnt certain things. I applied for a Ph.D. to migrate. I had these ideas to study economics then go back and help my country at the time. I lost my purpose... what am I living for? Get a degree? Then money? For what? Why? Everything around me is perfect. Maybe I'm not good at exploring, I need someone to lead.*

...

*F.M.: I'm hearing that connection is particularly difficult for you here in contrast to Iran. How are you connecting to people these days?*

*R.F.: I use twitter to "get in touch" with people. But I'm addicted to it. So I'm connected to people but it doesn't feel good because I become an addict.*

Upon arriving in Toronto, R.F. thought 'something was wrong' with him and figured he 'ought to change'. This is commonplace, as response scripts generate scripts for refugees to 'change into'. This is reflected further in the issues he brings forth in therapy. Furthermore, R.F. voices concerns around 'bonding issues' and 'not knowing how to do it' and oftentimes just lives to 'exist'. His 'worth' is found in 'producing material', but outside of this he cannot emotionally invest in others or himself. His vocational role, that of an 'international student', offers a script wherein he can seemingly discover his worth, however, outside of this is when he encounters the tension we have seen in the other cases: tension generated from the refugee role. Similar to M.K. and T.T., R.F. experiences social challenges as he is unable to connect to others *unless* he 'becomes an addict', or in other words, sick. R.S., on the other hand, does not exhibit 'sickness' in the conventional sense. Inversely, she reflects back a resiliency that is expected of her by M. and the host country. What we know from our analysis so far is that resiliency is just another

ascription, similar to trauma. It is at this time that we are confronted by the effects of the trauma trap. Expressed in a later session by R.S., we observe a flurry of rhetorical questions surrounding the decision to leave her family. In the same excerpt, she mentions that she finds it helpful to ‘not feel’ herself, the way that R.F. can’t come to ‘care for’ himself while he is just ‘existing’ in the host country. One can argue that to exist in the host country, one must divest oneself in order to simply exist. This requires sequestering a pre-migratory self from a disordered refugee role.

In the case of R.F., in a later session, psychoeducation is offered to aid in clarifying some of his feelings and a reaction of negation is expressed, followed by rhetorical questions that symbolize a clear rupture in the “I” and “me”. He first discusses his intention for migrating and then it comes to an abrupt halt. What appears to be unsparing questions of uncertainty of self erupt at that very moment. As if a pre-migratory self or “I” emerged and in its attempt to articulate and coalesce to the ‘present’ “me” a disturbance materialized, resulting in a rhetorical device. I theorize that the disturbance was a response to the refugee script and its corollary expectations filtered through my psychoeducational approach. It is in this moment that the “I” and “me” no longer reliably inform one another, and the rhetorical device emanates through the veneer of uncertainty. Two sessions later, I conducted a set of probing questions around R.F.’s experiences of his day-to-day. An active approach was assumed in the session due to R.F.’s visible discomfort with silence. The therapeutic process had become cumbersome, and at the time I had interpreted this as ‘resistance’ from a psychoanalytic standpoint. I stopped for a pause and it was at this point that R.F. shared the following:

*I have no special thing to talk about anymore. Picked up smoking again. I have a strong compulsion to smoke here in Canada. I’m not remembering a lot these days. I feel I don’t feel a lot. Again, I feel nothing special is happening these days. My memories are not being fully experienced is all. Memory involves focusing. I forgot to focus on you. Whenever I learn I need to know the purpose of learning something. I cannot absorb anything that has no immediate*

*function or objective. I'm not building individual memories of myself. They are all social and collective memories.*

In this moment we see, yet again, a clear rupture between the “I” and the “me”. The “I” that possesses a facet of the pre-migratory self appears to collapse under a refugee role that has been taken in. ‘Memories are not fully experienced’ unless there is a clear ‘purpose’. In other words, experiences cannot be taken in and converted into memories unless they belong to a different role and therefore a different script. Once a migratory mind is operative, as informed by the refugee role, the mind no longer ‘builds individual memories of oneself’. In other words, the “I” is confronted with a vastness of uncertainty which in turn threatens the pre-migratory self-part that holds a certainty within itself that the host country expects it to mourn. R.F. speaks to this in the following free association:

*The nature of conversations are different here. Here it can sometimes feel like an interview. Coming up with a topic here is something I don't like doing so it helps when you interview. This is not a 'friendly' conversation. This occupies a different place in my mind.*

In free associating, R.F. mentions the difficulty in free associating in therapy. The nature of ‘conversations’ in therapy are different as they hold a ‘different place’ in his mind. We see here how the migratory framework that produces the migratory diagnosis, which not only can include questions about one’s mind but *answers to those questions* through psychoeducation, is experienced. The experience involves the dislocation between “I” and “me” to ‘just exist’. In the earlier excerpt, R.F. mentions that in Canada, individual memories are not built but social and collective memories are. The “I” in Canada, under a migratory framework or regime that demands assimilation for one’s social existence to persist, is not functioning to continuously inform and enrich the “me”. If it did, one’s existential space in the host country would be threatened. The uncertainty in a lot of individuals who come to Canada is so extreme that the “I”

is overloaded with an uncertainty that it is not used to, and that it would not experience within their ‘certain’ nationality and ‘certain’ geographic spot. One year later, R.F. and I circled back to how he views himself. At this time, R.F. had been seeking external “structure and leadership”, as he put it, and exhibited deep self-doubt and an abundance of uncertainty of self:

*R.F.: There is a lot about “should be”. I ask: Am I like everyone else?*

*F.M.: You seem to want me to confirm you have a ‘normal psychology’.*

*R.F.: I like to mirror. That’s what I do. I am seeking normalization.*

*F.M.: Is what you are perceiving in yourself abnormal? Why is difference bad?*

*R.F.: Because I don’t want to be worse. I don’t want to be the center of attention. I want to be normal. I prefer following. I prefer someone to have authority over me. I’m not an out of the box thinker. You know, I used to create short movies in Iran, during undergrad. I was a good movie maker. Everyone in my cohort remembered my movies. Out of the box thinker there and I was so creative with my scripts.*

...

*F.M.: Do you sense you experience issues around control?*

*R.F.: I used to be shown alternative. I want a normal job, normal life... Why do I want this? I never wanted to be normal. I never thought I was normal. Past couple years, tired of being special. Die like everyone else. When I came here I tried to find Iranians. When with Iranians, I feel like home. You feel you belong there. They are home. I don’t share commonalities with non-Iranians. No where else feels like home. I was special in Iran. Now I’m not special here. I had a lot of important connections, now I feel I am another... IMMIGRANT! My addictions are so bad here. Before I had periods of concentration, here, it’s like people are smarter. I cannot engage here the way I used to.*

The above excerpts further corroborate a rupture we are observing that cannot be mended by standard mental health models. Eventually, R.F.’s suffering could not be addressed under the models provided through my practice. He sought out a formal diagnosis shortly thereafter and was treated with medication. In one of, what would be our last sessions, he appeared content and reported that he had received a diagnosis. He ended with:

*I know the structure of my mind better – does it make me a better person?*

Let us now move on to our last, and most short-lived, case. The case of S.I.

### **The Case of S.I.**

S.I.'s birthplace and residence was Uganda up until the age of 10. Her mother lost her life to HIV/AIDS and her father battled alcohol addiction from as far back as she can remember to present. The addiction interfered with her father's ability to parent and provide rudimentary support. Uganda's social welfare system coupled with its mass child poverty, regional instability and social deficits posed a mortal threat to millions like S.I., resulting in her eventual adoption. She was adopted by her paternal Aunt and her husband whom she knew very little about. Not long after she was flown to New York where her Aunt and Uncle lived at the time, and subsequently moved to Toronto. The excerpts here exclusively contain free association based thoughts. My intervention was minimal as S.I. had a lot to say and I primarily provided supportive – in lieu of analytical – therapy informed by a psychoeducational approach. In our second session I asked S.I. about her state of mind:

*F.M.: In our last session you mentioned feelings of helplessness...*

*S.I.: Yeah. I have been feeling hopeless too lately. I have no structure right now. I have no direction, I don't know anything. I can't form romantic relationships, I shut it down before anything happens. Friendships are superficial.*

*F.M.: Are these experiences you feel you've had before?*

*S.I.: The change in me really happened at 10 when I moved.*

*F.M.: What was that like?*

*S.I.: My Aunt and Uncle wanted me and my sister and brother to show gratefulness, or gratitude. They like to be praised a lot for 'saving us'. I was very chatty initially but it would upset my Uncle... it was a big thing... I would say things I should not have. Then there would be the threat that they would send me back if I continued.*

*F.M.: Send you back?*

*S.I.: Yeah. Then I would start peeing my pants out of fear, I was very scared. There was this big thing around if I didn't change, I would be taken back. And in Uganda children are left alone with no food or protection. Then I would go inside myself and be invisible... while being in a new place. I was crying a lot. I was always crying because I was afraid of everyone. My Dad was an alcoholic but he was an okay person. He just made a lot of promises he couldn't keep.*

S.I. mentions that she is without structure and therefore bereft of knowledge. The usage of the word 'structure' by S.I. is interesting, as R.F. has made use of it when referencing his 'mind' and his desire to 'seek it out', within the confines of therapy and Canadian society. As mentioned, the refugee role ignites a migratory mind that is constitutionally unstructured. Due to the expectations set out for the refugee, driven by the response scripts of the state, the pre-migratory self is expected to be mourned. It is within this pre-migratory self that knowledge of roles, nationality, family, one's social identity, how one perceives oneself in relation to others, self-presentation, and so forth is established. The "I" and "me" burst asunder once the role is in play. What we know so far is that integration and social interaction in the host country hinge upon the lack of correspondence and consistency between the "I" and "me". Therefore, S.I.'s lack of structure and knowledge, coupled with R.F.'s lack of capacity to 'build individual memories' while being able to hold the 'collective memories' from the host country, reveal to us an active migratory mind and the role that supports it.

I want to close this chapter with a small handful of depictions of an operative refugee role. In the aforementioned paragraph, structure of mind under an internalized refugee role scheme was discussed. Similarly, R.S. mentioned a change in her mental capacity to encode, store and retrieve information since migration. Under the migratory diagnosis, impregnated with trauma-informed models, a loss of semantic knowledge (previous knowledge about the world) and procedural knowledge (knowledge or memory of skills acquired and learned) commonly

falls under dissociative amnesia (Sapp 2015). Within *our* migratory formulation, once an individual switches out of a pre-authorized role, such as a vocational role, and enters into the refugee role, the structure or apparatus that upholds the functions between “I” and “me” is compromised. I must reiterate, this is a cardinal characteristic of the migratory mind seen across all five cases. The innards of this mind unwittingly disrupts working memory. The line of communication between the ‘historical’ “I”, which holds the memory of past “me”, or what we would say is the pre-migratory self, and the present “me”, is corrupted. Observed in all the cases is the importance of the rupture between the “I” and the “me”; between the refugee role and the pre-migratory self. The importance of rupture is key here, as it makes adaptation and integration possible. Sickness is not only inevitable under the refugee role, it is a social requirement. But what we discover in S.I. is her refusal to ‘change’ when she left her country of origin. This is reflected in her inability to ‘form’ relationships. She contextualizes this by speaking of the expectation to ‘change’ upon arrival to the host country when she was 10 years old. The “grateful refugee” (Nguyen 2023) is an ascription we have not spoken of till now, as it is not germane to the topic at hand. However, it is important insofar as it is an ascription similar to sickness, resilience and the like. In her formative years, S.I. was aware of the ‘gratitude’ ascription and rejected it by means of withdrawal and silence. This defiance led to increased suffering as she was ‘crying a lot’ and ‘afraid of everyone’ and developed what would be called psychosomatic symptoms, like ‘peeing her pants’. At a certain point, S.I. made attempts to ‘change’. This was shared a month into our sessions:

*S.I.: I lived in constant confusion. Am I always wrong? The guilt and shame comes from my Aunt and Uncle. Constantly feeling like I'm doing something wrong, never doing anything right. I had to be small and passive.*

*F.M.: Do you feel that elsewhere?*

*S.I.: It's weird, I could feel the same with friends. I feel guilty when I don't follow up with friends. I'm realizing I can't identify feelings - self-loathing maybe? There was a lot of guilt around us being adopted and brought here. We were talked to like adults like you 'should' be doing and feeling this and that. We operated under should.*

*F.M.: \*Psychoeducation is offered to normalize challenges of having to acclimatize to the host country; key terms used: trauma, abuse, challenges in sponsorship, resilience\**

*S.I.: Not excited for my future at all. Maybe if I was myself or anchored in my wants and desires I would've fought for it more. I can't think for myself – who am I?*

We bear witness to an uncanny shift in her narrative in the vignette above. Peppered throughout, one sees rhetorical questions when S.I. begins to 'operate under should' (i.e. operate under the refugee role). She speaks of having to be 'small and passive', fulfilling the socially imagined infantilized, obsequious refugee. After the refugee script is read and prescribed by me through the process of 'normalization' or rather how one 'ought' to feel and be, a rhetorical question of 'I can't think for myself – who am I?' appears. The refugee role is begotten and brought forth. Despite being told who she ought to be and reinforcing the 'change' she presents here as being, my migratory diagnosis is rebuffed. In one of our last sessions, S.I. appears increasingly upset:

*S.I.: I'm not open and involved with people. There's no real interest in others. As a person you have to be open and involved. In sessions I could have said more...*

Here she speaks of not being 'involved' with people and, on the face of it, with me. She 'could have said more', but one can argue the migratory therapeutic framework would have encoded and transmitted a migratory diagnosis that may be too perilous to a pre-migratory constitution wishing to be preserved. In the same session she goes on to say:

*I feel so much anger towards my Aunt and Uncle. They keep asking what I am grateful for. I feel so much anger towards them. I don't feel connected. How can I save another... when I can't save*

*myself? Interacting with others tires me out. I feel calmer when I'm not speaking. I don't look forward to this therapy. It's harder than I thought.*

*The hardest part of therapy is talking. If my vulnerability was controlled it would be okay. But I'm exposed and raw. I get anxious and think: What am I going to say?*

In our next and final chapter, we will examine the refugee in the present and its overlap with the refugee role script we have laid out in this dissertation. We will also be stating the importance of knowing refugee regimes and their response scripts. For as we can see, the refugee role has a past of its own predestined to repeat.

## Chapter 6: The Neo-Alien

### Introduction

This final chapter will synthesize key findings derived from the historical overview of the refugee role and the multicase study research conducted. Furthermore, this overview will focus on the implications of the migratory framework and its refugee role in future research in the refugee mental health field. I will restate my thesis and overall contribution to the psychosocial perspectives in refugee mental health and its repercussions for the present-day refugee. To start, a synopsis of the dissertation. Our case study research and analysis was preceded by a thorough review of the history of international refugee regimes and their emergent refugee role scripts: *alien*, *victim of war*, and the *refugee*. The final iteration occasioned multiple renditions of itself: *the living ideological symbol of the Global North*, *the traumatized refugee*, and *the resilient refugee*. At the end of Chapter one's survey of roles, we unearthed the 'internalist orientation'.

The uncovering of this orientation problematizes the humanitarian effort, for it makes appeals to an 'externalist orientation' claiming that human welfare is at the center of its mission. Our analysis challenges this notion and asserts the converse: the conception and development of the refugee was born within the confines of the host's mind and their state's ideological standard. This essentially impounded any human seeking refuge under what we have called the 'migratory framework'. Several attempts at an 'externalist orientation' have been made, in particular when stateless persons were designated with the title 'refugee'. Needless to say, these attempts continue to fail, as evidenced in this dissertation. Hence, my contribution seeks to redress the issues that have come out of this internalist position by proposing heuristic devices that can illuminate problems identified for future research. Now, for a brief overview of the subsequent chapters.

The first chapter was followed by a thorough literature review of refugee mental health models and approaches in the field of psychiatry and psychoanalysis. ‘The psychological birth of the refugee’ is hallmarked by psychopathology, illness, and ‘symbols of birth’ that confine imaginings of the refugee as infantile and intrinsically sick. The attempt at exploring a migrant’s mind only takes the clinician as far as understanding the *refugee role’s mind* (distinct from the *migratory mind* that arises in the current regime when the refugee role becomes internalized), nullifying all attempts at an externalist orientation. The leading combatant to the PTSD plagued refugee image was led by trauma critics, whose polemic studies and research simply produced more refugee ascriptions. At which point, we were able to identify and localize such gaps and contradictions that are informed by the prevailing response scripts. These response scripts, which we intend to demonstrably sketch out in this chapter, were proven to generate a system adhered to by refugees and host country members. We have come to understand this as the ‘migratory framework’.

This framework fortifies the refugee role through the reification of the *migratory mind* by way of a *migratory diagnosis*. This is done by generating and supporting refugee role ascriptions through social and clinical prescriptions like ‘trauma’ and ‘resilience’. These prescriptions ultimately describe varying psychosocial states and effects, but are constitutionally the same, as they effectuate ascriptions to role carriers. This results in what we have called the *trauma trap*, wherein migrants are ‘refugee-role-bound’ for decades after settlement due to constant reinforcement of sickness via ascription. Through our case studies, we have established that clients displayed sickness due to the internalized refugee role’s dominion over the self (i.e. they have a *migratory mind*). The internalized refugee role stifles the individual’s pre-migratory “I”, augmenting the post-migratory “Me” for assimilation purposes. Recent geo-political

developments are once again shifting the landscape for migrants and refugees. We are now in a time when there appears to be a return to its roots in North America: *alien*. The ‘return to alien’ will be covered in the section to come titled *Present day: Neo-Alien*. In the next section, an overview of my key findings will be presented and thoroughly reviewed through the lens of my proposed theoretical template.

### **Key Findings, Contribution and Future Research**

Through and through, this dissertation has paid special heed to the traumatized refugee role and the discovery of its isomorphic twin, the resilient refugee role. This finding led to the development of our term *trauma trap*. This trap exemplifies the pervasiveness of the migratory framework from the role it creates to the assessments and tools used to treat it. To help us better understand how we arrived in this trap, we traced the refugee role as far back as the Great War to postulate a *phylogeny of the migratory mind*. We explored the ancestry of the refugee role by illustrating its evolution over time in relation to objects, subjects, and situations. What we discovered is that international refugee regimes not only produced response scripts that guide behaviour and approaches to refugee treatment, but that these response scripts single-handedly engendered refugee ascriptors. This is a significant finding that we will unpack here before we further validate the cross-application of our migratory template.

An example of this cross application can be seen in the ‘alien’ from the Great War, where migrants were seen as a “perceived threat” to the “logic of the system” of a state (Lillich 1984: 1). The threat encompassed fears surrounding aliens instrumentalizing their “alien powers” to galvanize terrorism in exile states (Carter 2013: 102). To curb such potential dangers, restrictive policies, such as Canada’s first national ‘enemy alien’ internment operation (Kordan 2002), were invoked. These policies were meant to hegemonize ‘aliens’ and one sure way to do this –beyond

internment– was to surveil their movement. One effective strategy was the establishment of the Nansen Passport, a document that included the identification of stateless persons (Venke 2012). The incentive for stateless persons to pursue certification was not restricted to ‘accommodating’ travel by the exile state, it also “increased chances” for employment by making it “legally possible” for passport holders to pursue opportunities (Lettevall 2013: 16). States wanted to offer ‘refugee protection’ through ‘proper’ identity documentation that, as Dorothy Thompson said in 1938, “returned his [the ‘alien’s] lost identity” (in Giaimo 2017). However, what we know now is that the passport was primarily used to hold exclusive control over “legitimate means of movement” (Torpey 2000: 5). States issuing the passport to Russians at the time were “qualified to renew it as long as the refugee concerned continued to reside within its borders. The certificate would cease to be valid if the bearer at any time entered Russian territory” (Fosse & Fox 2015: 108). It is at this stage that ‘the refugee’ is conceived at an embryonic level.

I argue that the Nansen passport is one of the first physical products of a response script meant to ‘help’ the stateless individual. Arguably, the first forensic evidence of its kind. In consequence, the passport is one of the first visible indicators of a *post*-migratory identity – what we call the refugee role today. The certificate included “the holder’s identity, nationality and race” (Fosse & Fox 2015: 108), but more importantly, reflected the state’s interest: to repatriate all refugees by pushing for continuous movement. Should movement occur, it would be instrumental and economically fruitful for both states: one state is disburdened by a stateless person, while the receiving state addresses a labor shortage. In other words, the post-migratory – soon to be refugee – role was in its nascent stage, with a unidimensional character of labour and certification. The expectation for the ‘alien’ was perpetual movement and/or labor. The role’s ascriptions burgeoned and spread over the 50 countries that had recognized the Nansen passport,

and as a matter of course, they all accepted the post-migratory identity of ‘alien’. Interestingly, should the ‘alien’ return to their country of origin, the ‘certificate would cease to be valid’. Put differently, their post-migratory identity would cease to exist. In Chapter 4, we reviewed the case of M.K., who, upon his return to his country of origin, lost his ‘post-migratory identity’ (that being ‘traumatized’ and suffering from ‘addiction’). The outcome was confounding. His ‘symptoms of addiction’ suddenly abated once he was in Bangladesh, only to return when reengaging with the refugee role in Canada.

Indeed, the Nansen passport’s equivalent is far more pernicious today, for it targets the individual’s mental status more explicitly, as seen in the analytical chapters of this dissertation. Its equivalent, of course being diagnosis – which we have called the migratory diagnosis – originating from the mental health enterprise. And just as the Nansen passport was intended for ‘refugee protection purposes’, the migratory diagnosis seeks to do the same. The migratory framework in the ‘alien’ epoch granted an individual’s social right to exist through their literal ability to fill labor shortages. While the operative migratory framework of our time assesses worth in clinical settings and is determined by an individual’s ability to think, feel, act, work, and function like a refugee for assimilation purposes. This was best described through the case of R.S., where we saw the consequences of her internalizing the resilience ascription to ‘be normal’ and the repeated attempts to live with a social worth that stems from an ascription in lieu of one earned through a self-contained, harmonized “I” and “me”. Thus, the refugee becomes acquainted with the role script through imposed ascriptions emerging from a passport or its counterpart, in R.S.’s case, the migratory diagnosis. The longitudinal application of our findings from this case study research is highly invaluable, for it demonstrates the role’s adroitness and

perseverance across many international refugee regimes. Let us look at how it applies in the ‘victim of war’ role.

In post-war times, we saw the ‘alien’ mutate into the ‘victim of war’. This added another dimension and facet to the ‘alien’. The transmutation of the role was in large part due to legal scholars in the League of Nations, who were astonished by humanitarian aid on the ground (Cabanes 2014). At this time, one can see an overlap between the desire for labour acquisition from ‘aliens’ passing through, coupled with an impulse to ‘rescue’ them. The bearing of excessive responsibility and the compulsive need to ‘help’ the migrant or ‘alien’ is also prevalent today (Lee 2020; Baglama 2025). The additions to the script, prompted by what we described as the ‘internalist orientation’ from rescuers, made way for a new migratory framework, bolstering the inceptive refugee role. The pain reflected in Sampson Aroutiounian’s letter to the Armenian journal “Horizon” in 1915 or General Sir Charles Harington’s letter to Geneva in 1923 captures the irreconcilable pain in seeing floods of human suffering. Although the majority returned home, repatriation was not feasible for many who would be returning to genocide, revolution and post-war precariousness (Piana 2024).

In Chapter one, we covered the internalist approach that contributed to the construction of ‘victims of war’ and their script at the time. Inversely, within this dissertation, we have tried to provide an externalist orientation through our case studies, which revealed the role’s impact: individuals are left with a disharmonious, ruptured “I” and “Me”. The “I”, a simulacrum of a pre-migratory self, is often seen as ‘sickness’ or an ornamental object meant to reveal or uncover something more ‘meaningful’. We understand it as a part-self that is pre-migratory and strangulated under the force of an active refugee role. As we have observed, clients in this study have had to live with this rupture for relational opportunities and connectivity (as illustrated in

Chapter 4). Attempts at ameliorating the rupture have led to isolation, perceived combativeness in the clinical situation, and higher levels of suffering.

In an attempt to further apply our externalist theoretical application, I have taken steps to recover oral history interview recordings from stateless individuals. As this pertains to the ‘victims of war’ era, not many interviews of migrants in English can be found. However, I was able to locate an English-speaking interview of a migrant from the 1920s. Russian-Mennonites Mr. and Mrs. Johann Bergen were interviewed on July 15th, 1976 by Henry Paetkau. In the interview, both Mr. and Mrs. Bergen describe their immigration to Mexico and, after some time, their move to Canada and eventual arrival in Manitoba. There is no written transcript, but from listening to the barely audible cassette tape recordings, one immediately enters the migratory framework of Bergen’s time. Over the course of hours, from what was audible, I was able to transcribe the following:

*JB: An American guy asked “Do you speak German? Where do you come from?” I said Mexico. Then the train stopped. We went to the station. Then he bought sandwiches for us and the kids. Really nice guy. We had to get off the train again. We went to Winnipeg. Then we had to go again. Then go to London. Then we met people from there. Then he said you gotta go to the other station. We kept going from one station to the next. In Winnipeg, with two boys, I got paid 10 dollars a month. I worked a lot. You have to work to live. Then one guy had a factory. I worked 10 hours a day, and got \$1.25. 30 dollars a month. 10 dollars was rent. Kids went to school and we lived! We lived! We lived in Winnipeg for 10 years. Then it went up to 50 cents. Years later we moved again.*

*\*JB goes into extensive detail about the tasks he had to carry out for work\**

*We sold the farm, we then moved again. We started working and building homes.*

*HP: Did you ever think of going back?*

*Mrs. JB: I saw such a black future, rather be in Mexico. We lost everything there [in Russia]*

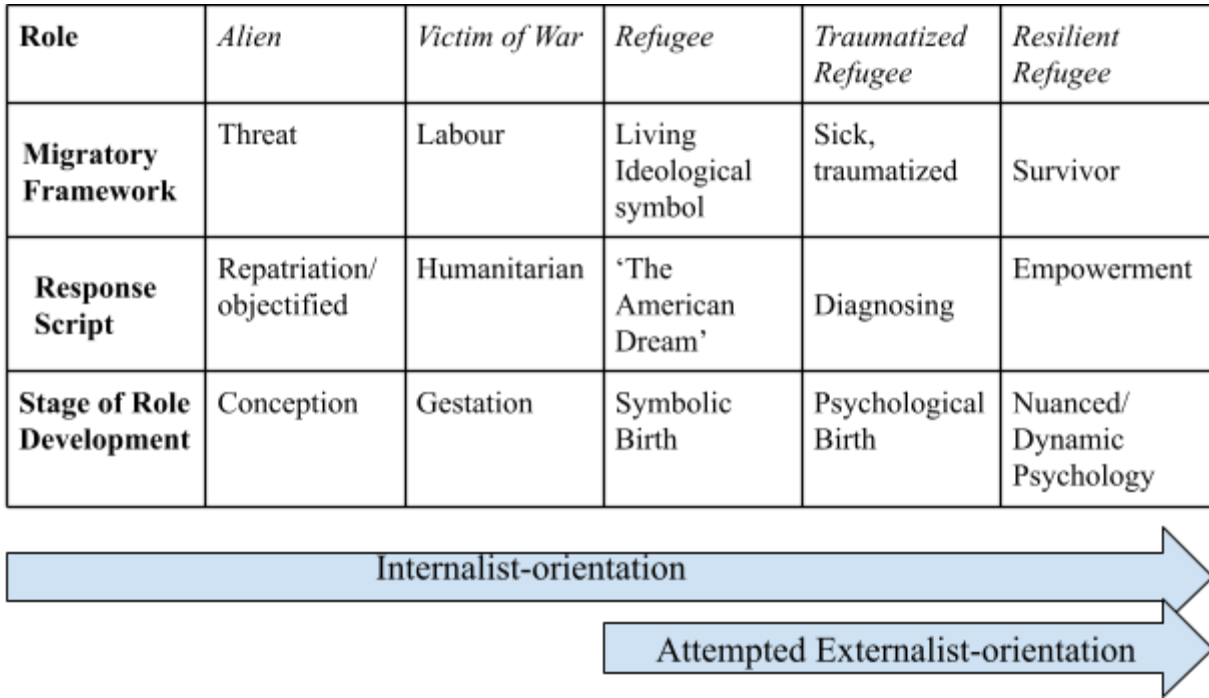
*HP: How was Canada?*

*JB: It was a little different...not too many people came [to my area]. Russian people were there. Our church was there too. We had a house. Our farm. We were OK there.*

*HP post-interview recording: I felt there were some memories more vivid, and perhaps they recalled more often in later years, which therefore Mr. JB had more detail, for instance his trip from Mexico to Canada. Minute details he recalled. Experiences from Russia were nebulous...they seemed reluctant or unable to give me much information from that period. It seemed straight forward, what they could remember. Easy to make generalizations... I felt they were deeper experiences that were generalized or summarized, perhaps due to the fact that they are happy, content, and satisfied in their lives. Very content... in later conversation, Mrs. JB indicated that she had a diary from Russia, across to Mexico that she wanted to release one day.*

The interviewee, Bergen, speaks of his migratory journey during the 1920s, where the ‘alien’ and ‘victim of war’ evolution was well underway. From his accounts, he and his family were shuffled around from station to station before landing in Winnipeg and finding ‘work to live’. During his journey, he and his family encounter a North American traveller who buys Bergen and his family a meal, arguably reflective of the ‘victim of war’ response script at the time. The alienness is exhibited in the segregated ‘area’ he describes, where ‘people’ did not frequent the area (presumably white Canadians) as only ‘Russian people’ presided over the sequestered territory. ‘Work’ and ‘living’ are prominent themes and keywords peppered throughout their biography. From listening to the cassettes, Bergen goes into meticulous and minute detail of each and every one of his employers and the duties he carried out in the work roles offered to him. As Paetkau points out in his post-interview recording, there are detailed memories of the migratory experience, while memories of Russia ‘were nebulous’. He later clarifies this by saying they appeared ‘reluctant’ to share. He concluded that ‘depth’ was perhaps ‘generalized’ or arguably reductive appearing because they are ‘happy, content and satisfied in their lives’, yet interestingly, Mrs. Bergen holds on to a diary from Russia that she may ‘one day’ release. Within the framework, the “me”, which at the time is saturated by work-based thoughts while meeting expectations of a grateful life of toil, has resulted in what the interviewer perceives as happiness, contentment and satisfaction.

However, what we have gleaned from our study is that functionality and assimilation to the role, which the Bergens display, is not always a clear sign of a lack of suffering. The ‘reluctance’ to share their pre-migratory life is noticed but not probed by the interviewer as the “me” reigns over a reluctant-manifesting “I” that we also saw in our case studies through the usage of the rhetorical device. As if the “I”’s manifestation under the refugee role order also underwent evolution, from reluctance to what we are seeing now: uncertainty, distortion, irrationality, deflection as depicted in a rhetorical device. What is also interesting is that not much was revealed about the subculture of Russians in Winnipeg, where the “I” would imaginably surface in a creative, unbound, sublimated fashion. When asked if they would ever return to their country of origin, Mrs. Bergen replied ‘I saw such a black future...we lost everything there’. A peculiar response to the question. Under the refugee role, the “I” a ‘historical figure’, is disconnected from the “me”, often flooded and blinded by immense uncertainty, ‘blackness’ and loss. What is quite noteworthy is that all the clients in our case study had a creative “I” in a true Meadean sense, but only if they occupied a vocational role or if they were in a context that terminated the refugee role’s tenure. What would come after, which is the establishment and solidification of the refugee through the living ideological symbol of the Global North, is the facet of permanence, as repatriation was abandoned and assimilation was well underway. This is the beginning of the establishment of the refugee role’s permanence. Having a past that includes being a ‘living ideological symbolism’ has led to *perennial* illness, another layer explaining why refugees continue to remain sick well after settlement. In Figure 1 you will find a diagram of our framework.



**Figure 1. The Migratory Framework**

**Present Day: Neo-Alien**

According to the UNHCR’s Mid-Year Trends 2024 report, we have seen unprecedented displacement trends and numbers in the past 12 years. These numbers have reached a cumulative total of 122.6 million displaced persons. The conflict in Sudan, the military takeover in Myanmar, the armed conflict in the Democratic Republic of the Congo, the war in Ukraine, the political and economic instability of Latin America and the Caribbean, gang violence in Haiti, and the destruction of the State of Palestine have resulted in millions of refugees seeking international protection. In line with Orchard’s (2014) non-entree regime that resorts to “policies of refugee deterrence, detention and extraterritorial processes” (17), Canada released its immigration levels plan and controlled targets that will span from 2025-2027. Targets were presented on October 24th, 2024 in a news release from the Honourable Marc Miller, Minister of

Immigration, Refugees and Citizenship, who spoke of the “decisive measures to attract some of the world’s best and brightest” after Canada reopened its economy post-pandemic. The goal at the time was to “integrate them [migrants] into the economy quickly”, but now the time has come to reduce permanent resident targets. Miller concluded by saying that “we have listened to Canadians, and we will continue to protect the integrity of our system”( <https://www.canada.ca/en/immigration-refugees-citizenship/news/2024/10/government-of-canada-reduces-immigration.html>). In other words, migrants were collected to address the lack of available workers. Once they adequately fulfilled this demand, it made room for economic assimilation, rendering social assimilation a secondary concern. The latter very quickly became a primary concern once economic stability was achieved. We can see here how the refugee role’s past regimes and layers are drawn out and solicited based on the state’s immediate needs and demands to satiate itself.

While refugees were critical to kickstart the economy by filling labor market shortages post-COVID, once demand decreased, we saw changes in both refugee targets and Canada Border Services Agency (CBSA) cost recovery for removing inadmissible individuals. In 2024 alone, the CBSA removed over 14,000 inadmissible foreign nationals, the highest level since 2012, as seen in the annual detention statistics of 2012 to 2024 (<https://www.cbsa-asfc.gc.ca/security-securite/detent/stat-2012-2024-eng.html>). Not long after Miller, the Canadian Council for Refugees released a public statement with the headline “Canada betrays refugees” on the same day. There has been a noticeable decline in refugee targets, and as it stands, 1 out of every 5 refugees and their dependents will gain permanent status. Expected wait times can be as long as 3 years, with some refugees already waiting for over 4. The puzzling matter in all this involves privately sponsored refugees, who are and will be affected by these

changes. Even though the costs are often paid by private citizens, wait times for this segment will nevertheless be extended. Refugees in Canada, along with their families, will see a 31% reduction in admittance as cuts to the Protected Persons and their Dependents have to reflect new refugee targets

(<https://ccrweb.ca/en/canada-betrays-refugees-ccr-statement-2025-levels-announcement>).

We have shown the progression of the refugee role from alien to its birth and evolution through versions of living ideological symbol, traumatized and resilient, and with their associated elements (migratory framework and response scripts). This building of the notion that the refugee role has a past gives us a historical context to critically view the present. With this in mind, an outmoded policy like repatriation, which we saw explicitly with the *alien*, can happen contemporarily in both the literal sense (physical deportation) and within an ideational field (extended wait times and uncertain status). Further amplification of the refugee role is highlighted here. We see that although a pre-migratory self is compelled to be left behind, the refugee role's past remains, as the Canadian Council for Refugees reminds us of 'the victim of war' and the birth of the refugee as 'living ideological symbol' that is deserving of placement and security. I do not question or disparage the important work being done here, but rather draw attention to how it impacts the refugee role. Our central concern all along has been how our current refugee regime obstructs and ultimately hampers the historicity of the "I". The mandatory mourning of one's past, coupled with pressure for ascription acceptance from the role-carrier, results in successful acclimatization to the host's norms. However, as we see here, the individual is forced to mourn their self, but their role's past remains and is acted upon to preserve the refugee's agency, not a pre-migratory agency. Why? The pre-migratory self belongs within the externalist realm of thought and therefore stands outside the host, while the refugee role's history

is internal to the exile country and therefore can remain. While this arrangement persists, the objectification and disposability of refugees will persist in the Global North – among them, the United States.

A neo-alien regime is in full effect. On January 20th, 2025 the United States' newly sworn president operationalized an executive order entitled “Realigning the United States Refugee Admissions Program (USRAP)”. President Donald J. Trump declared the USRAP inoperative until realignment with the interests of Americans is reached. He went on to reference the previous administration’s record number of admissions (2024 saw 100,034 resettled refugees, the largest resettlement number in 30 years (Chishti, Bush-Joseph & Greene 2024)) as a problem that “compromises the availability of resources for Americans” and jeopardizes their “safety and security”. However, this also endangers refugees who are overseen by the USRAP. Of course not all refugees are banned. President Trump has allowed the U.S. to “admit only those refugees who can fully and appropriately assimilate into the United States” (<https://www.whitehouse.gov/presidential-actions/2025/01/realigning-the-united-states-refugee-admissions-program/>).

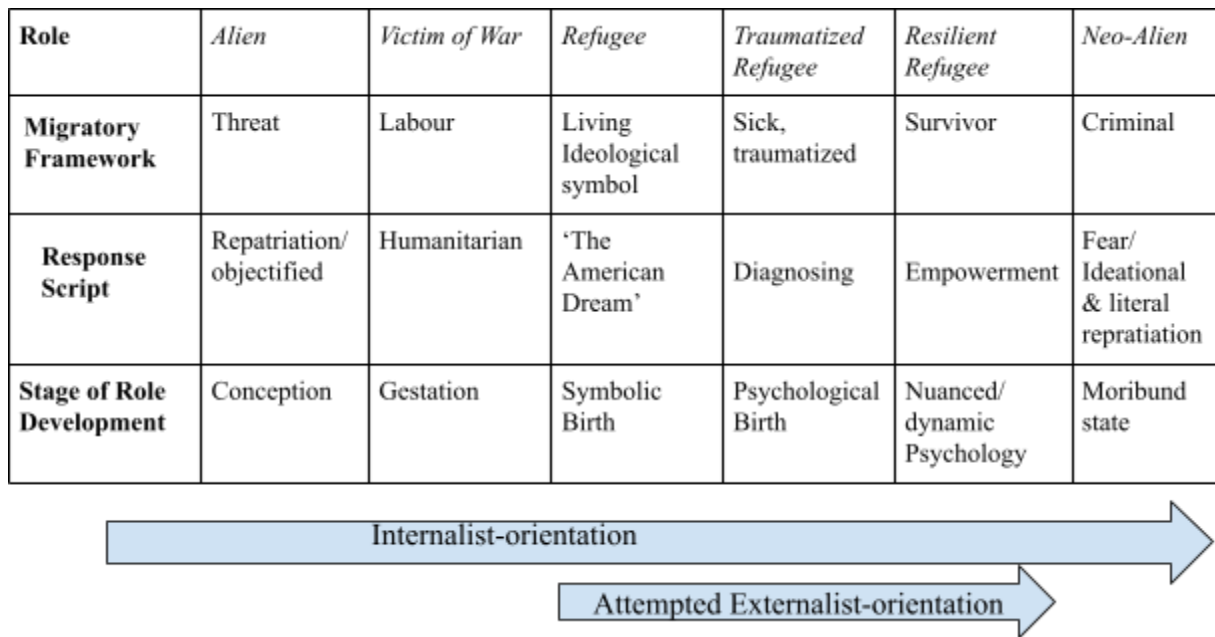
For further context on the term ‘assimilation’ from this administration, on January 19th, 2019 President Trump remarked on American citizenship. He went on to say the following: “When we swear in new citizens, we do more than give them a permit; we give them a history, a heritage, a home, and a future of limitless possibilities and potential... our ability to instill the spirit of America into any human heart, into any human being” (<https://trumpwhitehouse.archives.gov/briefings-statements/remarks-president-trump-naturalization-ceremony/>). The newly sworn in citizen successfully completes the work of their mourning by understanding that what is left behind is simply a memory, a “futureless past memory” (Tahka

1993). This is reminiscent of Mrs. Bergen's 'black future' comment when asked to speak about her pre-migratory thoughts. The history President Trump is referencing here may not be what he intended (i.e. bequeathing America's great history onto one's acquired citizenship), but he is partially right in that there is a refugee role history that the state retains. The refugee will unknowingly be tasked to carry this, possibly for decades after resettlement. They are expected to live with this history, for it facilitates assimilation and protection, but also, under the current regime, their fall. For what precedes its victimhood is its alienness that previously threatened terrorism and mutiny.

This has called for 'new' action. The presidential action on January 20th, 2025 titled "Securing our Borders" where the term "illegal aliens" stood in for 'asylum-seekers'. In an article entitled "Immigrant women describe 'hell on earth' in ICE detention" on March 24th, 2025 in USA TODAY, a detainee had said: "We smelled worse than animals" as she described the conditions while in detention. She and other detainees were forced to defecate and urinate on themselves for 3 to 4 days while detained. The subhuman reference in relation to odour and the placement of bodies in conditions that promote a lack of bowel control, often seen in infants, reinforces the infantilizing and fetishistic image of the refugee. These instances, of which there are many, can only induce further erosion between a historical "I" and the expected "me", which appears to be a state's goal depending on the exigencies of the state.

Within the current regime, we continue to be exposed to ever-changing policies and response scripts. President Trump regarded mass migration and resettlement as a "flood of illegal aliens" and resettlement was redrafted as "hostile actors with malicious intent" that include but are not limited to: "potential terrorism, gang and violent transnational criminal organizations and acts, violations of immigration law, violations of Federal or State law"

(<https://www.whitehouse.gov/presidential-actions/2025/01/securing-our-borders/>). Here is the neo-alien, with its scripts, its role history, and its moribund “I” (see Figure 2). The “I” is not symptomatized away, but rather criminalized before being extinguished. The “me” is expected to be saved now more than ever and returned to its victimhood. Within the borders of the victim condition, one will find its infant-like structure and presentation. Should the role carrier refuse the objectification of having to be saved by host sympathizers, they must then accept their bestial fate and be banished from ‘earth’ and sent into ‘hell’. This is the inescapable ‘catastrophic birth’ of the refugee.



**Figure 2. The Migratory Framework (Extended Version)**

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