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Journeys to health: The Case of Chilean Exiles in the UK

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Introduction

In a 2018 article Newbold and McKeary (2018) call for recognition of the 'journey to health' made by refugees. This should encompass an acknowledgement of all the different stages of the refugee process, including pre-refugee and post arrival in destination country. As they contend,

health status and need for health services within refugee populations cannot be considered as only 'current' or existing health status, but rather as a continuum of experiences (2018: 699).

For many refugees, health is entwined with their story and their journey (Newbold and McKeary 2018: 700). Creating spaces to hear these individual stories within the health-care setting are vital to successfully engaging health resources and ultimately improved health status (2018: 700). Similarly, the rising global burden of forced migration due to armed conflict is increasingly recognised as an important issue in global health. Evidence has shown that forced migrants are at a greater risk of developing mental disorders than other population groups (Langlois et al., 2016; Siriwardhana et al., 2014). Yet within the context of Europe's 'refugee crisis' political debates around the needs and entitlements of refugees has become ever more complex and the legitimacy of people's claims to

international protection are frequently challenged. The likelihood of creating well-resourced spaces for refugees to tell their stories is increasingly compromised. Moreover, refugees may be unwilling or apprehensive about telling their stories and sharing their health concerns due to fears of deportation (Newbold and McKeary, 2018, 700). Across Europe there is an increasing mismatch between the legal and normative frameworks that define the existing protection regime and contemporary forms of migration (Crawley and Skleparis, 2018). The seemingly neutral and objective category of 'refugee' is in fact being constantly formed, transformed and reformed in response to shifts in political allegiances or interests on the part of refugee-receiving countries and the evolution of policy and law (Crawley and Skleparis, 2018: 51).

Drawing on the case of Chilean exiles in the UK this paper argues that hearing people's 'journeys to health' expands current understanding of the health and well-being of refugee communities. These stories reinforce claims that health needs to be understood as part of a continuum. Furthermore, it underscores the lasting impacts on health of terror and torture that for many refugees accompanies them through their health journeys. This study of exiles who have been settled in the UK for several decades, many after experiencing torture and detention in Chile, allows for a more nuanced understanding of people's health and well-being that shows how people are both able to 'move on' in the years after their arrival while at the same time they may continue to suffer some longer term impacts of their experiences.

The choice of the term 'exile' is deliberate, reflecting the fact that many Chileans in the UK— including those interviewed for this study —continue to self-identify as political exiles. After the military regime ended in 1990 many Chileans did return 'home' but the challenges they faced when doing so have been the focus of several studies (Hirsch, 2015, Roniger, 2016). Given the decision of many Chilean exiles to remain in their adopted

countries some authors have suggested that the term 'post exile' may be a better descriptor for those who remain living in the UK (Olsson, 2009; Roniger, 2016).

The Chilean case discussed in this paper also highlights the critical role played by support services following arrival to the UK and sheds light on how refugee groups, particularly those who experienced trauma, can have on-going needs that directly relate to the circumstances that initially forced them to leave their homes and become refugees. While clearly not possible to generalise about all Chilean refugees the stories discussed in this paper raise concerns and show how for some at least, becoming an exile can have lifelong consequences.

Chilean exiles in the UK

On the 11th September 1973 a brutal military coup led by Augusto Pinochet occurred in Chile. Over subsequent months and years many opponents of the regime were exiled, often following torture and imprisonment. Figures suggest that around 200,000 Chileans were exiled internationally, 3000 of who came to the UK (Hirsch, 2015: 2). Many came to the UK following two agreements between ICEM (the International Committee of the Red Cross), the National Refugee Commission (CONAR) within Chile – a small organisation run with the support of the Lutheran Church, and the Chilean government to allow for the transfer to exile of those detained without trial under the provisions of the State of Siege. This was followed by a similar agreement in April 1975 permitting those who had been tried and sentenced to apply under Decree Law 504 to have their sentence commuted to exile. Once visas were negotiated for prisoners, ICEM handled their travel arrangements and in total assisted around 3,000 prisoners to leave under this programme (Angell and Carstairs, 1978: 151). Within the UK several support organisations including the Joint Working Group for the Resettlement of Refugees (Joint Working Group), Academics for

Chile and the World University Service (WUS) helped bring Chileans to the UK (Angell, 2019; Ribeiro de Menezes, 2019). Once in Britain the majority were granted refugee status, something which is reflected in the sample recruited for this study since all participants had been given full refugee status.

Following the official return to democracy in 1990 exiles were able to return to Chile. The number of Chileans who returned is not known but it is estimated that around half those exiled to the UK have since returned (interview with Alan Phillips, World University Service General Secretary 1973-1981). However, many Chilean exiles have continued to live in Britain and their knowledge offers a unique insight into a hard to reach community and their experiences of living in exile for over four decades.

Methodology

The paper draws on oral histories collected from forty participants between 2014 and 2016. Participants all lived in the UK, mainly in and around Cambridge, London and Sheffield. Respondents were recruited through the author's personal networks as well as snowballing techniques. In the main interviews were conducted in the person's home or other place of their choosing, in a small number of cases where other options were not viable the interviews took place in the author's office at XXX. Respondents were given the choice of telling their story in English or Spanish and in the majority of cases interviews were conducted in English. Interviews conducted in Spanish were subsequently translated by the author into English. In addition, three focus groups also took place (two of these only included female participants while the third was an all-male group). Discussion within the focus groups was open-ended with participants being invited to identify significant issues affecting their lives as exiles. Six additional interviews with other key informants - including individuals who worked with refugee and human rights

organisations concerned with bringing Chileans to the UK in the 1970s - also occurred. These participants were predominantly identified through the author's academic networks and again snowballing techniques were used. These interviews along with a wider reading of the academic literature also offered a means of triangulating the research findings, enabling a more objective analysis of the oral histories.

It is important to acknowledge that there was a certain in-built bias within my sample of exiles as it only included individuals who were willing to talk about their experiences of exile and my findings cannot claim to represent the community as a whole.

The sample included 21 (9 women and 12 men) respondents who had been imprisoned and tortured and 10 women who came as the 'wife of' political prisoners (though in some cases were now divorced), two men and one woman political activists who had been advised to leave in order to avoid incarceration and the remainder included the spouses of political activists or people, who while not necessary direct targets, had left as they were worried about their personal safety or that of their families. Participants were aged between their mid-60s and mid 80s and all were 'first generation' exiles who arrived in the UK in the 1970s. The discussion in this paper draws primarily on the interviews conducted with female participants – both ex-political prisoners and 'wives of' ex-political prisoners. To preserve the anonymity of respondents, fictitious names have been used.

Approaches to refugee health

Interest in the mental health needs of refugees gained credence in the period between the 1970s and 1990s. The inclusion of PTSD in the American Psychiatric Association publication, Diagnostic and Statistical Manual of Mental Disorders (DSM - considered to be the global authoritative guide to the diagnosis of mental disorders) in 1980 led to a

proliferation of epidemiological studies in the refugee mental health field (Silove et al., 2017). It was this recognition of PTSD that marks the start of increasingly medicalised approaches to mental health and introduced the term 'trauma' into the 'refugee health' discourse (Summerfield, 1999). Ideas around PTSD emerged from the work of the anti-war movement in the United States who argued that Vietnam War veterans were not just perpetrators of violence but were also victims, traumatised by roles thrust on them by the US military establishment. They lobbied for veterans to receive a distinctive and specialised medical care, to be organised around a distinctive diagnosis of PTSD – the successor to older formulations like shell shock or war neurosis (1999: 1450).

Critics of the medicalisation of trauma experienced by refugees have argued that this approach has led to the development of a whole industry oriented at sustaining the wide-scale medical intervention required in both humanitarian and everyday contexts (Pupavac, 2002; Theidon, 2013; Watters, 2001). Within this approach macro political events are transferred 'into a series of micro, medicalised experiences inappropriately divorced from both the wider contexts of their creation and the political commitments required for their solutions' (Brough et al., 2012: 210). Such methods fail to acknowledge the social, political and economic factors that shape refugees lives as well as acknowledging their responses to these processes (Watters, 2001); moreover, within biomedical paradigms no space is offered for refugees to define their own needs and priorities.

It has also been argued that there has been a tendency to focus on the impact of refugees' exposure to violence, rather than taking into account the stressors encountered by refugees once they go into exile, that is, post-migration or exile-related stressors (Miller et al., 2002: 341). Furthermore, there has been a questioning of the construction

of trauma as an individual pathology that can be addressed through a narrow application of mental health technologies. Indeed, as Summerfield argues,

Health and illness have social and political roots: post-traumatic reactions are not just a private problem, with the onus on the individual to recover, but an indictment of the socio-political forces that produced them (2000: 234).

In the mid-2000s the publication of two systematic reviews of refugee mental health prompted recognition that not all refugees were 'traumatized' and in need of counselling and also acknowledged the importance of other factors that may impact on refugee mental health, including the stressors of exile (Silove et al., 2017). Nevertheless, it remains clear that exposure to torture and the total number of trauma events experienced are the strongest predictors of PTSD and depression, respectively and this remains a significant concern for refugee populations (Silove et al., 2017).

Research has found inconsistencies in rates of PTSD and depression and has shown general unpredictability in terms of reactions to trauma across cultural groups. Studies demonstrate that despite a correlation between trauma and psychiatric symptoms, the biomedical model is unable to explain relatively low rates of psychiatric symptomatology in post-war societies that has been identified in a wide number of studies (Miller et al., 2002; Sherwood and Liebling-Kalifani, 2012). As Pupavac (2002) argues, distressful experiences do not automatically translate into post-traumatic stress disorder and there is a clear need to distinguish between the two and avoid classifying all refugees as traumatized, despite growing pressures to do so, for example in the context of humanitarian crises. This has led to the questioning of the suitability of Western trauma models as a framework for addressing refugee experiences (Borwick et al., 2013).

Scholars of refugee health have also pointed to the tendency within the biomedical approach to concentrate on the pre- or post-migration phase, therefore failing to consider

the temporal nature of the refugee experience – including resettlement and repatriation (Khawaja et al., 2008). Furthermore, the lack of longitudinal research poses an important challenge to our understanding of the long-term mental health of refugees—few studies have followed up refugees for more than a ten-year period (Silove et al., 2017; Siriwardhana et al., 2014). Existing studies broadly show that while most refugees continue to show low or no symptoms; a significant minority show a pattern of gradual recovery; and a small group remain chronically traumatised (Silove et al., 2017: 132. Yet the lack of longitudinal data limits our understanding of the dynamic of resilience over time and limits the identification of the temporal nature of protective or promoting factors of resilience, reducing its dynamic nature to a static concept (Siriwardhana et al., 2014: 11). This study aims to address that gap.

Coping Strategies among refugee groups

In response to the 'medicalisation of trauma' attention has turned to the development of resilience among refugee groups and a focus on coping strategies employed at both an individual and community level. Particular attention has been given to the ways in which people cope following forced migration and trauma. A systematic review of resilience and mental health outcomes among forced migrants identified a number of coping strategies that have been found to promote resilience and help refugees deal with the stressors of exile include social support and community networks, religion and personal qualities (Siriwardhana et al., 2014). Other studies have pointed to the contribution of political activism and point to some of the gendered aspects of these coping mechanisms (Gideon, 2018).

Yet, in such contexts the majority of coping strategies are often very 'ordinary' and there is a need to differentiate between the 'extra-ordinariness' of the trauma and the often very 'ordinary' responses to traumatic events (Marlowe, 2010). Moreover, 'everydayness' is often itself an achievement and a potential aspect of resilience (Sherwood and Liebling-Kalifani, 2012).

There is some consensus that coping strategies are also shaped by age and gender (Kabachnik et al., 2013; Marlowe, 2011; Miller et al., 2002; Markussen, 2018; Jansen, 2008; Holm Pedersen, 2012; Siriwardhana et al., 2014). Seguin & Roberts (2015) contend that women are more likely to engage in emotion-oriented and support-seeking coping than men, who are more likely to engage in problem solving (e.g. finding work) and recreational activities. While some of the explanation for this may lie in gendered social norms which shape what is seen as socially acceptable behaviour for women and men, research has sought to understand gender differences in dealing with mental health issues and responses to depression. It is acknowledged that women are often more inward looking than men in terms of how they deal with depression (Rosenfield and Smith, 2010). However, research advocates the importance of differentiating between contemplation and rumination of problems which can be a way of reflecting on how to deal with and attempt to overcome problems; and brooding which can be a more negative form of rumination which can create more anxiety and gloomy thoughts (Treyner et al., 2003).

Depression and anxiety in the early years of exile

The majority of respondents in the study faced numerous challenges following their arrival in the UK. While many received practical support from organisations such as the World University Service, the Chile Solidarity Campaign, trade unions and even local

councils in some cases (Angell, 2019; Ribeiro de Menezes, 2019), this did not help in dealing with the overwhelming nature of what had happened. Some individuals, both women and men, arrived in the UK more or less directly following their release from prison. Others had been in hiding while arrangements were made for them to leave the country while others came as the partner of a political prisoner so may even have been directly involved in making plans to leave. Nevertheless, few respondents spoke good English when they arrived or were emotionally prepared for life in the UK.

The interviews suggest that many of the Chilean exiles employed 'typical' coping strategies as identified in the wider literature (see above). The support of other Chileans in the UK was critically important for many in terms of promoting their well-being and a shared understanding of what had happened to them. Nevertheless, a number of women in particular reported experiencing depression and anxiety in the early years of life in the UK. For some of the respondents in the study the challenges of life in exile combined with the responsibility for children and other family members, many of whom were traumatised by their experiences, resulted in them experiencing depression. This resonates with wider research that argues women and men are likely to experience different types of mental health disorders, with women more likely to suffer from depression and anxiety while men are more likely to experience higher rates of substance abuse and antisocial disorders (Nolen-Hoeksema et al., 1999 and 2001; Rosenfield and Smith, 2010). For some the 'cost of caring' that is often assigned to women can be a significant factor in women's tendency to suffer greater anxiety and depression (Rosenfield and Smith, 2010; Robillard, 2010).

Evelyn's story illustrates this cost of caring. She followed her husband into exile after he faced growing persecution because of his political and professional position. Her husband had previously been married and they had six children between them. Tragically

the mother of her step- children died in exile, something her ex-husband attributed to the events in Chile. For Evelyn this meant supporting the bereaved children while facing challenge of being a step-parent as well as life in exile. She initially recalled the financial difficulties of living as a family of eight following their arrival in London without the safety net of extended family:

We had a very difficult life because we were poor, we had no idea, I mean, we never...we never thought about benefits, we didn't have a clue about that. ... and also, one of the problems of not being in your own country is that you're totally [on your own], you know, in your own country you have relations and in Chile family do lend money ...your family was your bank.

She described cramped living conditions which also made things difficult given the trauma and bereavement the family had experienced:

... we had a little three bedroom flat with six children. So, we were there so cramped, ... the one boy had to sleep in the living room and everybody was angry and everybody was in a bad mood.

In time she found a full-time job and started to study again for a degree as she had been forced to abandon her studies in Chile when the family left. The combination of the challenges of exile as well as the added complexity of her step-children's bereavement made life particularly hard:

I was very depressed I remember arriving home by car, because everybody drove in those days and, uh, thinking oh, I don't want to get out of the car. This is not my house, going in is...it was horrible because the two older [step] children were just...they hated me ...

In time she accessed psychological support for the children as well as herself and completed her studies and had a successful career in her chosen field but she felt that the situation of being an exile always stayed with you and she now deliberately sought out other Chilean exiles as she felt she needed to spend time with others who understood what she had experienced. She explained a recent conversation with her analyst:

...She asked me once out of the blue – looking back if you had a choice again would you have left Chile? And before realising it I said, no because everybody says, you know, there's a bit of a competition what's been worse, being through the dictatorship or being an exile.. I was not involved in anything so I could have stayed in Chile. But I wanted to...well I already had a relationship with [my husband] and we wanted to stay together. But now thinking of all that, not taking that into account, exile has been very hard. And she told me you have had a very hard life. I also, you see, I had my own traumas from before the coup because of my previous divorce and all that.

Similarly, the burden of emotional and physical care for the family in exile fell on Clara. She arrived, in the UK after four years of imprisonment and when she left, she was reunited with her young son who had been living with her parents:

I think there is something about survival in women. The will to survive and to keep going and yes, your children are your reference, definitely.

Her husband remained in prison for another year following her release but did later join her in the UK. They went on to have two more children but the marriage was constantly difficult, Clara felt this was because he was not able to cope with the aftermath of prison and torture and experienced psychological difficulties. In the circumstances she had to take on the full responsibility of ensuring the well-being of the children and carrying out a wide range of caring activities. She was also suffering from the aftermath of what had happened to her but she was determined to make sure the children were ok:

I had to find a school for the children, I went to the parents' evening, I took them on holidays, I helped them choose their university career... I was involved in every stage. I think I wasn't that good in terms of accompanying them in their emotional development because I was so... I was just overwhelmed by life in general.

Her caring work has been successful in that her children did not now feel that they had suffered any long-term negative consequences:

Apparently, the reason why they are mentally healthy now, and very good human beings is because as a mother I was there for them. That's what the literature tells you, that in those cases the children are saved by one of the two in the couple. And apparently, I was the sane one.

For some however, the early feelings of isolation have never really gone away and continue to shape people's well-being. This was explained by Josefina, who came to the UK as the wife of a political prisoner. She reflects on the complexities of life in exile and how this can change over time:

As I say, the main thing is the language, that I feel that I'm two persons. [My daughter] told me, when we went to Chile the first time, I went with her, and she said, mummy, you are absolutely another person, nothing to do with who you are in England ... I try not to speak at all when other English [people are around] or if I go to buy something and I cannot find it, I go round and round – but never ask. In Chile, I go there, and I am walking in the street and I can hear what is going on around me. I can hear people talking there and I see, I can hear what they're saying, you know. I'm aware of what is going on. Here, no. If you don't speak face to face to me, I don't understand anything. So, I'm – how can I describe that? That I'm not part of this world, so I become in my world. I made my world, that is quite happy, but I cannot be happy sharing... So that lack of communication, I think, has made me a different person, in a way, and I cannot enjoy my life as I would like. But at the same time, I am happy, so it's very strange. Maybe I could be more happy, I don't know.

Coping strategies: community networks

One of the most widely cited coping strategies was the support of other Chileans living in exile. For many, given the absences of their own families, this support was essential. Wider research identifies how separation from family can significantly increase the risk

of depression, particularly among female refugees. Moreover, the risk of depression seems to increase with the length of time away from close relatives (Shishehgar et al., 2017). In the context of forced migration women may encounter difficulties when their identity as wives (and mothers) is completely undermined (Guruge et al., 2010). While men are also affected by the loss of family networks they tend to speak about family as a buffer against hardship and marriage difficulties whereas women tend to see family as a defence against loneliness (Shirpak et al., 2011). The impact of the loss of extended family for individuals also points to the centrality of the subjective aspects of wellbeing alongside the importance of more material dimensions (Wright, 2012). Many felt the loss most keenly at key moments in the life cycle, such as the birth of a baby when they struggled to adapt to life without family networks. For some the loneliness of being without family combined with the knowledge of events in Chile was overwhelming, with several women experiencing breakdowns in the early years of exile.

In the case of Josefina, she was heavily pregnant when her husband was arrested following the coup. He was detained for a week but then released but it was then no longer safe for him to stay in Chile and friends helped him leave for Britain. Given her pregnancy Josefina was not able to leave Chile and had to stay behind and only joined him four months later with her young baby and a toddler. She explained how a short time after her husband had been released a military death squad, known as the Caravan of Death (*Caravana de la Muerte*) reached the town where they were living and all of the political prisoners in the garrison were executed. She said that at that point she realised how naive she had been previously and how fortunate her husband had been that he had escaped torture and death. She reflected that one reason she had not anticipated the horror was that her own father had been in the military although he had died when she was a child. She had very positive memories of him and this was reflected in how she

viewed the military in general. Nevertheless, after she moved to the UK, she felt very isolated and experienced depression:

My main trouble was to leave my mother and my sister and my family, all my culture and my life that I was working there and I was studying at the same time. I had just got to university doing another degree, so all my life came to an end over there, so we have to start again without any money...We didn't have a future, really, but at the same time, we lived day by day and because we had that fantastic welcome from the English people, it wasn't that bad. But at the same time, it was bad because I couldn't be myself again.

She later had a breakdown and was briefly hospitalised. She reflected that the combination of leaving her family, leaving her country and not speaking much English was incredibly hard, these problems were further compounded by problems with her marriage.

For me, it was my personal thing that, as I say,...being aware of what I know, with my country, my language, my family, so I think everything is, it was too much for me to cope and being in trouble with [my husband] at the same time, I think that just I couldn't cope. I was lucky, as I say, that I found my psychiatrist because if he wasn't here, I don't think maybe I would have had as good recovery.

Through Chilean networks she was put in touch with a Chilean psychiatrist who was able to support her and arrange for her to be admitted to a psychiatric unit where she received

treatment and stayed under his care for a year. She remained on medication for some time after this but gradually things improved for her as she started to learn English and found a job. By this point her and her husband had split up and she was alone with the children. However, she had also become more immersed in the local Chilean networks and had become part of a Chilean folkloric group who performed music and dance as a way of raising the profile of the situation in Chile. It was this network of Chilean friends that were integral to her well-being and better mental health even though she was now a single parent.

A large number of respondents also emphasised the on-going importance of their Chilean networks, particularly in later life given their shared history and understanding of life as an exile. This was articulated by Evelyn, who had arrived as the wife of a political prisoner:

I have lots of women friends now, Chilean women friends and we sort of seek each other out. What happened with the 40 years is that lots of people who had been political prisoners and perhaps have never said because it's very shameful for them because now we all know what happened to all of them. Yes, but anyway it's horrible... but we enjoy each other's company ... [and we meet] ... to talk. And that has opened up with the years.

However, it is also important to note the limits of community and recognise that for some people community can be a source of tension and some may opt to deliberately isolate themselves (Escandell and Tapias, 2010; Gideon, 2016; Menjivar, 2002; Miller et al., 2002). As discussed elsewhere (Gideon, 2018) this has been the case for a number of

Chilean women in particular who felt constrained by gendered social norms and expectations.

Political solidarity work

Political activism was central to the majority of the Chilean exiles in the early years in the UK. While some women took on more gendered roles for example cooking 'typical' Chilean food to sell for fundraising other women were active with trade unions and giving public talks about the human rights abuses they had experienced (Gideon, 2018; Hirsch, 2015; Kay, 1988). For many women this was an important coping strategy in the early years of exile and a number of women commented that in part it was also a way of avoiding thinking about what had happened to them.

Clara arrived in 1978 after four years in prison and despite being alone in the UK with her young son, she spent a lot of time immersed in political activism:

I was just so committed and... When I came out... I had lots of information to pass on to Amnesty and I'd lots of information about disappeared people and all of that. So, I really had no time for anything! I... For me, my priorities were my son and to let people know what was going on there. And try to help people who were in prison as much as I could, from here. And, I... Amnesty... Because I was one of the few people who'd come out and I could speak English, they... They absorbed me completely and they... Because I was the resource that they needed to speak at different levels! ...So, I went from Parliament to grassroots groups everywhere in the country. I spoke at conferences... And I never had time for myself, really!

She remembered how she felt at the time:

I always felt very tired. And, containing the need to cry because I had to have a firm voice and be alert, answer questions... So, I entered in a kind of routine ... I was really stupid because I should have used opportunities to see a psychotherapist.

Although she never asked for support, she had received a grant from WUS so knew help was available and that other *compañeros* had received some mental health support. When asked why she didn't ask she replied,

Because I felt that it was my obligation to do what I was doing and that there was no time to be weak! And... Because I also felt that there was not a real knowledge of what was going on.

Similarly, Camila also felt her political activism helped her to cope with life in exile:

So, it was a quite busy time because apart from the studying I was doing all these political activities. I was active in ... my organisation and I was in all the Solidarity groups and also, because I learned the language, better than the other, I was always asked by people in the organisation to go with them to meetings. So, I was the official translator to trade unions, when we went to meeting with the trade unionist or conferences ... So, I used to leave the house at seven o'clock and come back at about midnight from all this because from university I would go to the meetings and that was for three years, I tell you. It was full time thing, it was a really busy, busy time... You get so involved for that... you don't allow time to think about anything ...

She reflected how her activism helped her to maintain a positive approach to life and gave her new opportunities:

Well, because I got that place [at university via a WUS grant] and I thought well, if I have this opportunity to study, I have to take it and I have to do good and ... I was involved in all these Solidarity ... activities ... things that was actually 24 hours, more or less, work. And ... I never had time to think oh, ... I don't remember ever having sat and thinking oh I went through all this and I'm so sad or. No, I didn't have time. I didn't allow time for myself.

She also emphasised the importance of political activism and being resilient as a critical means of survival after her imprisonment:

And also, because during the time I was in prison, for me you know it's a survival tool ... I thought oh no, Pinochet, what Pinochet wanted with all this is to defeat you, to make you unhappy and it would be a, a triumph...To Pinochet if I am sorry, if I'm ill, if I'm defeated and I will never, ever give them this success... they didn't win because I have done my life and I came here and I did as much work as I could, went back to Chile, work underground. I was part of the whole movement again and I was really active and all that and I thought well, you know, this is my, this is what—my vengeance, if you want [laughs] to them.

Nevertheless, she does however reflect that with the passing of time she acknowledged she may have had some mental health needs that were never addressed:

Now actually, if you asked me, I probably should have paid more attention to myself because I feel I had a lot of... If I look that I think that a lot of things are because of that...

Political activism has remained central to the lives of many of the exiles and in 1998 the arrest of Pinochet in London was a significant moment. A Spanish magistrate had issued a warrant for Pinochet to be tried for committing crimes against humanity during his military regime between 1973 and 1990. Following this news Chileans from around the country mobilised in London and began a protest that lasted 503 days calling for his extradition to Spain (Ramirez, 2012). In the end, after 18 months of legal battles, despite the fact that the magistrate had given consent for extradition, Pinochet failed the senility test and was sent back to Chile on medical grounds. Nevertheless, for many of those living in exile Pinochet's trial was 'a chance to come to terms with their own experiences of loss, oppression, and displacement - "all that history."' (Ramirez, 2012: 30).

This was certainly the case for Katia, an ex-political prisoner, as she explains:

I also have come to rationalise my sense of guilt for my family. You know, all the impact I brought to them because in the end, it's not my guilt. You know, it's not my fault. I was put into that situation. I didn't create it. I didn't voluntarily say this is what, you know, is going to happen. So that sense of guilt... It's a burden I had brought with me for years. It was only with the detention of Pinochet that I rationalised that, you know, that why I should be

feeling guilty when I didn't cause the situation. ... But that is, you know, something that comes with rationalising what actually happened.

PTSD and exile

A number of the respondents I interviewed all believed that they suffered from PTSD although very few of the participants had been formally diagnosed with the condition. This points to a reluctance among the Chilean exile community to seek help from the NHS for mental health issues. Unlike other refugee or migrant groups, the Chileans do not face any specific barriers relating to their status as all had full entitlements to the system. Perhaps the most overwhelming explanation that emerged from the interviews was the lack of trust in the NHS in terms of having a viable solution for their symptoms. This was clearly articulated by Josefina, the wife of a political prisoner, who had experienced a break down a few years after her arrival in the UK:

The doctors were very good for things that, you know, if you've got a cold or something like that but not a mental problem.

Similarly, Silvia, another ex-political prisoner explained her reluctance to discuss her situation with her GP although she thought it was probably noted in her medical records that she had been the victim of torture:

Because obviously, I don't know, in my records it said the situation of the torture. But... but... people don't understand. They just can't... can't. They can't. ... Look, if I'm very honest, the more I do, I feel a lot of solidarity with the

people... with the Chileans that have been tortured. Yes? Because they're elderly now, like me, that have been tortured, yes? We are experiencing a lot of problems. A lot of problems. And they are not things that the NHS could solve for us... We are damaged. I think that's the right word.

For Watters (2001) the lack of trust articulated by the Chileans is a clear manifestation of the limitations of the bio-medical approach to trauma and refugee health. He argues that in this type of approach the experiences of refugees are

'condensed into that which is deemed "clinically significant". The refugee's story is structured within a framework of a biomedical explanatory model. Furthermore, the telling of refugees' stories takes place within a clinical arena in which the process of telling the story is, in itself, viewed as having a therapeutic effect' (2001: 1710).

Yet as Watters argues, refugees are rarely given a voice in policy debates around the most appropriate forms of treatment or prioritising their needs in terms of service provision. As he notes,

'Refugees may be the subject of institutional responses that are influenced by stereotypes and the homogenising of refugees into a single pathologized identity' (2001: 1710).

In the majority of cases people managed their PTSD in their own ways without professional support. Rosana had been imprisoned for two years and had also been

subject to sexual torture during her incarceration. She believed she had suffered from PTSD and even today continued to experience symptoms from time to time:

Well the first thing that I do most of the time is just to withdraw and cry alone, and think about it you know, ...sometimes ... when I feel down, I don't necessarily know why I feel down yeah. So, I may think that it's something to do with work but then I am more or less clear what it's about ... But the other issue is that you know, life pushes you [to carry on], ... I feel down but not depression, not really depression because if it was depression, I wouldn't be able to function ... So ... you put that aside and you carry on until the next time when you get low again. And so that is why I'm saying to you, you look at something for years and I have been looking at the same issue for years.

For some, the passing of time and change in life circumstances as children left home and people retired from work, meant that they were able to spend more time thinking about their experiences and try to make sense of them. Now she was retired and living by the coast Clara spent a lot of time going for walks and practicing yoga and trying to find 'peace of mind'. She explained,

That's what I need, ... [to] be emotionally balanced, at ease, with myself and the rest of the world. Which I think I'm achieving now. It's been a long journey, but I'm getting there... I think it's a benefit of age ... Because age means time, not because I'm getting older, but it's simply because I've had the time to reflect. Reflection for me is very important...And.. you become less of a multi-tasker and you concentrate more ... on the things that are important for you, not for other people. Yes.

It is worth noting that wider research reveals that 'growth experiences' are not unusual among those who have experienced PTSD and trauma but that 'moving on' and experiencing psychological growth does not put an end to distress in trauma survivors (Hussain, & Bhushan, 2011; Powell et al., 2003; Tedeschi and Calhoun, 2004).

Cervical smears

The lack of trust in health providers was not only confined to speaking about mental health. For many women their experiences of torture have left them with gynaecological problems for which they rarely seek help. Although initially denied and ignored in the aftermath of the dictatorship in Chile, the sexualised nature of torture inflicted on many of the female prisoners has now been slowly acknowledged (Hiner, 2009; Joffily, 2016). Yet while the use of rape as a weapon of war is now recognised at an international level (Buss, 2009) in the main discussion within the 'refugee health' literature tends to focus on women's immediate maternal health needs rather than the long term implications for women's gynaecological health, including cervical smear tests. Within the wider literature there has been little attention given to understanding the psychological or emotional reasons why some women fail to undergo cervical smears. However, research has shown how women who have experienced sexual abuse are less likely to have smear tests – reasons include the physical pain, the mechanics of the exam, the power dimensions of the exam and the impact on their own coping strategies (Cadman et al., 2019). There is some resonance with the experiences of the Chilean women included in this study, many of whom spoke about the particular difficulties they encountered around cervical smears. Even though the majority of these women had given birth to children since their imprisonment the issue of cervical smears in particular remained an on-going

challenge. This is a particularly distressing example that emphasises the importance of understanding individual's health journeys in order to make sense of their current situation. Moreover, few of the women felt able to disclose their history of torture to health professionals carrying out the smear test which added to the distress of the situation. Maria explained her own experiences of going for a smear test:

If there's anything that I can think of that has left a mark, is the fact that if I have to go for a gynaecological examination I feel so weak that I almost cry ... and ... how can you possibly tell them actually, you know it's because, I mean I did it once because they had to do some smear tests and it wasn't working and ... it was just really bad and I had to say to them I'm sorry, I didn't tell the details, she felt terrible, terrible and said, so why have you never told this, because I mean it's not easy ... it's just that moment that I feel incredibly fragile.

Camila also expressed similar feelings:

And I always try, well, I always go for that test but it's really difficult and I think it's not only me actually. I think that's one of the things that's really bad. [Sighs] Is, that, that is horrendous, it really, that is really bad. Of all the thing I think that that's the only thing that I really impact when I go to that.

Although on one occasion Camila did speak to the nurse this did not really solve the issue for her as the nurse, though sympathetic, was unable to respond effectively and confirmed Camila's view that there was no point in telling health professionals about their history. Only one woman, Florencia, reported finding a particularly helpful female

doctor who had provided her with practical help so that she now felt comfortable having the test. As she explained though, it took her a long time to find a sympathetic GP:

So, my experiences were horrendous until I moved here ... and my GP now, still my GP, she was great because I explained to her.... We talked and... I said to her couldn't you give me something to relax and she said no she said you have to have control over it. So ... she said what we're going to do, I will teach you how to do, see? You are going to do it yourself. So that is how we continued doing the smear test... So, I bless that woman...It makes things less traumatic and you have a bit of control and you know what you can do.

Conclusions

Taking Newbold and McKeary's (2018) idea of refugee 'journeys to health' as a point of departure this paper confirms the need for conducting research into health and wellbeing over the long term. The paper explores the journeys to health made by several Chilean exiles and highlights the challenges and opportunities that refugees may face along their route and how things change over time. While the paper can not claim to represent the experiences of all Chilean exiles, particularly since many of the research participants were recruited through specific exile networks where people had a shared history of opposition to the military regime, this does not detract from the importance of their stories. Moreover, a longer-term analysis allows for a greater understanding of how refugees and forced migrants themselves make sense of their experiences and how this can contribute to a better sense of well-being. At the same time the discussion shows how the impact of trauma and torture can stay with people for decades and continue to impede both their physical and mental health. The Chilean case also points to the central role

played by a variety of support services in the early years of arrival for many of the exile community. Respondents reflect on the critical role these inputs were in ensuring people were able to 'move on' and build new lives for themselves and their dependents in the context of exile. However, the Chilean case also points to the importance of health providers engaging with the complexities of refugee journeys to health and creating the necessary spaces for people to tell their stories. Without this type of engagement with refugee communities, critical barriers to care will remain firmly in place leaving many unable to complete their journeys.

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