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MIGRATION-RELATED STRESS AND RISK OF SUICIDAL BEHAVIOUR AMONG "NEW" POLISH IMMIGRANTS IN THE UNITED KINGDOM

Immigrants are at a higher risk of developing various mental disorders, such as neuroses, depression, anxiety and distress, alcoholism and drug addiction as well as psychiatric illnesses, including psychoses and schizophrenia. The relation between international migration and mental health problems was first discovered in 1840, when the US Immigration Service Officers observed "a disproportionately high percentage of psychiatric patients among immigrants" (Kawczyńska-Butrym 2010: 92). These findings were later confirmed by other studies conducted e.g. in Sweden, Canada and Australia. Migration-related stress is caused by several factors, including cultural and language barrier, adjustment difficulties and culture shock. One of the main stressors for Polish post-accession migrants in the UK and other EU countries is the phenomenon of "de-skilling". Despite having high qualifications many immigrants are forced to work in low-skilled sectors. The reality of living abroad is often completely different from their preconceptions and expectations.

According to the research carried out by the author[1], 36% of respondents were under permanent stress and other 5,6% experienced high levels of stress. It should be underlined that a long-term exposure to stress can lead to serious physical and mental conditions. Therefore, it may be argued that over 40% of Polish immigrants in the UK are at increased risk of developing different health problems due to migration-related stress. The major causes of stress included language barrier (32,2% indications[2]), separation from family/ feeling of loneliness (29,4%) and problems at work (28,3%). Other stressors involved financial problems (27,3%) and adapting to the new living and working conditions (24,8%). Respondents also listed sense of alienation (16,8%), living conditions (16,4%), family problems (12,9%) and lack of sense of security (10,8%). The least

[1] The survey was conducted from October 2010 to January 2011 first in Scotland (Glasgow, Edinburgh) and afterwards in England (London). The sample included 286 adults (145 women and 141 men) staying in the UK for a minimum period of 12 months. Respondents were recruited in various Polish organisations, institutions and companies operating in the UK. The research tool was the author's inquiry questionnaire.
[2] Respondents could choose up to 3 options.

frequently chosen options included difficulties in finding a job (5,2%) and health problems (4,5%).

Additional statistical analysis showed that casually employed persons were suffering from higher level of stress than regular employees. Lack of vocational and financial stability increases mental distress, especially in case of economic migrants.

Despite experiencing long-term stress, most Polish immigrants did not seek professional help. The study found that only 5% of respondents consulted psychologist and 1% consulted a psychiatrist. In cases of emotional crises, migrants tend to rely on their family and friends' support or try to cope with stress on their own. It appears that they are not likely to undergo psychotherapy or psychiatric treatment. Such a strategy for dealing with mental health problems might be effective only on condition that the problems are temporary. Otherwise, there is a risk of developing serious mental disorders in the future.

Experiencing a high level of stress, migrants often suffer from the so called Ulysses/ Immigrant Syndrome characterised by depressive moods that can lead to suicide attempts, frequent crying fits, anxiety and fear of the future (Kuźma 2005: 271). According to a study conducted by the University of Wolverhampton a substantial percentage (48,6%) of the post-accession Polish migrants taking part in the survey "suffers from psychological distress and is at risk of developing a mental disorder" (Kozłowska, Sallah, Galasiński 2008: 6). The respondents have reported "suffering from displacement, discrimination, lack of social support, underemployment, and uncertainty about the future" (Kozłowska, Sallah, Galasiński 2008: 7). The study has also found that "new" Polish immigrants experience significantly higher level of distress than the British or any other ethnic group in the UK (Morrison and Stevens 2011). Despite suffering from depression and other mental disorders, Polish migrants are generally unwilling to seek professional help and prefer coping with problems on their own. Negative attitude towards psychological and psychiatric services stems from the fact that immigrants do not believe in their effectiveness. Another factor preventing them from undergoing treatment is the stigma associated with mental health problems. Thus, it can be assumed that in case of many Polish migrants mental distress is left untreated, increasing the risk of developing other health problems, aggression, self-directed violence and suicidal behaviour.

Suicide risk appears to be higher among certain groups of immigrants, including those suffering from mental illnesses and disorders, addicted to alcohol and/or other psychoactive substances as well as the homeless. However, in unfavourable circumstances suicidal inclinations can be shown by other economic migrants, especially those who are

exploited and paid starvation wages. Many Poles seeking employment in the UK fall victim to unfair practices of recruitment agencies, such as "selling" the non-existent job offers. Another problem concerning post-accession migrants is the phenomenon of de-skilling and the so called "brain waste" (Currie 2008: 72). A significant number of highly-skilled Polish immigrants in the UK have to take up jobs below their qualifications, without prospects of professional development. In extreme cases serious financial problems can lead to a suicide attempt, especially if they coincide with other personal issues (e.g. a relationship breakdown or a sense of frustration, isolation and loneliness). Experts claim that pressures related to living abroad often result in violent behaviour and self-harm (Morrison and Stevens 2011).

It has to be noted that the exact scale of suicide in immigrants remains unknown and the available information is partial and involves a substantial risk of error. British institutions do not keep complete records of migrants' deaths. Polish Embassy and Consulates are notified of the deaths of Polish citizens if the surrounding circumstances are suspicious or unclear, however, not all the coroners fulfil this duty. Both Polish and British media have been describing suicide incidents among Polish migrants (including cases of double and extended suicides), using mainly qualitative data.

Additionally, it should be stressed that there is a problem of quantitative data accuracy. Experts suggest that statistics concerning suicides are often inaccurate due to an incorrect classification of some deaths. According to Hołyst, even the most advanced forensic techniques often do not allow to unambiguously determine whether the death was a result of homicide, suicide or other unnatural cause (Hołyst 2002: 650). It can be assumed that some cases of deaths classified for example as car accidents, accidents at work or overdosing on sleeping pills, were in fact suicidal acts. Therefore, the actual suicide rate can be higher than the reported rate.

At author's request the Consular Section of the Embassy of the Republic of Poland in London provided data concerning suicides of Polish citizens residing in southern England (see table 1). In the years 2009 – 2012 the Embassy was notified of altogether 67 cases of suicides, committed by 61 males and 6 females. The victims were aged 17 – 57 and the dominant age group (78%) was between 22 and 39. In most cases the length of the victims' stay abroad is unknown, however the shortest reported stay was only 1,5 month and the longest – 12 years. Therefore, we may assume that the length of stay in the United Kingdom did not affect the occurrence of suicidal inclinations of the victims.

Table 1.

Suicides committed by Polish citizens residing in southern England in the years 2009 –2012.

Gender	Age	Length of stay in the UK	Suicide method/ surrounding circumstances	Probable cause reported by a coroner
2009				
Male	22	2 years	Jumping off the roof of a multi-storey car park	Family problems
Male	24	no data	Drowning	no data
Male	28	no data	Hanging	no data
Male	29	no data	Hanging in prison	no data
Male	30	no data	Hanging	Marriage problems
Male	30	no data	Jumping off the roof of a block	no data
Male	31	no data	Found dead in a hotel bathroom	no data
Male	32	no data	Hanging	no data
Male	34	no data	Hanging	no data
Male	38	no data	Hanging in prison	no data
Male	41	no data	Hanging	no data
Male	49	no data	no data	no data
Male	53	13 months	Hanging	Depression
2010				
Male	22	no data	Hanging	no data
Male	27	6 years	Hanging	Splitting up with a girlfriend
Male	30	no data	Hanging	Suicide committed under the influence of alcohol
Male	32	4 years	Massive blood loss after slitting his wrists	no data
Female	33	no data	Hanging	no data
Male	33	no data	Hanging	no data
Female	33	7 years	Suffocation using a plastic bag	no data
Male	34	no data	Hanging	Depression
Male	37	no data	Hanging	no data
Male	38	no data	no data	no data
Male	38	4 years	Hanging	no data
Male	52	2 years	Hanging	Job loss
Male	55	10 months	Hanging	no data
2011				
Male	17	no data	Hanging	no data
Male	24	no data	no data	no data

Male	24	no data	Hanging	Separation from wife
Male	24	1,5 month	Hanging	no data
Male	27	no data	Hanging	Suicide committed after an argument with a partner
Male	28	7 years	no data	no data
Male	29	4,5 years	Hanging	no data
Female	30	7-8 years	Hanging	no data
Male	31	no data	Hanging	no data
Male	31	no data	Hanging	no data
Male	31	no data	Drug overdose	no data
Female	32	no data	Hanging	Extramarital affair, depression
Male	33	no data	Hanging	no data
Male	34	no data	Hanging	no data
Male	35	no data	Hanging	no data
Male	36	no data	Hanging	Eviction
Male	37	no data	Hanging	no data
Male	38	12 years	Jumping under a truck	Wife's accusation of sexual harassment of their daughter
Male	39	no data	Hanging	Splitting up with a partner
Male	44	no data	Hanging	Marriage problems
Male	45	no data	Jumping under a train	no data
Male	50	no data	no data	no data
Male	52	no data	Hanging	no data
Male	52	no data	Hanging	Job loss
Male	57	no data	Hanging	no data
2012				
Female	23	no data	Hanging	no data
Female	28	no data	Jumping under a train	Post-natal depression
Male	28	no data	Hanging	no data
Male	28	no data	Hanging	no data
Male	29	no data	Hanging	Depression
Male	29	no data	Hanging	no data
Male	30	no data	Hanging	no data
Male	34	no data	Hanging	no data
Male	35	no data	no data	no data
Male	36	no data	no data	no data
Male	37	no data	no data	no data
Male	37	5 years	no data	no data
Male	39	no data	Hanging	no data
Male	40	no data	Hanging	Rejection by a woman
Male	47	no data	Taking unknown substance (empty bottles were found on the spot)	no data

Male	50	no data	Hanging	no data

Source: statistical data provided at author's request by the Consular Section of the Embassy of the Republic of Poland in London.

Out of the 67 suicides, as many as 47 (70%) were committed by hanging. It should be noted that hanging is one of the most common and most lethal methods of taking one's own life and it is estimated that in Poland about 65% - 70% of all suicides are committed this way (Hołyst 2002: 677). 10 victims killed themselves by jumping from height (2 persons), jumping under a train (2 persons), jumping under a truck, wrist slitting, drug overdose, taking unknown toxic substance, suffocation using a plastic bag (also called 'a suicide bag' or 'an exit bag') and drowning. Circumstances surrounding deaths of 10 other victims have not been reported.

A probable cause of the suicidal act was established in respect of 18 victims. It is assumed that 9 persons committed suicide because of personal and family issues (such as marital conflict and relationship breakdown) and another 4 were suffering from depression (including one case of post-natal depression). 2 persons killed themselves after losing their jobs and 1 person after an eviction. There was also a case of a 38-year-old man who committed suicide after his wife accused him of sexual harassment of their daughter and a case of a 30-year-old man who killed himself under the influence of alcohol.

It should be emphasized that determining a major cause of suicidal death is very difficult. Hołyst argues that the occurrence of suicidal behaviour results from a combination of suicidological situational configuration and personal suicide inclinations (Hołyst 2002: 1202). Therefore, suicide should be considered a complex phenomenon, related to a number of socioeconomic, environmental, cultural and psychological/ psychiatric factors. Suicidological situational configuration that leads to suicide usually consists of a few – and in some cases more than ten – unfavourable circumstances. Thus, establishing one, even the most "obvious" cause of suicide may be an oversimplification. At the same time, Hołyst stresses that suicide victims have specific personality traits which make them capable of taking their own lives in crisis situation. In other words, people who have no suicidal inclinations are far less likely to commit suicide regardless of external conditions.

It has to be noted that suicides constituted a relatively high percentage of all unnatural deaths of Polish immigrants in southern England. According to the data provided by the Embassy, the coroners confirmed 13 suicides (out of 113 unnatural deaths) in 2009,

13 suicides (out of 117 unnatural deaths) in 2010, 25 suicides (out of 107 unnatural deaths) in 2011 and 16 suicides (out of 76 unnatural deaths) in 2012. Thus, in the years 2009 and 2010 suicide accounted for respectively 12% and 11% of all unnatural deaths. However, in 2011 the number of suicidal acts committed by Polish migrants increased dramatically, accounting for almost ¼ of all deaths from unnatural causes in this group. In 2012 suicide constituted 21% of all unnatural deaths. Moreover, there is a possibility that the suicide rates are even higher among Polish migrants living in other parts of the UK. It is estimated that "up to 30 per cent of all Polish deaths in the north of England and Wales are the result of suicides" (Morrison and Stevens 2011).

Given the fact that we know very little about the victims (for example we do not know whether they had any previous suicide attempts), it is rather difficult to speculate on the impact of migration on their suicidal behaviour. However, there is some evidence to suggest that migration increases suicide risk. On the one hand, many studies show that suicide rates among immigrants tend to correspond with those of their country of origin (Ratkowska and De Leo 2013: 126). In other words, suicide rates are usually higher among those migrants who come from the countries with higher suicide rates, especially Northern and Eastern Europe (Ide 2011: 1). For example, a study conducted in Sweden reported the highest risk of suicidal behaviour among female immigrants from Poland, Finland and other Eastern European countries, with Polish women having a suicide rate twice as high as Swedish women (Montesinos *et al*. 2013: 62). These findings indicate that suicidal behaviour among immigrants could be partly determined by some genetic and culture-specific factors. However, other studies conducted in Sweden and Australia have found that suicide rates among immigrants are generally higher compared to those of their countries of origin and in most cases higher than those of the host countries (Liu and Cheng 2011: 51). Therefore, it can be argued that to a certain extent migration is associated with an increased suicide risk. Several studies show that Eastern European migrants have one of the highest suicide rates, which can be attributed to a number of factors, including excessive alcohol consumption (Ratkowska and De Leo 2013: 126). It also appears that "new" Polish immigrants are a high-risk group for suicide behaviour. Taking this fact into account, it would be advisable to prepare and implement suicide prevention programme addressed to this group, with particular consideration of its issues and needs. This requires improving data collection and quality as well as further research in this field.

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