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Review Article

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# Embodied Trauma: Understanding the Relationship Between Psychological Stress and Physical Health Symptoms among Middle Eastern Migrant Women in Post-Pandemic London

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**Abstract**

*Migration is more than just moving to a new place; it often comes with psychological stress that can manifest physically in the body. For many Middle Eastern migrant women in London after the COVID-19 pandemic, stress turned into embodied trauma, where emotional pain appeared as physical symptoms such as headaches, tiredness, stomach problems and difficulty sleeping [1,2]. Past trauma and the difficulties of starting a new life already create stress for migrant women. But during COVID-19, isolation, fear of illness and problems accessing services made everything worse. Because of this, their mental and physical health became more fragile, and more people experienced emotional and physical problems [3]. Migrants may express distress through physical symptoms rather than emotional ones because of cultural, language, or service-access barriers [2]. For women, gender-specific roles, such as caregiving, household responsibilities, and economic insecurity, add further stress and make embodied trauma more likely. In London's post-pandemic context, most women immigrants faced increased risk of social isolation, disrupted ESOL (English for the Speakers of Other Languages) or community support classes, and fear of infection or financial loss, all contributing to somatic symptoms such as headaches, sleep disturbance, fatigue and gastrointestinal problems. Using literature on migrant mental health, somatisation and embodied trauma, this paper discusses how psychological stress and physical health are connected for Middle Eastern migrant women in London. The concept of embodied trauma helps to frame how emotional wounds become bodily ones, and why health services must recognise both the mind and body, particularly in-migrant women's care. The paper argues for trauma-informed, culturally and gender-sensitive health and integration support that addresses physical health symptoms as signals of deeper emotional distress. Recognising the body's role in migration trauma can lead to better outcomes for mental and physical well-being among migrant women in post-pandemic London.*

**Keywords:** Embodied Trauma, Migrant Women, Middle Eastern Migrants, Somatisation, Physical Health Symptoms, Psychological Stress, Post-COVID-19, London, Gendered Migration, Integration Challenges

## 1. Introduction

### 1.1. Rationale and Research Focus

This study explores a significant yet understudied area at the intersection of migration, gender and health, both physical and psychological aspects. It examines how psychological stress related to migration may become physically manifested, what is conceptualised here as "embodied trauma", among Middle Eastern migrant women in London after the COVID-19 pandemic. Middle Eastern women constitute one of the largest migrant groups with a unique combination of vulnerabilities in London. Many have arrived with experiences of displacement, conflict and cultural disruption. In addition to these experiences, they often face gendered pressures, such as disproportionate caregiving responsibilities, limited prior education and language barriers, which further raise their risk of both emotional and somatic (physical) health problems [4]. London is one of the primary settlement areas for Middle Eastern migrants in England, offering a complex socio-cultural context characterised by both rich support networks and high levels of social inequality [5]. There are multiple areas where gaps exist in emotional and physical health support for migrant women in London. For example, many migrant women face language and communication barriers when accessing healthcare, including a lack of professional interpreters and difficulties understanding how the system works [6,7].

Additionally, services often lack cultural sensitivity and tailored care, which limits effective support even in urban environments with many resources. These factors combine to create significant support gaps, despite the presence of numerous health and social services. Additionally, the post-pandemic period is a critical focus because the COVID-19 pandemic intensified many pre-existing vulnerabilities for migrants, including increased isolation, restricted access to health and support services, fears about illness, and economic uncertainty [8]. These additional stressors can magnify both psychological distress and somatic symptoms such as chronic fatigue, sleep disruption and pain [9]. Investigating this period helps to capture how embodied trauma may have developed or deepened in the target population.

The findings of this study are intended to benefit multiple stakeholders. For policymakers and health practitioners, the insights can support the design of trauma-informed, gender-sensitive and culturally responsive health and psychosocial integration services. For ESOL community and migrant support organisations, the paper can highlight how emotional stress can manifest as physical symptoms and suggest practical strategies to support women learners and community members. For academics and researchers, the study can propose a conceptual framework of embodied trauma in this specific population, paving the way for further research in the fields of migration, gender, health and intersectionality. Existing literature on migrant health frequently considers psychological distress and physical health outcomes as separate issues and often focuses on male or generic migrant populations rather than on women [10]. Besides, there is limited conceptual work on how emotional stress is somatised, for example, becoming physical symptoms, in the context of London [4].

This study aims to fill that gap by:
(a) proposing embodied trauma as a conceptual lens to understand the mind-body connection in migrant women's health;
(b) directing attention specifically to Middle Eastern women living in London, a population less represented in the literature;
(c) focusing on the post-pandemic period to include the extra layer of stress from COVID-19; and
(d) integrating psychological, physical and integration aspects rather than viewing them in isolation.

### 1.2. Research Objectives

• To identify the key stressors experienced by Middle Eastern migrant women in London, including pre-migration trauma, language barriers and caregiving pressures, which may contribute to embodied trauma.
• To map the pathways through which emotional distress transforms into physical health symptoms among this group in a post-pandemic context [9].
• To examine what gaps, exist in current emotional and physical health support services for migrant women in urban settings like London [5].
• To develop a conceptual framework that links migration-related stress, embodied trauma and integration outcomes, offering a model for trauma-informed, gender-sensitive service responses.

Migration is a life-changing transition that affects individuals across emotional, social and physical dimensions [11]. Research shows that migrants are at greater risk of mental-health challenges due to the multiple pressures of displacement, adaptation and uncertainty [12]. These pressures do not end upon arrival in the host country; instead, they continue to shape everyday experiences during settlement, influencing health, identity and well-being. For many migrants, psychological distress may be expressed through bodily symptoms, linking emotional experience with physical health outcomes [13]. Although migrants share common reasons for relocation, such as conflict, economic hardship, or the search for safety, opportunities, and stability, the motivations for migration among women are often more complex and gender specific [14]. Many women leave their countries to escape forced marriage, domestic violence, honour-related threats, the denial of education or restrictions on basic freedoms [15]. Gender-based persecution and the lack of autonomy create additional layers of trauma before migration has even begun [16]. These experiences position women within unique patterns of vulnerability that differ significantly from male migrants. Such gendered pressures do not disappear after arrival in the host country but continue through responsibilities such as childcare, household management and financial insecurity, which intensify ongoing stress [17]. As a result, emotional distress among migrant women is more likely to be expressed through physical symptoms, particularly when cultural norms, stigma or language barriers limit verbal expression of psychological suffering [18]. This pathway helps explain why somatic symptoms, such as chronic fatigue, headaches, body pain and sleep disturbance, are more visible among migrant women than among other migrant groups [16]. Therefore, understanding the gendered nature of migration and trauma is essential for recognising embodied expressions of distress.

Middle Eastern migrant women represent a particularly vulnerable group in London, as many have histories of conflict, loss and forced separation that can influence health long after settlement. These pre-migration experiences, combined with gendered expectations such as caregiving responsibilities and cultural pressures to appear strong, increase the likelihood of internalising emotional suffering [19]. When emotional expression is limited by cultural or linguistic barriers, distress is often redirected into the body, resulting in somatic symptoms [2]. This process is increasingly recognised within migration health research as a pathway through which trauma becomes embodied [1]. The context of London is significant because, although the city offers wide access to services and a large multicultural community, evidence indicates persistent health inequalities for migrant women [5]. Barriers such as limited English proficiency, lack of culturally sensitive care and difficulties navigating the healthcare system contribute to unmet needs in both emotional and physical health support

[6]. The COVID-19 pandemic created an additional layer of vulnerability. Service disruptions, isolation, economic instability and increased uncertainty intensified psychological stress, making somatic symptoms more common and more severe among migrant populations [3]. For women already carrying the emotional weight of migration and gendered expectations, these pressures deepened the connection between psychological distress and physical suffering [9]. Despite increasing interest in migrant mental health, the relationship between emotional stress and physical symptoms remains under-examined, particularly for Middle Eastern women in post-pandemic urban environments. The migration health literature still largely separates mental and physical well-being, instead of recognising them as interdependent [10]. Therefore, there is a need for conceptual work that explores how embodied trauma develops and how it affects integration, health-seeking behaviours and long-term well-being. This study contributes to this gap by focusing on the embodied health experiences of Middle Eastern migrant women in London after COVID-19 and by highlighting the need for trauma-informed, gender-sensitive support systems.

## 2. Literature Review

Recent research in migration studies highlights that the body and mind should not be viewed as separate domains when understanding migrant health [20]. A growing body of work argues that trauma and emotional strain can be stored in the body, influencing biological systems such as the nervous and immune response [21]. This perspective suggests that psychological experiences may "leave a physical trace," shaping long-term health outcomes. Such views align with emerging work on embodiment, where the body becomes a site that reflects social and emotional experiences and wounds [22]. In the context of migration, trauma is not limited to past events; it often continues across time and space. Researchers describe migration as a continuum of stress, where uncertainty, instability and identity disruption persist long after physical relocation [23]. For many Middle Eastern migrant women, this continuity of stress intersects with gendered expectations around silence, endurance and emotional resilience, which can restrict open expression of distress [19]. When emotional disclosure is culturally discouraged, distress may instead be expressed somatically through pain, fatigue or sleep disturbances. Middle Eastern migrant women often carry what can be described as hidden reproductive burdens, including pressure to manage fertility, childcare and household responsibilities in contexts where access to reproductive and maternal healthcare was limited before migration and remains restricted after resettlement [17].

Evidence indicates that women from ethnic minority backgrounds in urban areas like London face persistent reproductive and maternal health inequalities linked to structural barriers, cultural expectations and service-access difficulties [4]. These reproductive demands create additional psychosomatic pathways through which stress may become embodied. For example, menstrual irregularities, pregnancy-related complications, chronic pelvic pain and fertility concerns have been identified as physical manifestations of emotional strain in migrant women experiencing cumulative trauma and adaptation stress [24,25]. Such pressures may intensify embodied trauma by placing persistent physiological load on the body and limiting opportunities for self-care or professional support [3]. Migration often results in dietary disruption and nutritional vulnerability, particularly for women who relocate to environments with different food culture, availability and physical activity norms [26,27]. For example, Iranian migrant women in London reported a shift from familiar home-diet patterns, including traditional fresh produce and active household labour, to more sedentary routines and increased consumption of processed or convenience foods, which affected sleep regulation, energy levels and metabolic balance [26,27]. These changes create conditions for embodied physical symptoms, such as fatigue, digestive problems or muscle pain, because the body's regulatory systems (metabolism, sleep-wake cycle, hormonal balance) respond to the cumulative stress of dietary change, reduced activity and ongoing emotional strain [28,29]. At the same time, nutritional disruption may compound other stressors like caregiving burden or isolation, meaning the body carries an added somatic load that may not be recognised as trauma-related [26]. Over time such subtle bodily responses may escalate into more visible physical health complaints, yet they are often framed as "just stress," which delays intervention and deepens embodied trauma pathways [3].

Societal invisibility also plays a significant role in shaping embodied trauma among Middle Eastern migrant women. Many become what has been described as "service shadows," navigating informal support networks rather than formal health systems due to mistrust, stigma, discrimination, or previous negative encounters with institutional services [3,7]. Reliance on informal pathways often delays timely medical care, increases the physical and emotional workload placed on women and intensifies somatic expressions of distress such as chronic pain, sleep disruption and gastrointestinal problems [24,25]. When distress is not verbalised or recognised by health professionals, the body becomes the primary communicator of suffering through symptoms that may otherwise be overlooked or dismissed [18]. Informal support networks refer to the web of relationships and community resources that migrant women use when formal healthcare or social services are inaccessible or untrustworthy. These networks may include family members, friends, neighbours, religious groups, women's circles, cultural associations, peer mentors, and community volunteers, offering emotional comfort, practical advice, childcare, or sharing referrals [25,30]. In many cases, women hear about health or social services through word of mouth within these informal channels before ever engaging with a formal provider [31]. When formal systems are hindered by language barriers, digital exclusion, cultural mismatch, or institutional mistrust, informal networks become primary lifelines; yet, they often lack professional oversight, structured follow-up, diagnostics, or funding, which can delay diagnosis or limit access to evidence-based interventions [32,33].

For example, navigating symptoms such as persistent fatigue, digestive issues or pain within these informal environments may mean that the underlying trauma is never explicitly identified or treated, heightening the risk of somatic escalation and embodied health problems. In sum, for Middle Eastern migrant women, the intersection of reproductive labour, nutritional transition and service invisibility creates distinct pathways through which migration-related stress becomes embodied [4,17]. Recognising these interconnected processes expands the understanding of embodied trauma beyond generic stress frameworks and highlights the urgency of gender-specific and culturally nuanced healthcare responses that address both emotional and physical dimensions of migrant women's well-being [16]. Another significant line of research focuses on migrants' help-seeking behaviour. Studies indicate that migrants may hesitate to seek mental-health support because of mistrust, fear of judgment, stigma or past negative experiences with institutions [34]. Instead, physical symptoms are seen as socially acceptable expressions of suffering and are therefore more likely to be communicated than psychological struggles [18]. This trend is especially visible among Middle Eastern women, who may prioritise family needs over their own health and delay seeking care until physical symptoms become severe. The post-pandemic context has intensified these challenges. COVID-19 increased isolation, reduced access to face-to-face services, and moved many support systems online, thereby widening the digital divide for migrants with limited access to technology or digital literacy [35]. Research indicates that digital exclusion has a significant impact on health outcomes, particularly mental health, due to reduced opportunities for support, community engagement, and language learning [36]. For migrant women who relied on ESOL or community spaces for social connection and emotional relief, the closure of these services removed critical sources of coping and belonging.

Another emerging theme concerns the relationship between belonging and the body. Neuroscience-based research shows that loneliness and social exclusion activate the same neural pathways as physical pain, meaning that social disconnection can literally "hurt" the body [37]. This offers a useful lens for explaining why migrant women in post-pandemic London may experience physical symptoms without an apparent medical cause. When belonging is threatened, the body may respond as though it has been physically injured, further supporting the value of "embodied trauma" as a conceptual framework. Despite increasing recognition of these issues, migrant-health research continues to prioritise general populations rather than focusing on gender-specific lived experiences. Middle Eastern women remain underrepresented in research, particularly within the city of London context, and few studies integrate trauma, embodiment and post-pandemic conditions in a unified analysis [38]. This gap limits the development of trauma-informed policies and gender-responsive health services aligned with the realities of migrant women's lives. To address this gap and provide a more integrated understanding of how trauma is experienced and expressed in the lives of migrant women, this study proposes a conceptual framework called the Embodied Trauma Pathway.

### 2.1. Conceptual Framework: The Embodied Trauma Pathway

This paper proposes a conceptual model called the Embodied Trauma Pathway to explain how psychological stress related to migration may transform into physical health symptoms among Middle Eastern migrant women in post-pandemic London. The model is grounded in three theoretical foundations. Embodiment theory argues that the mind and body are inseparable, and that emotional experiences can directly shape physiological processes, meaning trauma can be held in the body and expressed through symptoms such as pain, fatigue or sleep disturbances [21,22]. Trauma theory explains how exposure to violence, fear, loss or displacement disrupts emotional regulation and activates long-term stress responses, which may continue long after the traumatic event has passed [1,3]. Migration-health research highlights that migration is a continuous process involving stress experienced before, during and after relocation, shaped by factors such as language barriers, discrimination, insecure housing and social isolation [12,23]. These theoretical perspectives together provide the conceptual grounding for this study because they explain how emotional distress can become embodied physically, why trauma responses persist over time, and how cumulative post-migration pressures intensify somatic expression, particularly among women facing gendered expectations and limited access to culturally responsive healthcare [19,34]. The pathway does not say that symptoms are definitely emotional. It only helps clinicians consider emotional causes as part of the picture, especially if medical tests show no clear explanation. The purpose is:

- to prevent misdiagnosis
- to avoid dismissing women with "it is nothing"
- to connect mind + body + lived experiences
- to guide further support

### 2.2. Operational Process of the Embodied Trauma Pathway

The Embodied Trauma Pathway offers a practical clinical framework that can inform healthcare decision-making.

*Embodied Trauma Pathway Clinical Cycle*

**Symptoms → Screening → Trauma–stress connection identified → Trauma-informed support + Medical care**

*The Embodied Trauma Pathway Clinical Cycle illustrates how physical symptoms can be understood within a holistic framework when no medical cause is identified. The process begins with symptoms and continues with a brief screening stage, enabling clinicians to explore whether stress or trauma may be contributing to the patient's physical experience. When a trauma–stress connection is identified, trauma-informed support is provided alongside medical care, rather than replacing it, allowing for more compassionate, culturally responsive and time-efficient treatment.*

The Embodied Trauma Pathway offers a practical clinical cycle that supports holistic care, particularly within time-limited NHS consultations. Before the appointment, patients complete a short screening questionnaire, which helps identify potential stress-related or trauma-based influences behind physical symptoms. An example questionnaire containing suggested screening questions for the Embodied Trauma Pathway can be found at the end of the paper (following the reference list). This pre-screening tool reduces the need for lengthy conversations, enabling clinicians to ask only a few additional pathway questions if necessary [39,40]. As a result, the ETP prevents unnecessary and costly medical investigations when no physical cause is present, reducing pressure on the healthcare system [18]. Avoiding repeated or excessive diagnostic testing also protects patients from increased anxiety and uncertainty about their health. Research shows that invasive or repeated tests in the absence of a medical explanation can worsen psychological distress and negatively affect well-being and recovery [3]. This emotional strain can further disrupt integration, daily functioning, and self-care, especially for migrant women who already bear multiple pressures related to family responsibilities, adaptation, and survival [23].

When symptoms are explored through a trauma-informed and culturally sensitive approach, patients feel understood and respected, which can shorten recovery time and strengthen overall well-being [12]. This is especially important for Middle Eastern migrant women, among whom trauma-related physical symptoms are common due to cultural expectations of gender-related silence, emotional suppression and stigma around mental health help-seeking [19,34]. In many communities, women are encouraged to stay quiet about distress, violence or emotional struggles to maintain family honour and avoid shame, which makes it difficult to seek support or express their needs [41,42]. Most of the women from patriarchal cultural contexts have been socialised to appear strong, avoid discussing emotional pain, and feel shame when seeking support, which results in distress being expressed physically rather than verbally [21]. Therefore, the Embodied Trauma Pathway provides a holistic and compassionate framework that can significantly improve outcomes for ethnically diverse women. It supports emotional safety, reduces unnecessary medical procedures, and enables dignity-centred care that facilitates integration, resilience and agency in their lives [18,43].
This model offers a comprehensive approach to interpreting physical complaints as significant indicators of underlying emotional and social distress. The framework begins with pre-migration trauma, including experiences of conflict, displacement, persecution or family separation. Such events can activate long-term stress responses in the body, affecting the nervous system and increasing vulnerability to physical health problems [21]. When the body remains in a prolonged state of alert, this can lead to ongoing physical symptoms, even years after the traumatic event is over. The second stage involves post-migration stressors encountered during adaptation to life in London, including language barriers, unfamiliar institutions, discrimination, insecure housing and financial instability. Research shows that ongoing stress during resettlement can intensify psychological strain and increase the likelihood of physical health complaints [23]. In this stage, emotional distress may become somatised, meaning it is expressed through the body rather than words. The third stage considers gender-specific expectations and a culture of silence. Many Middle Eastern women may feel pressure to remain strong, prioritise family needs and avoid speaking openly about emotional suffering. Cultural norms around shame and stigma can discourage seeking psychological help [34]. As a result, distress may be expressed through symptoms such as headaches, chronic fatigue, muscle pain, gastrointestinal issues or sleep problems [18]. This reinforces the embodiment process: the body becomes the communicator when the mouth cannot speak.

The fourth stage incorporates pandemic-related intensification. The COVID-19 period created isolation, increased care burdens and reduced access to community spaces, which deepened emotional strain and physical symptoms [35]. Research suggests that social isolation activates the same brain regions involved in physical pain, explaining why loneliness can have a physical impact [37]. For migrant women in London, the pandemic amplified embodied trauma by removing emotional support pathways. Finally, the model highlights service-access barriers. Limited culturally responsive care, lack of interpreters and digital exclusion can prevent early support and allow symptoms to worsen [25]. When health systems respond only to physical complaints without recognising emotional causes, embodied trauma remains invisible. Trauma and stress are shown in stages because they build up over time rather than happening all at once, and each layer increases vulnerability to emotional and physical strain [21,23]. Separating these layers makes it easier to see how different pressures interact, such as gendered silence, pandemic isolation and barriers to support, and how they intensify one another [34,35]. This staged structure shows how emotional pain becomes embodied and why physical symptoms continue when underlying causes are not recognised [25]. However, implementing the Embodied Trauma Pathway in practice may require the use of interpreters and longer consultation times, which can create additional challenges in already pressured healthcare systems. These difficulties can be addressed through cost-effective strategies such as involving bilingual community support workers or cultural mediators instead of professional interpreters, which may be more accessible and financially sustainable in community and primary care settings [44]. Digital or telephone interpreting services can reduce costs and alleviate time pressure when face-to-face interpreting is not available [43]. These approaches can make trauma-informed practice more realistic and allow clinicians to provide compassionate care while protecting privacy and emotional safety for migrant women, without increasing waiting times or workload. Overall, the Embodied Trauma Pathway functions as a theoretical and forward-looking framework that can guide future research, policy and practice in migration and health settings, rather than a tool for assessing participants.

### 2.3. Conceptual Methodology and Analytical Approach

This paper adopts a conceptual research design rather than an empirical model. Conceptual studies aim to generate new theoretical insights by analysing existing knowledge and synthesising diverse perspectives into new explanatory frameworks [45]. In this context, the Embodied Trauma Pathway was developed through an interpretive and analytical process that draws on interdisciplinary literature from migration studies, trauma theory, embodiment research, gender studies and post-pandemic health scholarship. The conceptual approach employed in this study involves the thematic synthesis of published research to identify recurring patterns and theoretical gaps within the current knowledge base [46]. Sources were selected based on their relevance to trauma, somatisation, gendered migration, and health inequalities, with an emphasis on peer-reviewed work produced after the COVID-19 pandemic to capture the shifting landscape of migrant health [47]. The analysis examined how emotional distress, structural barriers, cultural expectations and bodily symptoms are connected across different stages of the migration journey, enabling the construction of a layered model explaining how trauma becomes embodied. This methodological positioning aligns with interpretivist epistemology, which emphasises subjective meaning-making, lived experience and contextual understanding rather than universal generalisation. Within this paradigm, knowledge is understood as socially constructed, and complex human experiences cannot be reduced to numerical measurement. Therefore, the model was developed not to categorise individuals, but to provide a conceptual tool that explains how multiple stressors interact and produce embodied health outcomes among Middle Eastern migrant women. The Embodied Trauma *Pathway* emerged from the synthesis of theoretical insights rather than primary data collection. Its purpose is to offer a structured lens that can guide future empirical research, improve practitioner awareness and support trauma-informed, culturally responsive policy design [10]. *Conceptual models* play a key role in shaping new directions in social and health sciences by organising existing evidence into frameworks that reveal previously hidden relationships and suggest new analytical possibilities [45]. With the conceptual pathway established, the following discussion explores the broader meaning of these connections and examines how embodied trauma reshapes our understanding of migrant women's health, integration and post-pandemic recovery.

## 3. Discussion

The concept of embodied trauma offers a transformative perspective for understanding the health experiences of Middle Eastern migrant women. Traditional medical models often separate "mental health" from "physical health", assuming that physical symptoms originate solely from biological causes. However, trauma-informed and embodiment-based research challenges this separation and argues that emotional events and stress can be stored within the body and shape physical responses [21]. Within this framework, the body functions not only as a biological system but also as a container of memory, identity and emotional history. For Middle Eastern migrant women living in London, the body often becomes a primary site through which distress is communicated. Cultural expectations surrounding silence, strength and modesty may discourage direct expression of emotional suffering [19]. In many Middle Eastern contexts, physical expressions such as chest pressure, stomach pain, heaviness in the limbs or fatigue serve as acceptable idioms of distress and can communicate suffering without violating social or cultural norms [48]. This also highlights the body's symbolic role in negotiating trauma, belonging and self-protection. The post-pandemic context further intensified embodied distress. COVID-19 restrictions removed key cultural and social coping mechanisms such as communal gatherings, extended family networks, and face-to-face support environments, including ESOL classes and community centres. Studies indicate that social isolation activates neural mechanisms similar to those associated with physical pain, demonstrating that emotional disconnection has direct bodily consequences [37].

Digital exclusion, limited internet access, and low confidence using technology increased these effects among migrant women [35]. As a result, somatic symptoms such as chronic fatigue, headaches, and sleep disturbances became more common and severe during the pandemic period. Embodied trauma also interacts with the politics of visibility. Health systems in high-income cities such as London frequently prioritise measurable and clinically observable indicators. When medical tests fail to provide clear diagnostic explanations, somatic complaints are sometimes dismissed or minimised [49,50]. A recent review demonstrated that refugees and migrant women presenting bodily distress are frequently overlooked due to a lack of assessment frameworks addressing trauma-related somatisation [3]. This invisibility is amplified by language barriers, stigma and mistrust towards health institutions: structural factors that silence embodied suffering instead of addressing its roots. The conceptual pathway presented earlier positions embodied trauma as a multi-dimensional process shaped by migration history, gender norms, cultural expectations, pandemic pressures and service-access limitations. Such framing challenges linear understandings of integration, suggesting that adaptation is not solely an economic or linguistic achievement, but also a bodily journey shaped by safety, belonging, and recognition. The body becomes a site of negotiation where identity, trauma and resilience interact, and through which integration success or struggle may be physically experienced. Emerging research also highlights the healing potential in *embodied and community-based interventions.* Body-mapping, movement-based practices, dance therapy and trauma-sensitive yoga are increasingly recognised as effective modalities for survivors of displacement, helping participants externalise internal pain and reconnect with a sense of agency [51].

Such interventions offer non-verbal pathways for expression, which may be particularly suitable for migrant women who face cultural or linguistic barriers to accessing psychological support. Similar approaches, such as somatic experiencing therapy, can demonstrate reductions in trauma symptoms and improvements

in both physical and emotional health when used with displaced populations [52]. Somatic Experiencing is a body-based trauma therapy that focuses on regulating the autonomic nervous system and releasing unresolved physiological stress responses, offering non-verbal healing pathways for individuals affected by displacement and trauma [39,53]. These insights point to the need for trauma-informed, culturally responsive and gender-specific healthcare strategies that recognise the body as both an archive of trauma and a site of healing. Instead of focusing solely on the treatment of visible illness, future service models could incorporate early screening for somatic indicators of emotional distress, culturally sensitive communication frameworks, and collaborative partnerships with community-led organisations. Such approaches align with recent calls for health systems to adopt *cultural humility* rather than merely cultural competence, prioritising listening, co-learning and responsiveness over assumed expertise [25]. Overall, embodied trauma reframes migrant women's physical symptoms not as secondary problems but as meaningful signals of deeper psychosocial needs. Understanding health outcomes through an embodied lens encourages more holistic forms of support that acknowledge the interconnected influence of culture, gender, trauma history and social environment.

### 3.1. Implications for Practice, Policy and Community Support

A deeper understanding of embodied trauma highlights the need for support systems that recognise the interconnection between emotional distress and physical health. Traditional healthcare structures frequently respond to physical symptoms as isolated medical problems rather than as potential indicators of trauma or social suffering, which can result in misdiagnosis or delayed intervention [3]. Therefore, health services may benefit from adopting holistic, trauma-informed and culturally responsive frameworks that acknowledge the lived realities of Middle Eastern migrant women.

### 3.2. Implications for Healthcare Practice

Healthcare settings could incorporate somatic screening tools that identify emotional distress through physical indicators such as chronic pain, headaches, gastrointestinal problems or sleep disturbance. Somatic screening tools are short assessments that help clinicians recognise when physical symptoms may be connected to trauma or psychological stress rather than purely medical causes [39]. Trauma-sensitive communication practices, such as listening without rushing, validating patients' concerns and avoiding the dismissal of unexplained symptoms, may improve diagnostic accuracy and build trust between patients and professionals [18]. Introducing professional interpreters, rather than relying on family members, could enhance clarity and confidentiality, reducing the silence surrounding emotional suffering [6]. Training professionals in *cultural humility,* rather than just cultural competence, may support better patient relationships. Cultural humility emphasises active listening, self-reflection and awareness that healthcare workers cannot assume full knowledge of others' experiences [25]. Such an approach positions migrant women not as passive recipients of care but as experts in their own lived realities.

### 3.3. Implications for ESOL and Educational Spaces

ESOL classrooms and community-learning spaces have the potential to act as *low-barrier emotional support environments,* serving as early intervention points for embodied trauma. Movement-based or creative expression activities, such as drawing, storytelling or body mapping, can offer non-verbal ways of communicating internal experiences, particularly for learners managing pain or emotional fatigue [54]. Body mapping is a visual and creative method in which individuals use an outline of the human body to identify and express where they feel physical or emotional sensations, using colour, symbols or images to represent experiences that may be difficult to articulate verbally [55]. These approaches can support participants in connecting bodily feelings with psychological distress and create a safe space for expression when words are limited due to trauma or language barriers. Trauma-informed pedagogy may help educators recognise signs of somatic distress and respond compassionately without pathologizing learners. Creating peer-support structures within ESOL programmes, such as buddy systems, small group circles or multilingual emotional literacy sessions, may reduce isolation and encourage help-seeking, thereby strengthening community connection and belonging, which are essential for both physiological and psychological well-being [37]. Multilingual emotional literacy sessions involve supporting learners in understanding and expressing emotions using both their first language and English, helping them build emotional vocabulary and confidence, particularly when discussing sensitive experiences or seeking support. Such approaches can foster safer learning environments and promote mutual understanding among diverse groups.

### 3.4. Implications for Community Support

Community-based organisations and migrant-led groups can provide safe, culturally familiar environments where women feel able to share experiences without fear of stigma or misunderstanding. Body-centred interventions, such as dance-movement groups, trauma-sensitive yoga, or breathing-based practices, have shown positive outcomes among displaced women by reducing physical tension and reconnecting emotional expression with bodily awareness [51]. Such approaches support emotional recovery and counter the internalisation of trauma. Expanding digital inclusion initiatives may also improve accessibility to health and community support. Limited digital literacy can prevent migrant women from participating in tele-health, online ESOL environments or remote counselling services [35]. Providing mobile-based learning tools, multilingual digital navigation support and community Wi-Fi hubs could increase social connectedness and reduce barriers to care.

### 3.5. Policy Implications

Policies addressing migrant health could integrate gender-specific trauma frameworks, emphasising early intervention and prevention rather than crisis-response models. Funding structures

may prioritise co-designed services, where interventions are developed collaboratively with migrant women to ensure cultural and contextual relevance. Health, education and community systems may also adopt joint working models to avoid fragmented care and create a continuous support pathway from first settlement to long-term integration.

Such policy directions align with recent recommendations calling for intersectional approaches that recognise how gender, migration history and socioeconomic inequality interact to shape health outcomes [38]. The implications outlined above demonstrate the potential for significant change across healthcare, education and community environments when embodied trauma is placed at the centre of policy and practice. However, recognising this potential also requires reflection on the limitations and strengths of the conceptual approach, which frame the boundaries, value and applicability of the Embodied Trauma Pathway model.

### 3.6. Strengths, Limitations and Scope of the Model

Every conceptual study has methodological advantages and constraints. Conceptual research does not include primary data, which limits the ability to represent real-time lived experiences or measure direct causal relationships [46]. Instead, conceptual work relies on the interpretation and synthesis of existing literature, meaning that findings depend on the quality, scope, and availability of previous research [45]. For this reason, gaps or biases within available evidence can shape the final model, and the absence of empirical observations limits generalisability. A further limitation is that conceptual models cannot confirm whether the proposed pathways occur in identical ways across all individuals or cultural groups, as embodied trauma may vary according to factors such as ethnicity, religion, migration route, socioeconomic status, legal status, and personal coping resources [38]. Middle Eastern migrant women are not a homogeneous group; therefore, experiences of trauma and somatisation may differ significantly between Syrian, Kurdish, Iranian, Afghan or Iraqi women. The model does not show the differences that exist within the group itself. Future research could investigate these variations by using comparative or intersectional approaches [19].

Another limitation concerns the post-pandemic context. The COVID-19 period remains understudied, and literature continues to evolve. Therefore, conclusions drawn from current evidence may shift as long-term effects become clearer [35]. Conceptual models developed during periods of rapid social change may require revision as services evolve and new data emerge. Despite these limitations, conceptual frameworks offer important strengths. Conceptual studies enable the development of new theoretical insight where empirical work is limited or fragmented, bringing previously disconnected ideas together to create new knowledge [45]. This paper introduces the Embodied Trauma Pathway as a novel contribution that integrates trauma theory, somatisation, gendered migration and post-pandemic research: fields that are rarely combined in existing literature [10]. The model offers a structured analytical lens that highlights the connection between emotional distress and physical symptoms, challenging the dominant biomedical perspective that treats mental and physical domains separately [21]. A key strength is the model's practical relevance. By mapping the progression of embodied trauma across different stages of the migration journey, the pathway supports trauma-informed, culturally sensitive and gender-specific approaches to health, education and community services [4]. The model provides guidance for practitioners, policymakers, and researchers, helping to identify service gaps and enabling earlier intervention before somatic symptoms become chronic [3]. Additionally, the framework provides a foundation for future empirical research, including qualitative, mixed-methods, or participatory studies with migrant women, which could empirically test and refine the pathway. This context provides an appropriate point to conclude by summarising the core contribution of the study and outlining its implications for future research and practice.

## 4. Conclusion

The concept of embodied trauma offers an important lens for understanding the complex relationships between psychological distress, physical symptoms and social context among Middle Eastern migrant women living in post-pandemic London. The literature demonstrates that trauma can be held and communicated through the body when emotional expression is restricted by cultural norms, language barriers or stigma [18]. The body thereby becomes a central site for signalling distress, negotiating identity and managing adaptation pressures. This perspective challenges traditional biomedical frameworks that separate mental and physical health and highlights the value of holistic, trauma-informed approaches to migrant well-being [3]. The Embodied Trauma Pathway, developed in this paper, proposes that experiences of pre-migration trauma, post-migration stress, gendered expectations, and pandemic-related pressures interact in ways that intensify somatic responses, such as fatigue, headaches, digestive problems, and sleep disruption [1,3]. In this context, understanding physical symptoms as meaningful expressions of emotional and social suffering is essential. Recognising embodied trauma supports more responsive care, strengthens trust between migrant women and service providers and broadens the definition of integration beyond employment and language proficiency to include bodily safety, belonging and emotional recovery [5]. The findings presented also highlight implications for healthcare, ESOL education, and community policy. Trauma-informed screening, culturally responsive treatment, and non-verbal therapeutic approaches, such as movement-based practices, as well as improvements in digital accessibility, demonstrate potential pathways for enhancing the well-being of migrant women [35,51]. Integrating these approaches may support early intervention, reduce misdiagnosis, and prevent long-term deterioration of physical and psychological health.

### 4.1. Future Research Directions

Several areas require further academic attention. First, more research

is needed on the long-term health consequences of embodied trauma, including longitudinal and mixed-methods studies that combine biomedical, psychological and sociocultural data. Second, specific subgroups within Middle Eastern communities, such as Kurdish, Syrian, Iranian, Afghan or Iraqi women, may have different experiences of embodied trauma due to differences in displacement history, identity and community support [38]. Comparative studies could reveal important variations and guide more targeted interventions. Third, further investigation into body-based and culturally grounded healing strategies, including storytelling, art-based therapy, music, dance, breathing practices, and somatic intervention programmes, could offer insight into alternatives to conventional Western mental health models [54]. Fourth, research exploring how digital inclusion shapes access to linguistic, emotional and health resources would provide essential guidance for service design in increasingly hybrid or remote support environments [35]. Finally, policy research could examine the potential impact of trauma-informed, gender-sensitive frameworks on health outcomes, integration success, and service efficiency within the London context. Co-production approaches, where migrant women collaborate to design and evaluate interventions, can significantly contribute to the development of more equitable and effective care systems.

Understanding embodied trauma as a multidimensional process reframes physical symptoms as valuable sources of information about migration-related suffering. Positioning the body at the centre of research, practice and policy may support healthier and more humane pathways for migrant women as they rebuild their lives in post-pandemic societies. Community-based interventions and peer support structures can also benefit both migrant groups and the host society. By helping migrant women heal, recover, and engage confidently in social and educational spaces, these practices can reduce isolation, strengthen resilience, improve mental health outcomes, and contribute to a more inclusive community environment [25,40]. Women have a central role in families and communities, and supporting their well-being can strengthen families, enrich cultural understanding and improve social stability [56]. In this way, prioritising embodied trauma and the needs of migrant women creates shared benefits for individuals, communities and society as a whole. *As Mustafa Kemal Atatürk, the founder of the Turkish Republic, stated, "Everything we see in the world is the creative work of women."* This highlights the vital role women play in the fabric of society.

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**Screening Questions for Patients**
***(To support understanding of physical symptoms and emotional well-being)***
**Why am I being asked these questions?**

*These questions help us understand your symptoms in a more holistic way and provide the best care for you. There are no right or wrong answers—what matters is how you feel. Thank you for taking the time to complete this.*

**Basic Information**
Date: _____ Preferred language: _____
**Physical Symptoms**
(Please tick any symptoms you experience frequently)
□ Headaches or migraines
□ Chest tightness or heart racing
□ Stomach pain or digestive problems
□ Muscle pain or tension in the body
□ Fatigue or low energy

□ Sleep problems
□ Dizziness or numbness
□ Other: _____

**Screening Questions**
*(Please tick Yes / No)*

| Question | Yes | No |
|---|---|---|
| Have you been feeling stressed recently? | □ | □ |
| Did anything difficult happen in the past that still affects you now? | | |
| Has life been challenging since moving to the UK? | □ | □ |
| Do you feel alone or without support? | □ | □ |
| Is it difficult to talk about your feelings with others? | □ | □ |
| Did the COVID-19 period make things more difficult for you? | □ | □ |
| Do language or cultural barriers make it difficult to ask for help? | □ | □ |
| Do your symptoms become worse when you feel stressed or worried? | □ | □ |

***Short reflection***
*If you wish, please write one sentence about what makes your symptoms worse or better:*
---

**Thank you**
*Thank you for sharing this information. If you would like to discuss anything written here, please inform your clinician.*
*This form can be provided in multiple languages (for example: Turkish, Arabic, Kurdish, Farsi, Somali). Please let us know if translation or interpreter support would be helpful.*