

Early Childhood Trauma and Schizophrenia Risk Among First-Generation Migrants: A Multidimensional Review

Nandipha Ndenda
nan.ndenda@gmail.com

ABSTRACT

This paper examines the contribution of early childhood trauma to schizophrenia risk among first-generation migrants through an integrative review from meta-analyses, epidemiological studies, neurobiological research, and theoretical frameworks. Meta analytic findings indicate that childhood maltreatment is associated with a two- to threefold increase in the risk of psychosis, while migrant populations are additionally exposed to pre- and post-migration stressors such as discrimination, acculturative stress, and social exclusion.

These experiences may interact with genetic vulnerability within a stress-vulnerability framework, contributing to elevated rates of psychotic disorders observed in several migrant groups. Moreover, neurobiological evidence links chronic stress and trauma exposure to dysregulation of stress-response systems and structural changes in brain regions involved in emotion regulation and cognition.

However, risk is not uniform across groups and varies across populations due to socioeconomic conditions, cultural variation in symptom expression, and methodological limitations within psychiatric research. Overall, schizophrenia risk among first-generation migrants appears to result from cumulative and interacting biological, environmental, and structural factors rather than migration alone.

INTRODUCTION

Schizophrenia is a multifactorial psychiatric disorder characterised by disturbances in perception, thought, and behaviour, and is linked to structural and functional abnormalities in prefrontal, temporal, and dopaminergic systems. It typically emerges in late adolescence or early adulthood and is associated with substantial disability, reduced quality of life, and increased mortality (Leucht, 2025). Globally, lifetime prevalence is estimated at approximately 0.4% in the general population (Stefan et al., 2025), with higher rates reported in some migrant populations, ranging from 1.2 to 1.8 times that of native individuals (Eger

et al., 2022). Migration during early life has also become increasingly common, with the proportion of first-generation migrants arriving before the age of 18 in the United States rising from 4.7% in 1970 to 14.8% in recent years (Batalova, 2024).

Schizophrenia is therefore widely understood through the Stress-Vulnerability (Diathesis-Stress) Model, which proposes that psychosis develops through the interaction of biological susceptibility and environmental stressors rather than from a single causal pathway (Zubin and Spring, 1977; van Os et al., 2010). Within this framework, risk arises from a combination of genetic predisposition, prenatal and perinatal complications, immune dysfunction, substance use, and psychosocial stressors such as childhood trauma and migration-related adversity (Leucht, 2025; Varese et al., 2012; Henssler et al., 2020; Morgan et al., 2019). Twin and family studies further demonstrate substantial heritability while also showing that genetic predisposition alone is insufficient for disease onset without relevant environmental exposure (Sullivan et al., 2003; Trifu et al., 2020).

One proposed mechanism linking environmental adversity to schizophrenia involves neurodevelopmental change. Chronic stress and early adversity are associated with alterations in brain development through dysregulation of the hypothalamic-pituitary-adrenal (HPA) axis, prolonged cortisol exposure, and structural changes to brain regions involved in memory, emotional regulation, and executive functioning (Gispén-de Wied, 2000; Luvsannyam et al., 2022; Keefe & Harvey, 2012). These findings suggest that schizophrenia reflects dysfunction across distributed neural networks and reinforce the importance of early developmental experiences in shaping long-term vulnerability.

Despite extensive research examining childhood trauma, migration, and schizophrenia independently, considerably less attention has been paid to how these factors interact within first-generation migrant populations. Existing evidence suggests that genetic susceptibility, early adversity, and migration-related stress are likely to operate cumulatively rather than independently, yet the relative contribution of each pathway remains unclear (Henssler et al., 2020; Varese et al., 2012). Moreover, inconsistent prevalence estimates across migrant groups raise important questions regarding the influence of social context, cultural variation in symptom expression, and methodological differences between studies (Morgan et al., 2019).

Accordingly, this review aims to examine the extent to which early childhood trauma contributes to schizophrenia risk among first-generation migrants and to evaluate how biological vulnerability, migration-related stress, and broader structural determinants interact to influence this relationship. Understanding these interacting pathways has important implications for trauma-informed mental health care, culturally sensitive psychiatric assessment, and early intervention among migrant populations. By synthesising evidence across psychiatry, psychology, neuroscience, and migration research, this review seeks to provide an integrated understanding of schizophrenia risk that moves beyond single-factor explanations and highlights the cumulative influence of biological, environmental, and structural determinants.

LITERATURE REVIEW

Developmental Origins of Psychosis Risk

Research consistently shows that schizophrenia emerges from interactions between genetic vulnerability and environmental stressors across development. Within this framework, early childhood stands out as one of the strongest environmental risk factors. Meta-analytic findings demonstrate that childhood maltreatment, including abuse and neglect occurring before the age of 18 years of age (WHO, 2026), increases the risk of psychotic disorder by approximately two to three times, with stronger effects linked to higher severity, chronicity, and exposure to multiple trauma types (Varese et al., 2012). Longitudinal evidence further indicates that early adversity disrupts cognitive and emotional development, increasing vulnerability to later psychosis-spectrum outcomes. Together, these findings support the view that childhood trauma is not an isolated factor but part of a broader developmental process through which environmental stress becomes biologically embedded over time.

Neurobiological Mechanisms of Vulnerability

In terms of brain structure, chronic childhood trauma, particularly prolonged or severe adversity, can disrupt the hypothalamic-pituitary-adrenal (HPA) axis, which leads to prolonged cortisol exposure and long-term changes in brain development. This process affects the hippocampus and prefrontal cortex, which regulate memory, executive functioning, and emotional control. Neuroimaging studies consistently report reduced grey matter volumes in prefrontal and temporal regions, alongside white matter abnormalities affecting key associative tracts (Luvsannym, 2022). Consistent with these structural findings, neuroimaging research also links early adversity to reduced hippocampal volume and altered dopaminergic activity, which together increase vulnerability to psychotic symptoms (Gispén-de Wied, 2000).

Migration, Stress, and Psychosis Risk

Migration also increases the risk of psychosis through multiple interacting stressors. Epidemiological studies show that migrant populations experience higher rates of schizophrenia-spectrum disorder than native-born groups, with relative risks typically ranging from 1.5 to 3.0 depending on subgroup and host country context. Although meta-analyses consistently report elevated psychosis risk among migrants, the magnitude of this association differs substantially across host countries and ethnic groups, indicating that contextual factors are likely to moderate rather than simply increase risk. This variability suggests that migration alone cannot account for the elevated incidence of psychosis. Furthermore, age at migration, length of residence, and migration generation may influence vulnerability, as individuals migrating during childhood may experience developmental disruption during periods of heightened neuroplasticity and identity formation. Additionally, differences in host-country contexts, socioeconomic conditions, and composition of migrant populations may partly explain this variability (Henssler et al., 2020; Morgan et al., 2019).

Rather than representing a single stressful event, migration is increasingly conceptualised as a cumulative process in which individuals may experience adversity, before, during, and after migration (Cantor-Graae and Selten, 2005; van Os et al., 2010). Within this framework, the social defeat hypothesis proposes that repeated experiences of exclusion and subordinate social status may increase dopaminergic sensitivity, thereby elevating vulnerability to psychosis (Cantor-Graae and Selten, 2005).

This multi-layered interaction is summarised in Figure 1, which provides a conceptual overview of how childhood trauma, biological vulnerability, migration-related stress, and broader environmental exposures converge through stress-response dysregulation to increase psychosis risk (Ndenda, 2026).

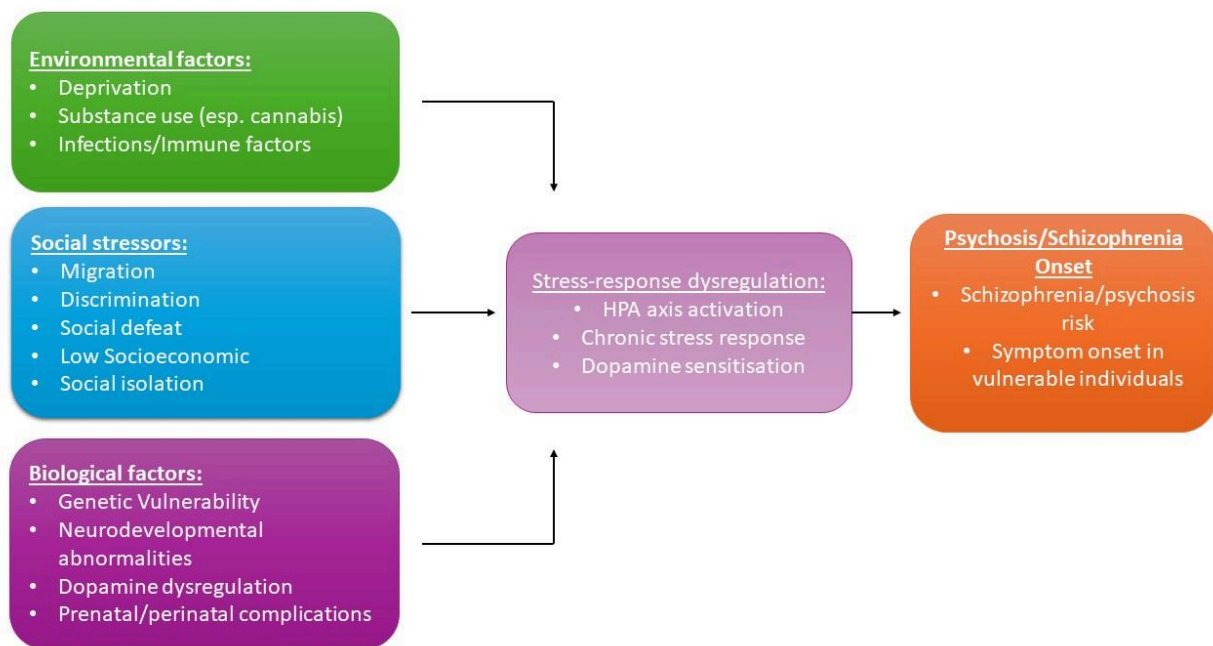


Figure 1: Illustrative conceptual model showing the hypothesised interaction between childhood trauma, biological vulnerability, migration-related stress, and broader environmental exposures through stress-response dysregulation. This figure is intended as a conceptual framework rather than an empirical causal pathway.

Methodological and Cultural Considerations

Despite strong evidence linking trauma and migration to psychosis risk, the literature still leaves key questions unresolved. Most studies examine childhood trauma and migration separately rather than jointly within first-generation migrant populations. This separation limits understanding of how these risk pathways interact. Studies also report considerable variation in psychosis prevalence across migrant groups. Some of this heterogeneity likely reflects genuine differences in social and environmental

exposures, while methodological inconsistencies, including sampling strategies, diagnostic criteria, and healthcare access, may also contribute to divergent findings (Morgan, 2019; Misra, 2025; Fernando, 2017).

Furthermore, several scholars argue that contemporary diagnostic systems remain influenced by historically Eurocentric psychiatry frameworks, potentially affecting how distress is recognised and classified across culturally diverse populations (Fernando, 2017). Consequently, differences in diagnosis may partly reflect variation in clinical interpretation rather than true differences in disease prevalence.

Current Gaps in the Literature

Collectively, the literature supports a multi-layered model in which early childhood trauma, migration-related stress, and biological vulnerability interact to increase schizophrenia risk. However, current research struggles to isolate the specific contribution of early trauma within first-generation migrant populations as trauma and migration are frequently examined as separate risk factors rather than interacting processes, limiting understanding of how these exposures combine across developmental stages to shape psychosis vulnerability.

Additionally, many studies aggregate diverse migrant populations into broad categories, overlooking important within-group differences and a substantial proportion of the literature is concentrated in Western contexts, particularly the United Kingdom and the Netherlands, which raises concerns regarding the generalisability of findings to non-Western settings. Notably, much of the existing research is also cross-sectional and association based, with limited longitudinal evidence tracking how trauma and migration-related stressors interact over time to influence schizophrenia onset which results in the temporal and causal mechanisms underlying these relationships remaining insufficiently understood.

Similarly, while neurobiological and psychosocial models suggest plausible pathways linking early adversity to psychosis, the precise mechanisms through which these processes converge remain underexplored. More broadly, variations in reported prevalence across studies may reflect not only true epidemiological differences but also methodological inconsistency, sampling variation, and diagnostic bias as much of the foundational literature is concentrated in studies conducted between 2005 and 2022, highlighting the need for more contemporary research that reflects current migration patterns and diagnostic practices.

Addressing these limitations through longitudinal, cross-cultural, and methodologically standardised research will be essential for clarifying how childhood trauma and migration interact to influence schizophrenia risk among first-generation migrants.

METHODOLOGY

This study adopts a narrative literature review methodology to examine the relationship between early childhood trauma, migration, and schizophrenia risk among first-generation migrants. A narrative review was selected because the research question spans multiple disciplines, including psychiatry, psychology, neuroscience, and migration studies, making an integrative synthesis more appropriate than a statistical meta-analysis. Rather than quantitatively combining study outcomes, this approach aims to identify recurring themes, compare findings across disciplines, and evaluate proposed biological, psychological, and social mechanisms that may contribute to schizophrenia risk.

A structured literature search was conducted primarily using Google Scholar to identify peer-reviewed studies relevant to the research question. Search terms included combinations of “schizophrenia,” “psychosis,” “childhood trauma,” “child maltreatment,” “migration,” “first-generation migrants,” “psychosis,” “psychosis and migration,” and “stress-vulnerability model.” Reference lists of key review articles and meta-analyses were also examined to identify additional relevant sources.

Studies were included if they examined schizophrenia or psychosis in relation to childhood trauma, migration, or both; were published in peer-reviewed journals; and employed systematic reviews, meta-analyses, longitudinal cohort studies, epidemiological research, or influential theoretical works. Preference was given to meta-analyses and large scale epidemiological studies because they provide more robust estimates of schizophrenia risk, while foundational theoretical works, such as the Stress-Vulnerability Model, were retained where essential to conceptual development. Most included studies were published between 2000 and 2026 to reflect contemporary migration patterns and diagnostic practices, although earlier seminal publications were included where they remained central to current understanding.

In light of these methodological considerations, several limitations should be acknowledged. The available literature demonstrates considerable heterogeneity in study design, sample composition, diagnostic criteria, and measurement of childhood trauma, limiting direct comparability across studies. Many investigations rely on retrospective self-report measures of childhood adversity, including the possibility of recall bias, while variation in diagnostic practices and cultural interpretation of psychiatric symptoms may contribute to differences in reported psychosis prevalence across migrant populations. Moreover, much of the evidence is derived from Western populations, particularly the United Kingdom and the Netherlands, which may limit the generalisability of findings to other cultural and geographical contexts. As this review relies exclusively on secondary sources, its conclusions are necessarily constrained by the quality, scope, and methodological limitations of the existing literature. Nevertheless, the narrative review approach provides a suitable framework for integrating interdisciplinary evidence in an area where substantial methodological diversity limits the feasibility of quantitative synthesis.

RESULTS

MIGRATION AS CUMULATIVE STRESS

Migration is a complex and often disruptive process that can significantly affect psychological well-being. Although migration is frequently driven by the pursuit of better opportunities, safety, or education, it involves profound changes to an individual's social environment, cultural identity, and support systems (Wiese, 2010). Migration during childhood may further intensify vulnerability to psychotic disorders, as early exposure to cultural disruption, identity conflict, and environmental instability during critical periods of brain development increases the child's susceptibility to long-term psychological disorders (Radjack et al., 2021).

In regard, one of the key psychological processes through which these challenges emerge is acculturation, defined as the psychological and cultural adjustment that occurs when individuals are exposed to a new cultural environment (Sam and Berry, 2006). This process can generate acculturative stress, particularly when individuals face language barriers, discrimination, economic hardship, and social isolation. When prolonged, these stressors may evolve into chronic stress, which is associated with significant psychological and physiological consequences (Baum, 1990).

Empirical evidence highlights the scale of this burden. In a primary care study of first-generation migrants in Italy, Aragona et al. (2013) found high rates of both pre-migration trauma and post-migration adversity, with 60.6% of participants reporting exposure to at least one potentially traumatic event and 73.65% experiencing serious post-migration living difficulties (PMLD). Additionally, 32.19% met criteria for post-traumatic stress disorder (PTSD). The most common reported stressors included material deprivation, loss or injury of loved ones, and exposure to violence.

Importantly, the cumulative exposure to trauma and post-migration stressors showed a significantly positive association with post-traumatic stress disorder risk. Among specific post-migration factors, loneliness was associated with nearly twice the odds of psychological distress (OR = 1.90), while limited access to healthcare increased risk by approximately 71% (OR = 1.71) (Aragona et al., 2013). These findings suggest that mental health outcomes among migrants are shaped not only by pre-migration trauma, but also by persistent social and structural adversity within host countries. However, these findings should be interpreted within the context of the study population, as participants were recruited from primary care settings and may represent individuals already experiencing greater psychological distress. Therefore, prevalence estimates may not directly generalise to all first-generation migrants.

Beyond trauma, broader epidemiological trends suggest increased vulnerability to severe mental disorders among migrant populations. Meta-analytic findings indicate that migrants have a two- to threefold increased risk of psychotic disorders, including schizophrenia, compared to native populations (Henssler et al., 2020). However, this elevated risk is not uniform and appears to be strongly shaped by social context, particularly levels of exclusion and discrimination. Higher risk among socially disadvantaged

supports the social defeat hypothesis, which links chronic social exclusion to dysregulation in dopaminergic pathways associated with psychosis (Canteer-Graae and Selton, 2025). Though, variation in reported risk estimates likely reflects differences in migrant populations examined, host-country contexts, migration histories, and the extent to which studies account for socioeconomic disadvantage and discrimination. Studies conducted in different countries may therefore capture distinct social environments rather than a universal effect of migration itself.

In line with this interpretation, socioeconomic context further moderates risk outcomes. For instance, migrants in higher-income or socially integrated environments demonstrate lower incidence rates, suggesting that social position and integration, rather than migration per se, are key determinants of mental health outcomes. Similarly, some migrant groups show comparable or even lower risk than native-born populations, reinforcing the view that migration itself is not inherently pathological but becomes associated with increased risk under conditions of sustained adversity (Tarricone et al., 2021; Hollander et al., 2016).

Overall, migration functions as a multidimensional psychosocial stressor, where pre-migration trauma, post-migration adversity, and social inequality interact. These findings indicate that migration-related adversity may represent an important pathway through which psychosis vulnerability develops.

INTERSECTING PATHWAYS OF TRAUMA AND MIGRATION IN SCHIZOPHRENIA RISK

A traumatic event is a frightening, dangerous, or violent experience that threatens a child's life or physical integrity. Such experiences can elicit intense emotional and physiological responses, including fear, helplessness, or terror.

Childhood trauma encompasses a broad range of adverse experiences, including physical, emotional, and sexual abuse, neglect, domestic violence, parental loss, poverty, war, and chronic instability. Meta-analytic evidence indicates that individuals exposed to childhood maltreatment (CM) have approximately two- to threefold higher odds of developing psychosis compared to those unexposed, with risk increasing in line with the severity, timing, and cumulative nature of trauma experienced (Varese et al., 2012). Psychosis incidence is also elevated among migrants and their descendants, particularly among those from non-Western regions, suggesting that early adversity may interact with broader social and environmental stressors (Morgan et al., 2019; Selten et al., 2020).

Nevertheless, the magnitude of this association differs across studies depending on how childhood trauma is measured, whether exposure is assessed retrospectively or prospectively, and the characteristics of the populations examined. Retrospective reports may be affected by recall bias, while clinical samples may overrepresent individuals with more severe illness.

Empirical findings indicate elevated rates of childhood maltreatment among migrant populations. D'Andrea et al. (2023) report that 26.2% of first-generation migrants and 22.6% of their descendants experienced childhood maltreatment (CM), compared to 14.8% in non-migrant reference populations. Higher exposure rates have also been observed in both non-Western (26%) and Western (22.1%) migrant groups relative to controls, suggesting that increased vulnerability is not limited to a single migrant category (D'Andrea et al., 2023).

Clinical evidence further supports this pattern. In a German sample of first-generation migrants, Neumann et al. (2025) found that 44.1% reported childhood maltreatment, with high rates of emotional abuse (84.9%) and emotional neglect (83%), alongside substantial levels of physical and sexual abuse. Ultimately, migrants in this sample exhibited greater lifetime trauma exposure and higher levels of psychopathology compared to non-migrant populations (Neumann et al., 2025).

These findings highlight the cumulative burden of trauma within migrant populations. Migration often involves stressors occurring before, during, and after relocation, which may compound the psychological impact of earlier adverse experiences. Meta-analytic evidence suggests that post-traumatic stress disorder affects approximately 25% of migrants, markedly higher than estimates in the general population (0.2% to 3.8%) (Amiri, 2022; Shalev et al., 2017, as cited in D'Andrea, 2023).

The cumulative nature of these stressors is central to understanding schizophrenia risk among migrants, as research consistently demonstrates that repeated or severe trauma is associated with higher rates of PTSD and psychosis. Migrants may experience overlapping stressors across multiple stages of migration, resulting in prolonged activation of stress-response systems, which, over time, can impair key brain regions involved in emotional regulation and cognition, such as the hippocampus, prefrontal cortex, and amygdala (Fan and Kang, 2025).

Neuroimaging studies further support these findings by identifying structural and functional abnormalities within these regions among trauma-exposed individuals. (Johnson, 2018). These converging lines of evidence suggest a possible pathway through which chronic stress exposure may contribute to long-term biological embedding.

As illustrated in Figure 2, these processes can be understood as an interaction between childhood trauma, migration-related adversity, and neurobiological stress mechanisms, which together contribute to increased vulnerability to psychosis. In response to threatening environments, children may also develop adaptive survival responses that become maladaptive when sustained over time, further reinforcing long-term dysregulation of stress-response systems (National Child Traumatic Stress Network, 2026).

Importantly, this model is intended as a conceptual framework rather than an established causal pathway. The relationships illustrated represent hypothesised interactions supported by existing literature but do not imply that all individuals exposed to these factors will develop psychosis.

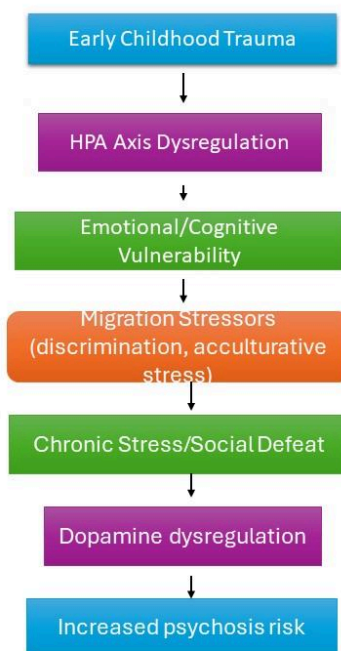


Fig 2: Interaction between childhood trauma, migration-related adversity, and neurobiological stress mechanisms in the development of psychosis (Ndenda, 2026).

Nevertheless, the risk of psychotic disorders is not uniform across all migrant populations, as some groups demonstrate lower incidence rates, especially those with stronger socioeconomic positioning or greater social integration. This indicates that migration itself is not inherently pathogenic either; rather, it is the broader social conditions that shape vulnerability. Key factors include discrimination, marginalisation, relative deprivation, and social exclusion.

One proposed explanatory mechanism is the social defeat hypothesis, which suggests that chronic exposure to exclusion or subordinate social status can increase dopamine sensitivity, thereby contributing to psychosis risk (Cantor-Graae and Selten, 2005).

Taken together, when childhood trauma intersects with migration-related adversity, vulnerability may be further amplified. This relationship is best understood as cumulative, interactive, and multidimensional. It aligns closely with the stress-vulnerability model, which conceptualises schizophrenia as the outcome of biological predisposition interacting with environmental stressors over time. Accordingly, schizophrenia risk among first-generation migrants appears to emerge through the interaction of early adversity, chronic social stress, neurobiological vulnerability, and structural inequality rather than migration alone.

DISCUSSION

Heterogeneity in Psychosis Risk Among Migrant Populations

Importantly, overall estimates of elevated psychosis risk among migrants should be interpreted with caution, as risk varies significantly across groups and contexts. For example, Black minority groups show the highest reported rates, approximately four to six times higher than majority populations, largely based on UK-based studies of Black Caribbean and Black African individuals (Morgan et al, 2019). In contrast, other minority groups show modest increases, typically around 1.5 times, or no significant elevation at all. Similar heterogeneity is observed across countries; elevated rates are reported among Moroccan and Surinamese populations in the Netherlands, whereas Turkish migrants do not show the same pattern. Notably no consistent increase in psychosis risk has been observed among migrants in Canada or Israel (Morgan et al., 2019). These findings suggest that migration alone does not account for increased risk and that the contextual and structural factors play a central role.

A more nuanced interpretation is that these differences remain challenging because migrant populations are not homogeneous. Studies often group individuals according to broad geographical origins, which may obscure important differences in migrant history, socioeconomic position, age at migration, and exposure to adversity. Hence, variation in psychosis rates may reflect differences in social environments rather than differences inherent to migrant identity.

Methodological and Cultural Influences on Diagnostic Patterns

However, cross-population comparisons are further complicated by methodological and diagnostic influences. Cultural variation in symptom expression, differences in help-seeking behaviour, and potential biases embedded within historically Eurocentric psychiatric frameworks may all influence diagnostic outcomes (Fernando, 2017; Halvorsrud et al., 2019). These factors limit the comparability of prevalence estimates and highlight the importance of culturally sensitive interpretation of epidemiological data. Furthermore, diagnostic practices may influence observed differences in incidence rates. Higher diagnosis rates among some migrant groups may represent increased exposure to risk factors, greater clinical visibility, or differences in pathways to psychiatric care. Consequently, epidemiological disparities should not automatically be interpreted as evidence of biological differences between populations.

Genetic Vulnerability and the Limits of Heritability

Schizophrenia is therefore best understood as a multifactorial disorder arising from the interaction of genetic, environmental, and social influences. Although twin and family studies indicate substantial heritability, estimated at approximately 60%-80%, genetic susceptibility alone is insufficient to determine disease onset (Sullivan et al., 2003; Trifu et al., 2020). Many individuals exposed to similar environmental adversities do not develop psychosis, demonstrating that genetic vulnerability increases risk rather than directly causing illness. Thus, schizophrenia risk is better conceptualised as the result of dynamic

interactions between inherited susceptibility and environmental exposures, including childhood trauma, chronic stress, and social adversity.

Multi-Hit Model of Psychosis Risk

While early theories proposed a “two-hit” model, where genetic predisposition is followed by an environmental trigger, current evidence is more consistent with a multi-hit model, in which risk accumulates across multiple domains and developmental periods, including prenatal and perinatal complications, childhood trauma, substance use, chronic stress, and social adversity (Fatemi et al., 2009; Keshavan et al., 2011). Other environmental exposures, such as substance use, may contribute to psychosis risk, although their effects are also influenced by genetic vulnerability and broader social context.

Childhood Trauma as a Central Risk Pathway

Among these factors, childhood trauma remains one of the most robust predictors with meta-analytic evidence indicating a threefold increased risk of psychosis and a population attributable risk of an estimate of 33% (Varese et al., 2012). Importantly, trauma interacts with other biological and social vulnerabilities rather than acting independently, contributing to both the onset and severity of symptoms. Nonetheless, childhood trauma should not be considered a direct or deterministic pathway to schizophrenia. Many individuals exposed to severe adversity do not develop psychosis, suggesting that protective factors, resilience, social support, and access to appropriate care may moderate outcomes.

Social Defeat, Structural Inequality, and Migrant Vulnerability

Social mechanisms further shape this risk profile. The social defeat hypothesis proposes that chronic experiences of exclusion, discrimination, and marginalisation may increase dopaminergic system sensitivity, thereby elevating vulnerability to psychosis. This is particularly relevant for migrant populations where low social integration, poverty, and perceived discrimination are strongly associated with higher rates of schizophrenia. Additionally, structural barriers such as limited access to mental health services and cultural stigma may delay diagnosis and treatment, further worsening outcomes. Yet, evidence linking social adversity to psychosis risk is difficult to separate from other correlated factors, including poverty, housing insecurity, healthcare accessibility, and discrimination. Future research should therefore examine these mechanisms using longitudinal designs capable of distinguishing between overlapping social determinants.

An Integrated Model of Psychosis Risk

As a whole, schizophrenia risk in migrant populations emerges from the interaction of genetic susceptibility, early adversity, chronic social stress, and structural inequality. Trauma represents a key component within this framework, but its effects are embedded within broader systems of social and

environmental disadvantage. Future research should prioritise longitudinal, culturally diverse studies that examine how trauma exposure and migration-related stress interact across development. Clinically, these findings highlight the importance of trauma-informed approaches and culturally sensitive psychiatric assessment that recognise both individual experiences and the wider social conditions shaping mental health outcomes.

CONCLUSION

Early childhood trauma is a significant and consistent risk factor for schizophrenia among first-generation migrants; however, its influence is substantial rather than deterministic. Meta-analytic evidence indicates that child maltreatment is associated with approximately a two- to threefold increase in the odds of psychosis, with an estimated population attributable risk of approximately 33% (Varese et al., 2012). Within migrant populations, this vulnerability is frequently compounded by exposure to both pre- and post-migration stressors (Zubin and Spring, 1977; van Os et al., 2010; Henssler et al., 2020; Morgan et al., 2019). Nevertheless, most individuals exposed to early trauma, including migrants, do not develop schizophrenia, highlighting that trauma operates as one component within a broader, multifactorial, and non-deterministic aetiological framework.

Elevated rates of schizophrenia among migrants should be interpreted with caution, as observed disparities may partly reflect methodological and diagnostic bias rather than true differences in underlying risk. Cultural variation in the expression of psychological distress can contribute to differences in diagnostic interpretation within Western diagnostic frameworks and evidence suggests that ethnic minority and migrant individuals are more likely to receive psychosis diagnoses than majority populations (Fernando, 2017; Halvorsrud et al., 2019).

Looking ahead, future research should prioritise longitudinal and culturally diverse studies that examine how childhood trauma, migration-related adversity, and biological vulnerability interact across development. Greater attention should also be given to trauma-informed mental health care and culturally sensitive psychiatric assessment, ensuring that diagnostic practices recognise both individual experiences and the social contexts in which psychological distress develops. Understanding schizophrenia risk through this multidimensional framework may improve prevention strategies, reduce diagnostic inequities, and support more effective interventions for migrant populations.

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