Migration, trauma och psykos

-

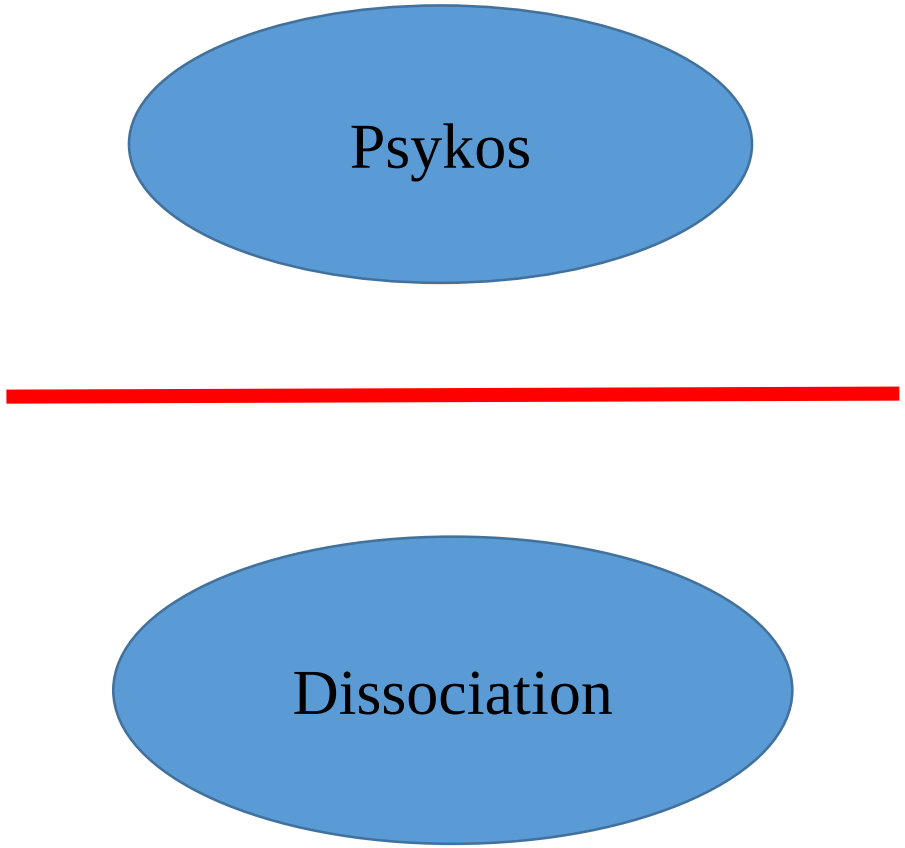
ett transkulturellt perspektiv

Giuseppe Valeriani

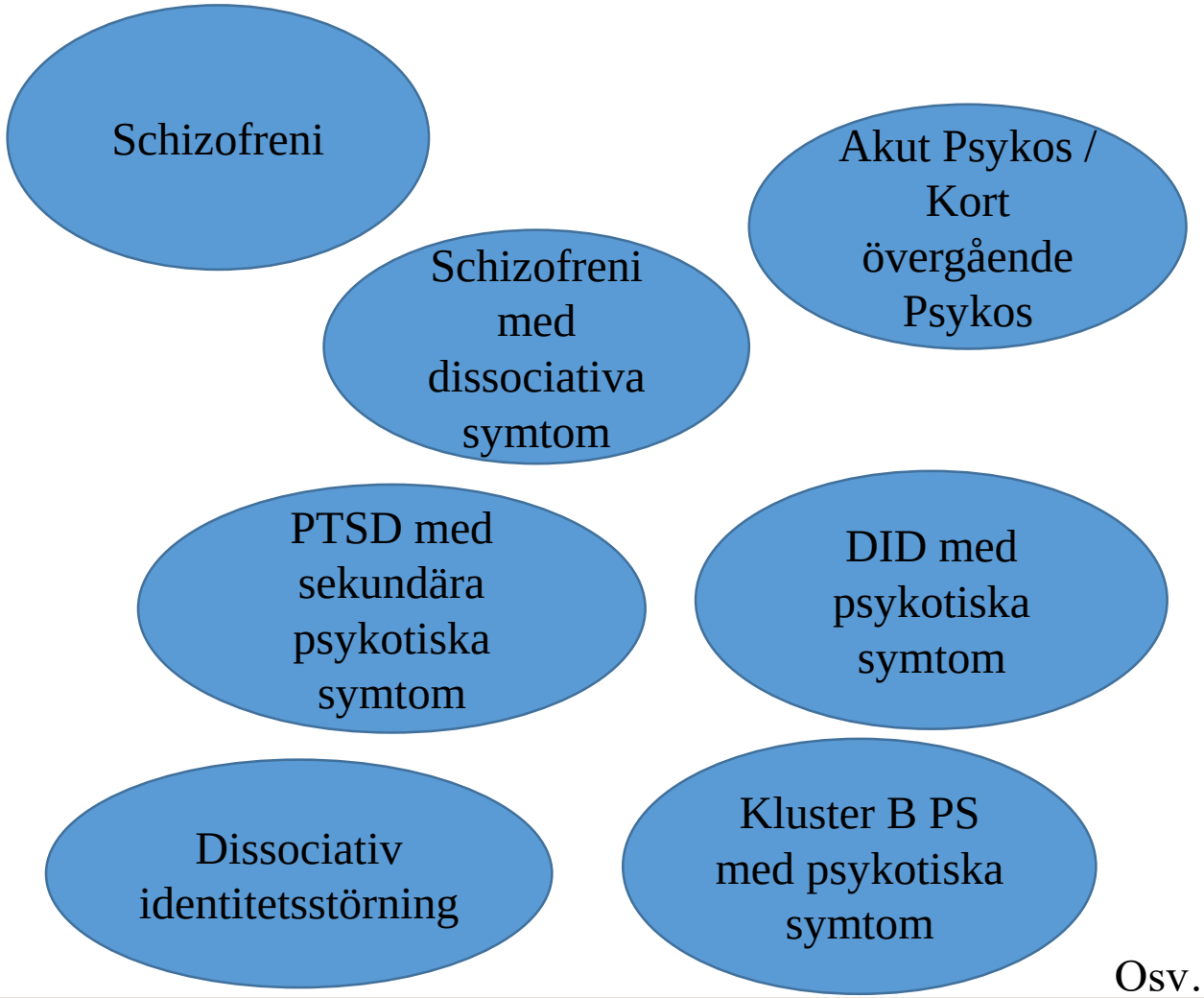
Transkulturellt Centrum

En översikt över relationen Psykos, Trauma och Dissociation

Traditionell syn, före DSM

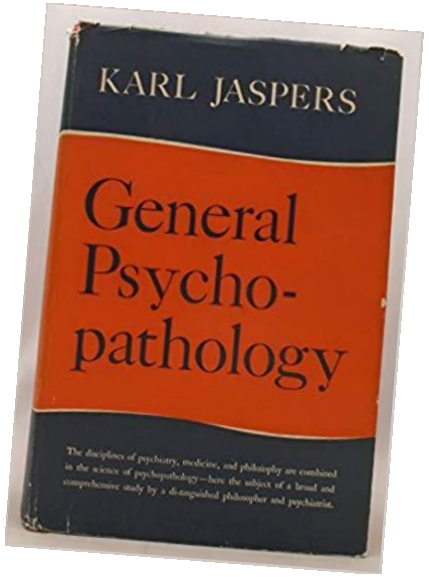


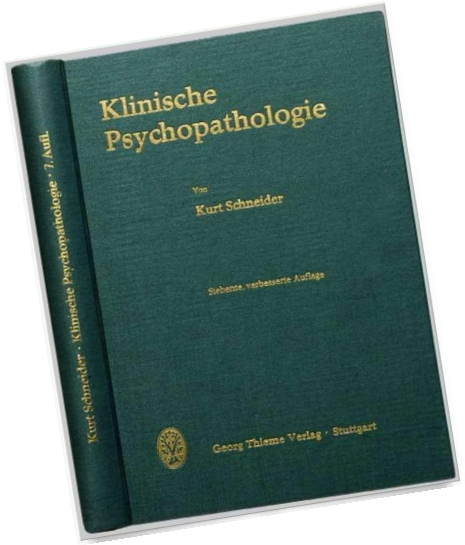
Under DSM-IV och DSM5 Era



Osv…

Tydliga gränser eller ett kontinuum?





Heidelberg skola

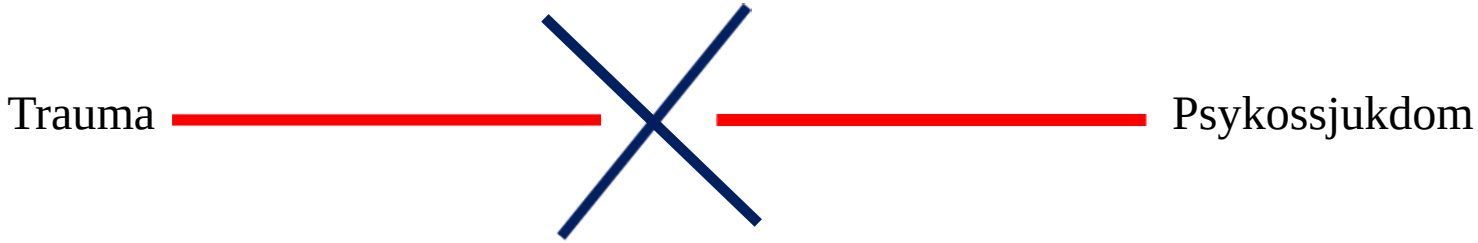
Starka hypoteser om biologisk natur av psykos / organiska avvikelser

Dikotomisering av metoder:
Process vs Utveckling

Obegriplighet av psykotiska upplevelser

Naturvetenskaplig kausal förklaring (psykos) vs psykologisk förståelse (affektiva tillstånd)

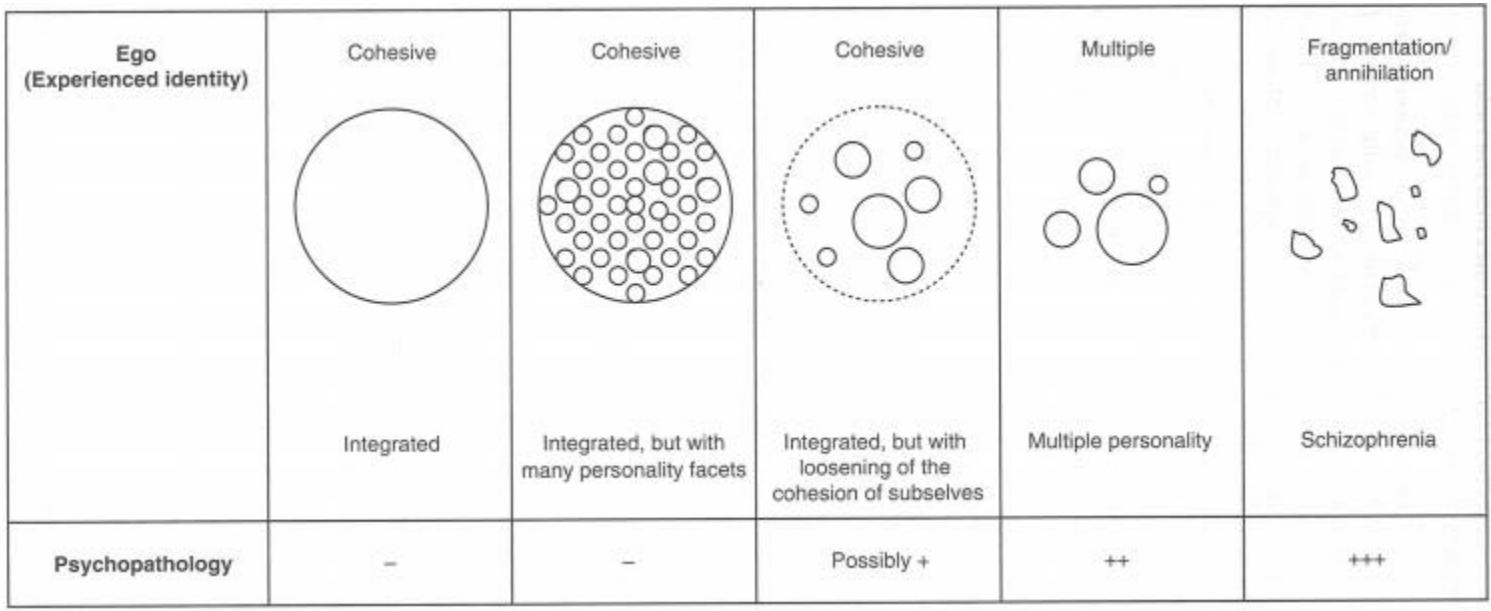
K. Schneider (1959): första rang symtom för schizofreni



Trauma och psykos: kontinuumhypotes

- Ej tillräcklig evidens för neurobiologisk förklaring av schizofreni
- Kliniska data / klinisk erfarenhet som talar för samsjuklighet / överlappningar mellan olika tillstånd
- Schneiders första rang symtom ej “patognomont” på Psykos, utan nästan vanligare i Dissociativa Identitetsstörningar
- Kontinuum

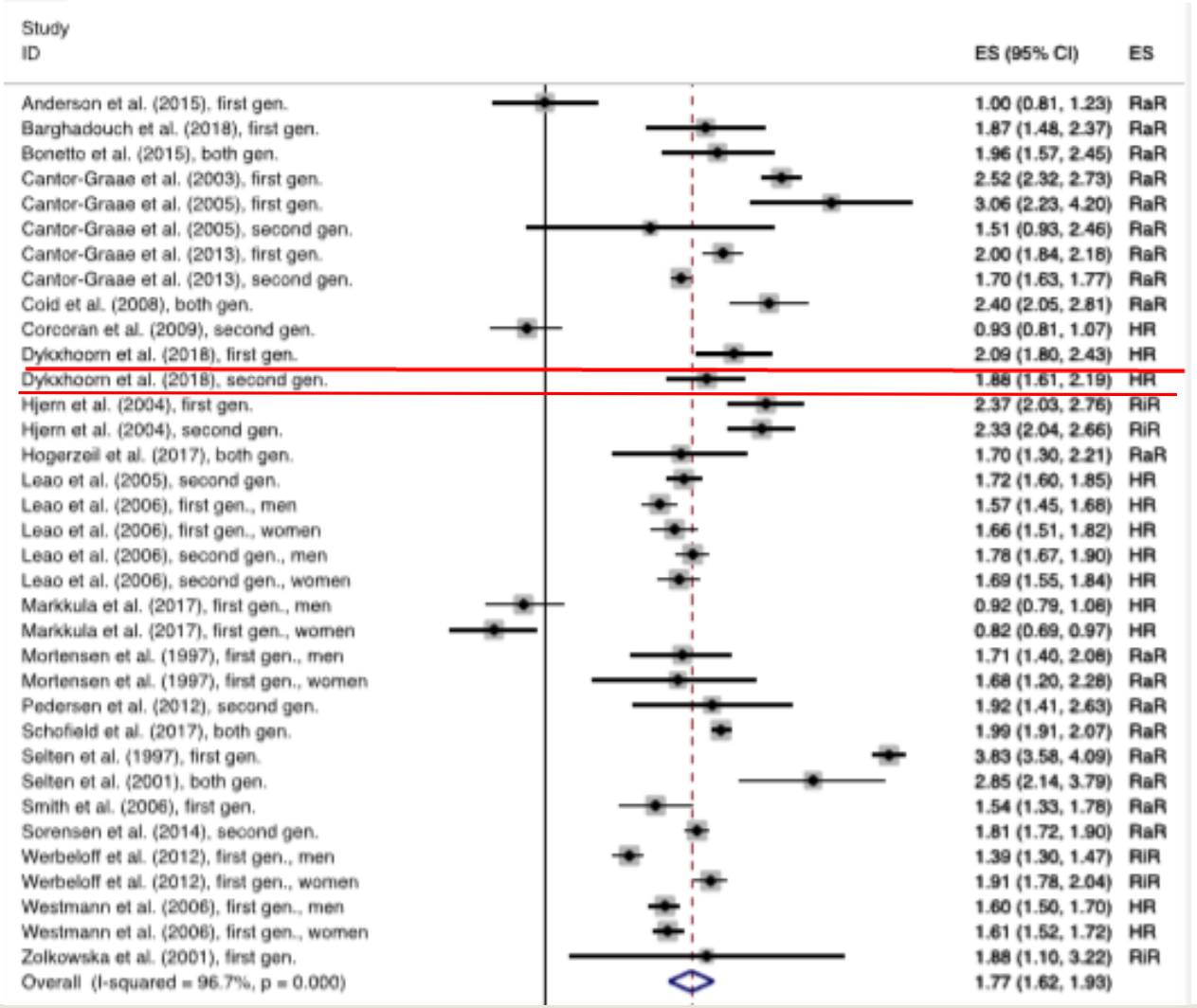
  Trauma - Dissociation – Psykos?



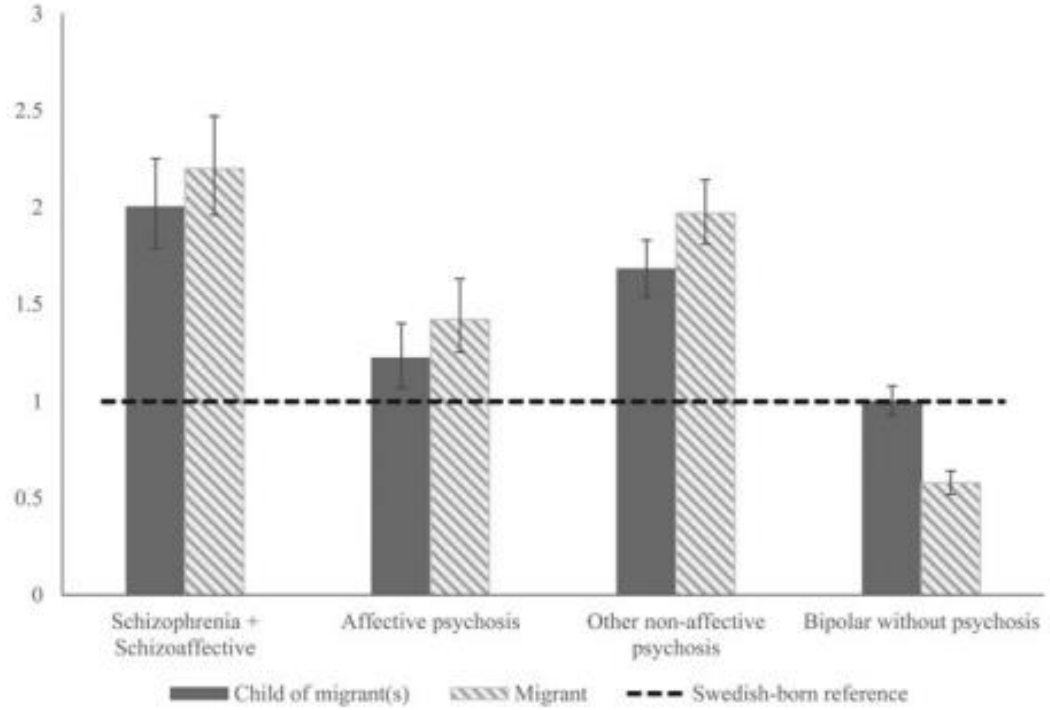
Epidemiologiskt Perspektiv

Migration and schizophrenia: meta-analysis and explanatory framework

Jonathan Henssler[1] · Lasse Brandt[1] · Martin Müller[2,3] · Shuyan Liu[1] · Christiane Montag[1] · Philipp Sterzer[1,4,5] · Andreas Heinz[1,4,5]



Epidemiologiskt perspektiv i Sverige



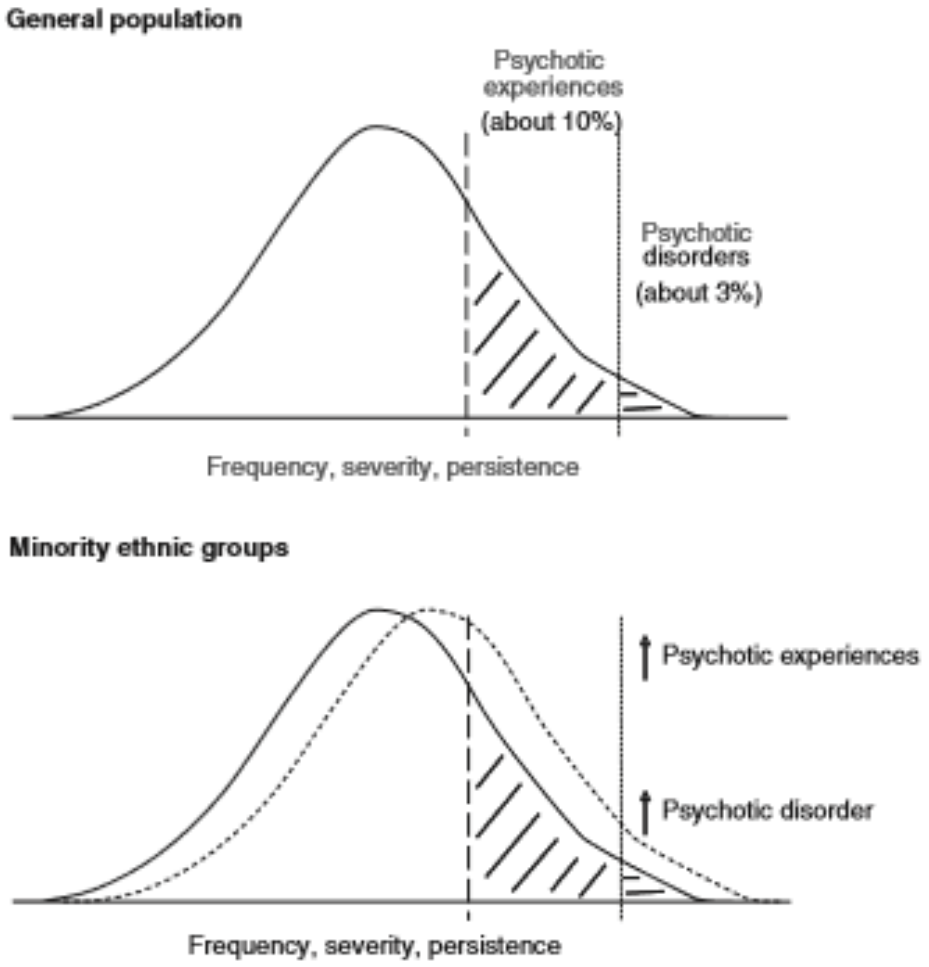
Hollander AC et al (2019)

Större risk för Icke affektiva psykoser hos kvotflyktingar än icke kvotflyktingar (HR=1,41).
Median tid till diagnos för Psykos: hos kvotflyktingar 2 år sedan ankomst till Sverige, hos icke kvotflyktingar 3,3 år.

Vad gäller PTSD:
Lägre risk hos kvotflyktingar än icke kvotflyktingar (HR=0,74). Mediantid till diagnos för PTSD sedan ankomst till Sverige: hos kvotflyktingar 2,7 år, hos icke kvotflyktingar 1,3 år.

			Unadjusted		Adjusted	
	N	%	Hazard ratio	95% CI	Hazard ratio[a]	95% CI
Schizophrenia + schizoaffective						
Swedish born (reference)	1333	61.4	1		1	
Infancy (0–2)	49	2.3	1.57	1.17–2.09	1.57	1.18–2.09
Early childhood (3–6)	89	4.1	2.16	1.74–2.67	2.14	1.73–2.66
Middle childhood (7–12)	132	6.1	2.34	1.96–2.80	2.32	1.94–2.78
Adolescence (13–18)	105	4.8	2.97	2.43–3.62	2.76	2.23–3.41
Early adulthood (19–29)	96	4.4	3.56	2.88–4.41	2.77	1.64–4.69
Affective psychotic disorders						
Swedish born (reference)	1532	70.8	1		1	
Infancy (0–2)	58	2.7	1.69	1.30–2.21	1.71	1.31–2.24
Early childhood (3–6)	58	2.7	1.27	0.97–1.66	1.29	0.99–1.68
Middle childhood (7–12)	67	3.1	1.07	0.83–1.37	1.13	0.88–1.45
Adolescence (13–18)	87	4.0	1.89	1.51–2.38	1.81	1.42–2.30
Early adulthood (19–29)	102	4.7	2.34	1.90–2.89	2.05	1.20–3.52
Other non-affective psychotic disorders						
Swedish born (reference)	2899	64.3	1		1	
Infancy (0–2)	126	2.8	1.92	1.61–2.30	1.95	1.63–2.33
Early childhood (3–6)	191	4.2	2.16	1.86–2.50	2.15	1.85–2.49
Middle childhood (7–12)	210	4.7	1.76	1.52–2.02	1.82	1.58–2.10
Adolescence (13–18)	207	4.6	2.58	2.24–2.98	2.16	1.86–2.52
Early adulthood (19–29)	190	4.2	2.58	2.22–2.99	1.17	0.80–1.72
Bipolar disorder without psychosis						
Swedish born (reference)	5130	81.5	1		1	
Infancy (0–2)	141	2.2	1.19	1.00–1.40	1.20	1.01–1.42
Early childhood (3–6)	83	1.3	0.53	0.42–0.66	0.54	0.43–0.67
Middle childhood (7–12)	97	1.5	0.45	0.36–0.55	0.49	0.40–0.59
Adolescence (13–18)	43	0.7	0.31	0.23–0.42	0.27	0.20–0.37
Early adulthood (19–29)	77	1.2	0.68	0.55–0.86	0.35	0.20–0.61

Migration and psychosis: our smoking lung?



Social cohesion / Low ethnic density

Economic disadvantages / Inequalities

Social isolation

Perceived discrimination

Experienced racism

Social Defeat

"things should be made as simple as possible – but not simpler!" (A. Einstein)

Pre-migrationsfaktorer och risk för psykos

Betydligt större risk att insjukna i psykos bland flyktingar (utsatta för tortyr, förföljelser osv) än andra migranter från samma ursprungsregioner (Hollander AC et al, 2016).

Category	All		Men		Women	
	Model 1	Model 2	Model 1	Model 2	Model 1	Model 2
Swedish-born as reference						
Non-refugee migrant	2.28 (1.99 to 2.62)	1.75 (1.51 to 2.02)	2.61 (2.22 to 3.07)	2.01 (1.70 to 2.38)	1.91 (1.58 to 2.31)	1.44 (1.19 to 1.76)
Refugee migrant	3.61 (2.87 to 4.53)	2.90 (2.31 to 3.64)	4.28 (3.28 to 5.58)	3.49 (2.67 to 4.55)	2.65 (1.80 to 3.92)	2.07 (1.40 to 3.06)

Model 1 was adjusted for age at risk and sex.
Model 2 was additionally adjusted for disposable income

Hur vanliga är traumatiska upplevelser i barndom hos patienter med Psykos?

- Morgan C, Fisher H: uppskattning av sexuell övergrepp i 42% av kvinnliga patienter och 28% av manliga patienter med schizofreni; fysiskt våld i 35% (k) och 38% (m) av patienter.

- Varese et al (metanalysis): personer som upplevde trauma i barndom var 2,78 gånger mer troliga att uppleva psykos (bl. a: sexuell övergrepp *2,38*; fysiskt våld *2,95*; mobbning *2,39*; neglect *2,90*)

- Matheson et al (metanalysis): 3,6 gånger större sannolikhet av psykosutveckling hos personer med upplevt trauma i barndom.

How do traumatic experiences influence the Psychosis development?

Earlier age of onset (Garno et al)

Higher number of hospitalizations (Schenkel et al)

More current PTSD (Brown et al)

More current or lifetime substance abuse (Conus et al)

More lifetime episodes of major depression (Duhig et al)

More likely to have been re-victimized later in life (Dean et al)

More severe clinical course (Leverich et al)

More suicidal ideation and suicide attempts (Romero et al)

More positive symptoms (Ajnakina et al)

Nygaard et al. BMC Psychiatry (2017) 17:5
DOI 10.1186/s12888-016-1166-1

BMC Psychiatry

RESEARCH ARTICLE Open Access

Secondary psychotic features in refugees diagnosed with post-traumatic stress disorder: a retrospective cohort study

- Psychiatric records from 181 consecutive patients at Competence Centre for Transcultural Psychiatry in Ballerup, Denmark
- 74/181 (=40,9%) diagnosed with PTSD + secondary psychotic symptoms (PTSD-SP)

		PTSD-SP	*PTSD*
Characteristics		***N (%)/mean (±SD)***	***N (%)/mean (±SD)***
Male		48 (64.9%)	56 (52.3%)
Female		26 (35.1%)	51 (47.7%)
Age (3rd May 2013)		44.8 (±8.8)	45.0 (±9.8)
Region of origin	***Countries***	***N (%)***	***N (%)***
Eastern Asia	China	0	1 (0.94%)
Southern Asia	Afghanistan, Iran, Sri Lanka	15 (20.3%)	32 (29.9%)
Western Asia	Iraq, Kuwait, Lebanon, Palestine, Syria, Turkey	45 (60.8%)	55 (51.4%)
Eastern Europe	Russia	1 (1.35%)	0
Southern Europe	Albania, Bosnia, Former Yugoslavia	9 (12.2%)	12 (11.2%)
Eastern Africa	Eritrea, Rwanda, Somalia	2 (2.7%)	4 (3.74%)
Northern Africa	Algeria, Morocco	1 (1.35%)	1 (0.94%)

	Comorbidity	*ICD-10 codes*	*N (%)*	*N (%)*	*Chi-square test*
	Depressive disorders	DF32.0, DF32.1, DF32.2, DF32.3, DF32.9, DF33.1, DF33.2, DF33.3, DF33.8, DF33.9	65 (87.8%)	91 (85.1%)	$P = 0.593$
	Other affective disorder	DF31.6, DF34.1, DF34.8	0	4 (3.74%)	
*	Personality change after catastrophic experience	DF62.0	24 (32.4%)	17 (15.9%)	$P = 0.009$*
	Mental and behavioural disorders due to psychoactive substance use	DF10.1, DF10.2, DF11.2, DF15.1, DF19.2	2 (2.70%)	3 (2.80%)	
	Schizophrenia, Schizotypal and delusional disorders	DF22.9, DF29.9	3 (4.05%)	0	
	Other anxiety disorders	DF41.0, DF41.1	3 (4.05%)	5 (4.67%)	
	Other personality changes	DF60.0, DF60.1, DF61.0, DF62.1, DF68.0	2 (2.70%)	3 (2.80%)	
	No-comorbidity to PTSD		6 (8.11%)	9 (8.41%)	

- F62.0: ***Varaktig personlighetsförändring till följd av katastrofupplevelse***

Tillståndet karakteriseras av en fientlig eller misstrogen attityd mot omvärlden, en social tillbakadragenhet, känslor av tomhet eller hopplöshet, en kronisk känsla av att vara ständigt hotad samt en främlingskänsla.

Type of trauma exposure	*N (%)*	*N (%)*
Exposed to torture *PTSD-SP (n = 69), PTSD (n = 92)*	47 (63.5%)	39 (36.4%)
Experienced imprisonment *PTSD-SP (n = 69), PTSD (n = 92)*	44 (59.5%)	38 (35.5%)
Lived in a war zone *PTSD-SP (n = 69), PTSD (n = 91)*	63 (85.1%)	88 (82.2%)
Lived in a refugee camp *PTSD-SP (n = 69), PTSD (n = 85)*	19 (25.6%)	26 (24.3%)
Soldier in war *PTSD-SP (n = 68),PTSD (n = 87)*	23 (31.1%)	23 (21.5%)

Psychotic symptoms		*N (%)*
Hallucinations	Auditory	49 (66.2%)
	Visual	22 (29.7%)
	Olfactory	5 (6.76%)
	Tactile	6 (8.11%)
Delusions	Persecutory	37 (50.0%)
	Delusion of control	4 (5.41%)
	Bizarre/strange delusion	1 (1.35%)

För det mesta var innehållet av vanföreställningar anslutet till tidigare trauma.
Bisarra innehåll var ovanliga.
Ej alltid klar om realitetsprövning var nedsatt. Ibland växlande / försämrat under behandling.

Kan man skilja på psykos och dissociation utifrån positiva symtom?

	Primary psychosis	DID/OSDD	PTSD
Auditory hallucinations	Often	Often	Often
Internally vs. externally perceived voices	Either	Either	More likely internal
Onset of voices	**After 18**	**Before 18**	
Number of voices	**Typically One**	**Typically Multiple**	**Typically one**
Child voices	**Possible**	**Often**	
Nonauditory hallucinations	**Possible**	**Often**	**Often**
Trauma-related content	Sometimes	Sometimes	Sometimes
Schneiderian first-rank symptoms	Often	More often	
Trauma exposure	Often	Often	Necessary
Dissociative symptoms	Possible	Necessary	Common

Schiavone et al, 2018

Hallucinationer, pseudo-hallucinationer eller flashbacks?

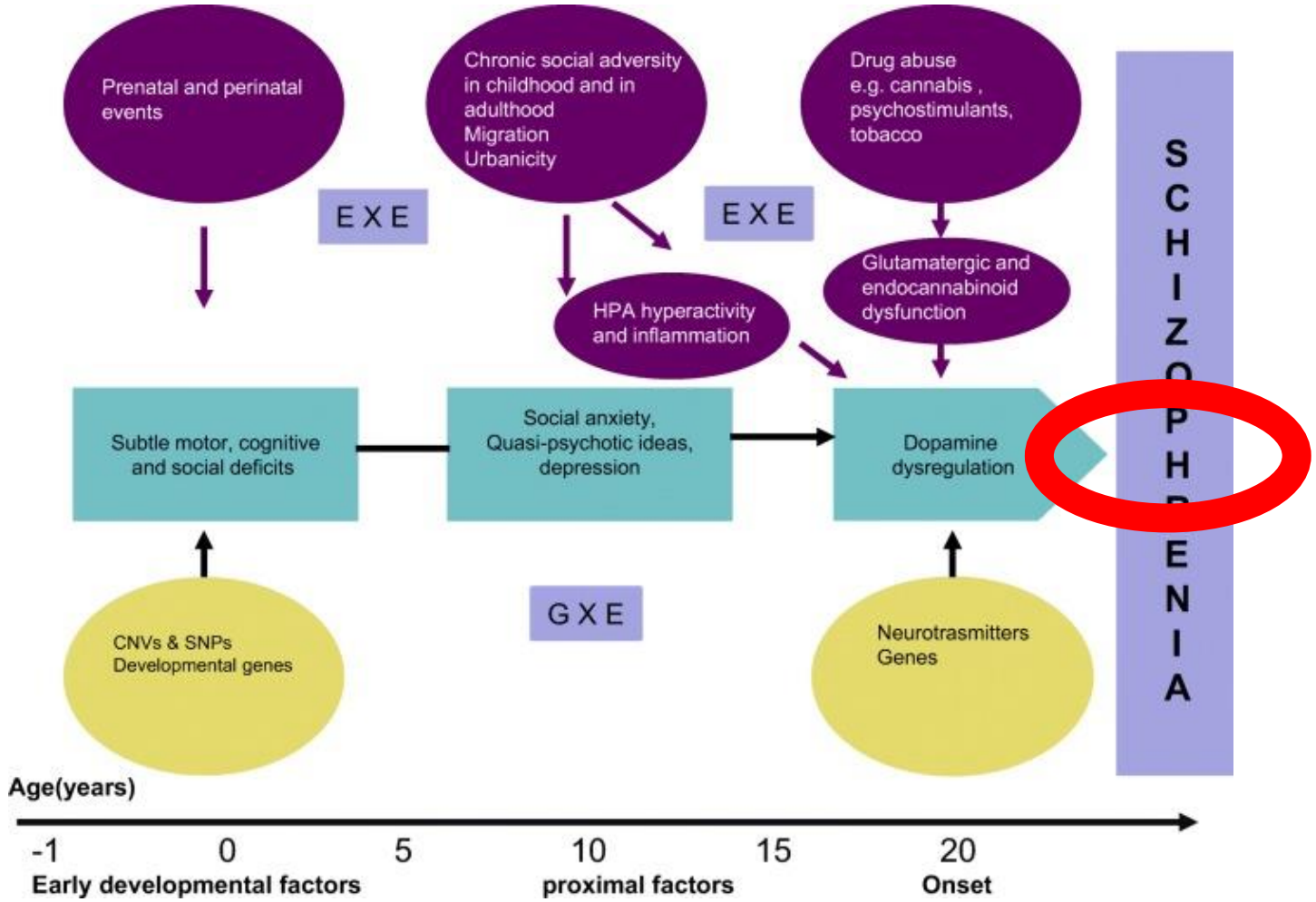
Variable	Hallucinations
Auditive	Often
Visual	Sometimes
Haptic	Rarely
Olfactory	Rarely
Gustatory	Rarely
Localization	Often external
Vividness	From lifelike to as-if character
Reality testing	Impaired
Continuity over time	Yes
Functional result	Often anxiety-provoking
Control	No
Secondary delusions	Often
Cue-triggering	Sometimes
Other	Often bizarre dreamlike

Variable	Obsessional Imagery	Fantasy and Imagery
Auditive	Yes	Yes
Visual	Yes	Yes
Haptic	?	Yes
Olfactory	?	No?
Gustatory	?	No?
Internal localization	Yes	Yes
External localization	No	No
Vividness	Lifelike	Low
Reality testing	Intact	Intact
Continuity over time	No	No
Functional results	Anxiety-provoking, wish-fulfilling	Supportive, wish-fulfilling
Control	No/temporary	Yes
Secondary delusions	Possibility	No
Other	Often sexual, or aggressive	Also: daydreams

Variable	Re-experiences
Auditive	Yes
Visual	Yes
Haptic	Yes
Olfactory	Yes
Gustatory	Yes
Internal localization	Yes
External localization	No
Vividness	Lifelike to faint/distorted
Reality testing	Intact
Continuity over time	Often
Functional results	Anxiety-provoking
Control	No
Secondary delusions	Possibility
Trauma	Yes
Cue-triggering	Yes

Van Der Zwaard R, Polak MA, 2001

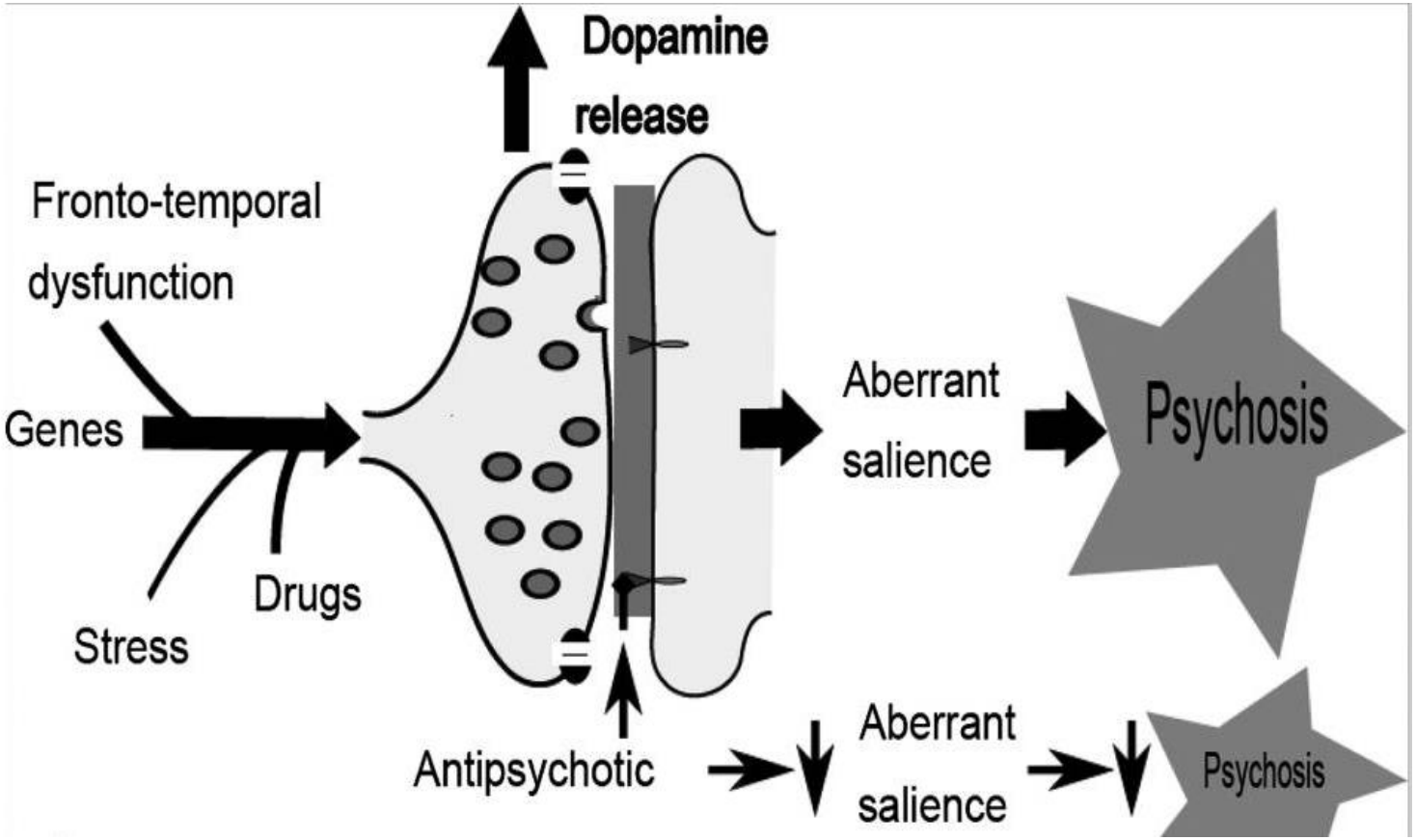
Psychosis: not a mistery, merely a puzzle



Complexity describes a state of the world. Complicated describes a state of mind (Donald Norman)

Murray R et al, An integrated socio-developmental-cognitive model of Schizophrenia, 2019

Hur hjärnan uppfattar stimuli: *Salience* hypotes, "from a neutral and cold bit of information into an attractive or aversive entity"



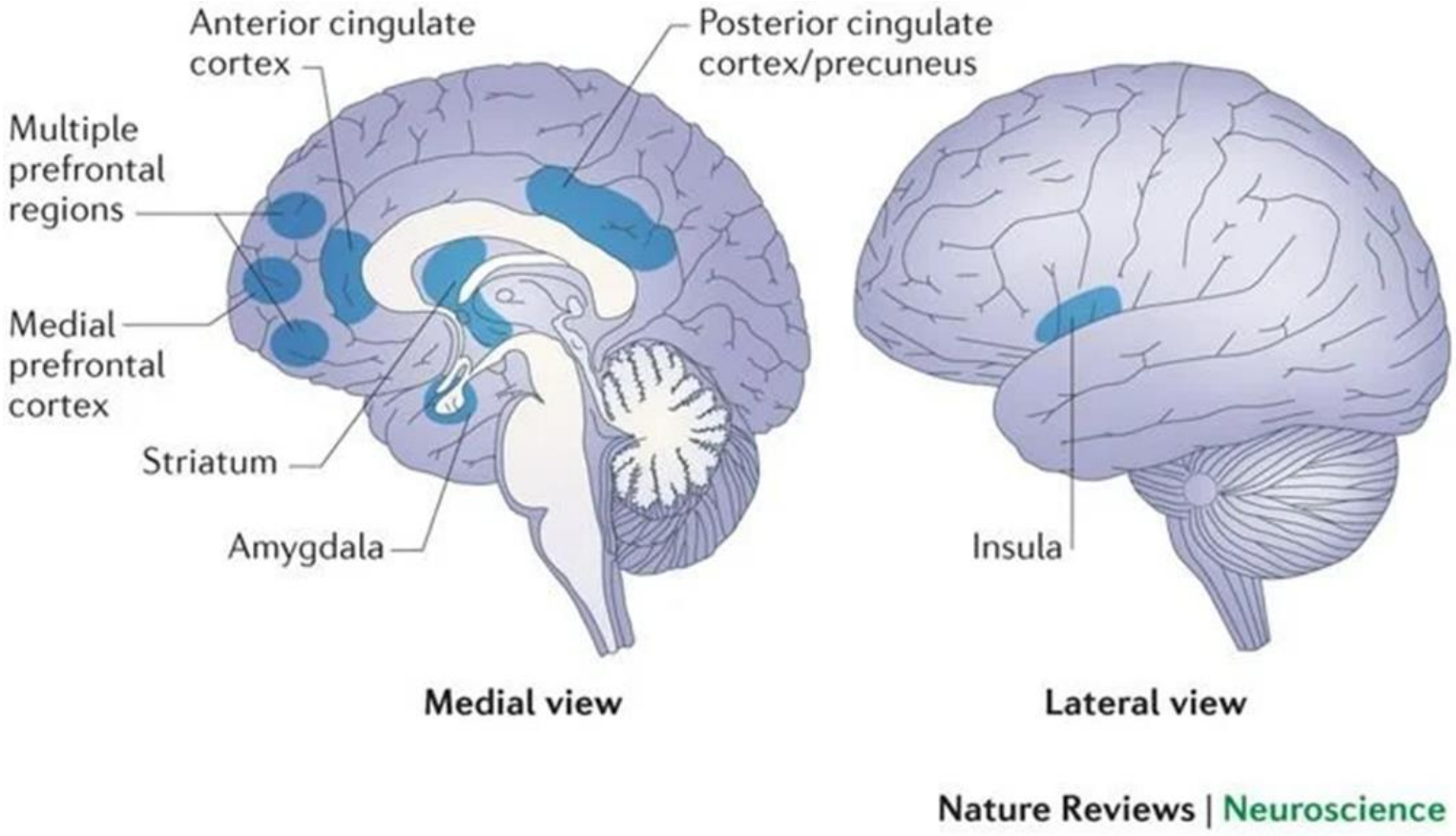
Aberrant attribution of salience to otherwise irrelevant stimuli

Effort to make sense (prodromal symptoms)

Cultural context of the individual

Delusions

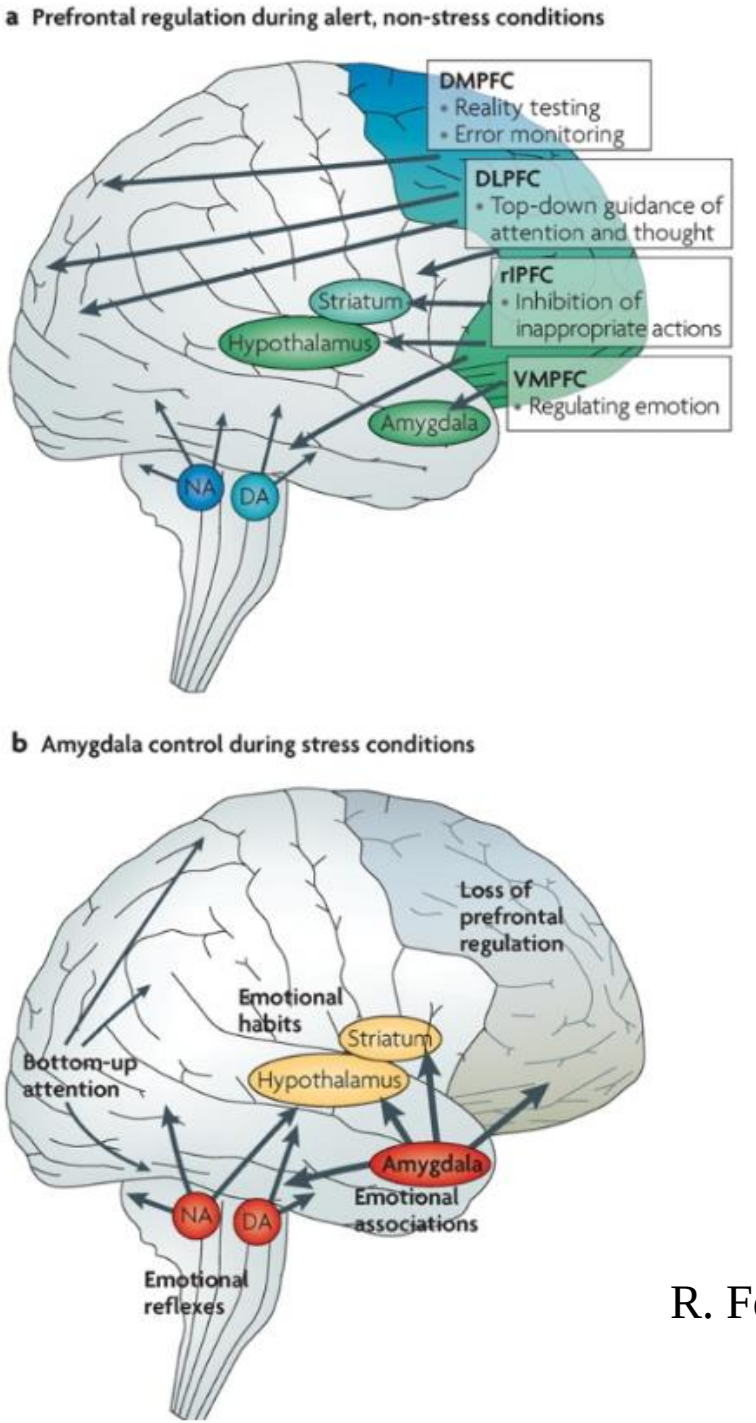
Neuroimaging data: likheter och skillnader mellan psykos och dissociation



Psykos vs dissociation: en hypotes

In subjects relative low on dissociative tendencies, a limbic, amygdala-centred route of information processing may be dominant in stressful situations.
Chronic, repetive stress may produce pressure on the prefrontal network of information processing, leading to *structural and functional compromise of PFC*.

In subjects with high dissociative capacity, dissociation may serve to dampen the limbic-amygdala route of information processing, thus limiting the detrimental impact of this route on the PFC networks.
This would lead to reduced pressure on PFC functions, and, in turn, *fewer deficits in cognitive processes*.



R. Fosse et al, 2018

Transkulturellt Centrum
REGION STOCKHOLM

From diagnosis to treatment: searching for methods

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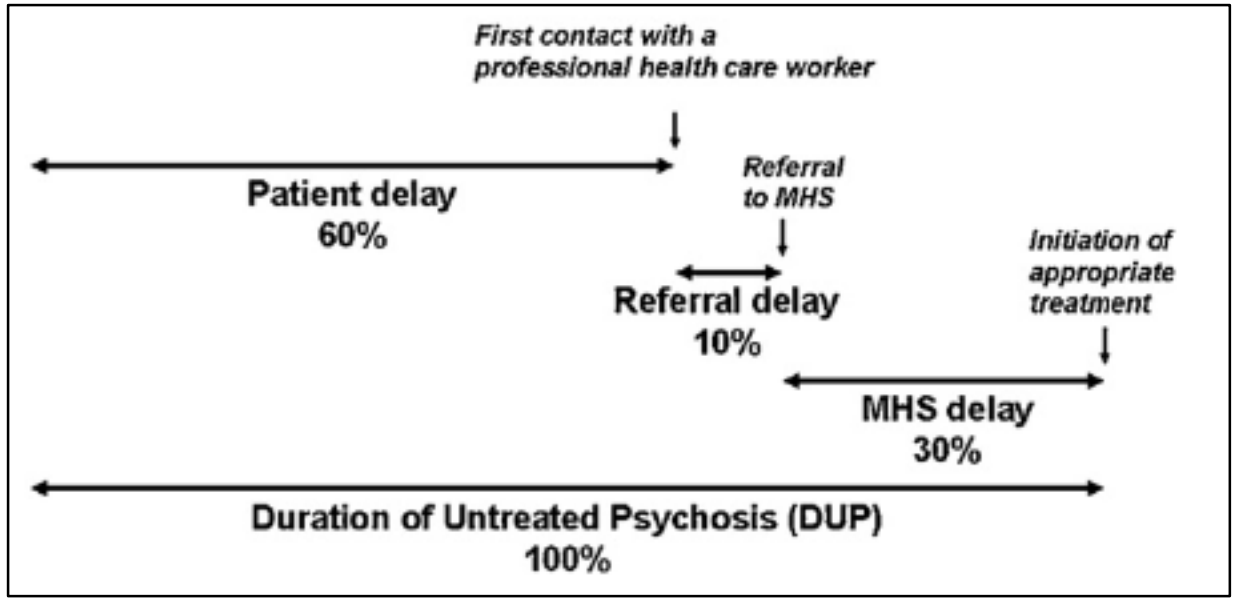
WILEY

REVIEW ARTICLE

Is early management of psychosis designed for migrants? Improving transcultural variable collection when measuring duration of untreated psychosis

Robin Martin[1,2] | Marie Rose Moro[1,3,4] | Laelia Benoit[1,3,5]



Patient-delay was significantly longer for patients from highly urbanized areas and for first generation immigrants.

MHS-delay was longer for patients who were treated already by MHS for other diagnoses.

Towards a more humanistic psychiatry: Development of need-adapted treatment of schizophrenia group psychoses

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(*Received 9 December 2008; final version received 3 February 2009*)

The group of schizophrenic psychoses is clinically and prognostically very heterogeneous. Contradictory views about etiology have had a major negative effect of the development of treatment, especially psychotherapeutic methods. There is an obvious need for more integrated approaches. We should study the development and precipitating factors of every person's psychosis individually and plan his/her treatment on this knowledge.

This has been done in the need-adapted treatment of schizophrenia group psychoses, developed gradually by the author and his co-workers in Finland over 40 years ago. Our aim is a comprehensive and psychotherapeutically oriented treatment approach for public psychiatric health care. A crucial step forward was the initiation of treatment with therapy meetings, including the treatment team, the patient, and his/her family members (or sometimes other persons close to him).

During the last few decades, several projects applying the need-adapted model have been developed. The author describes the experiences and results of some projects and also deals with the use of neuroleptic drugs in connection with the need-adaptive orientation.

Keywords: early intervention; family therapy; integrative approaches; psychodynamic psychotherapy; schizophrenia; treatment planning

- Basic psychotherapeutic attitude
- Development of hospital wards into psychotherapeutic communities
- Development of individual therapeutic relationships
- Development of family therapies and other forms of family-centered work
- Pharmacotherapy regarded as treatment mode supporting psychosocial therapies
- Establishment of comprehensive training and supervision activities to support active participation of all professional groups in therapeutic work
- Development of rehabilitative activities

Nationella riktlinjer för vård och stöd vid schizofreni och schizofreniliknande tillstånd

Stöd för styrning och ledning

Socialstyrelsen

Enhancing the Engagement of Immigrant and Ethnocultural Minority Clients in Canadian Early Intervention Services for Psychosis

The Canadian Journal of Psychiatry / La Revue Canadienne de Psychiatrie
2018, Vol. 63(11) 740-747
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DOI: 10.1177/0706743718773752
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SAGE

Anika Maraj, MD[1,2], Srividya N. Iyer, PhD[1,2,3,4*], and Jai L. Shah, MD, FRCPC[1,2,3*]

- ***Service providers require tools, training, and research for a meaningfully planned cultural adaptation***:
  family involvement is a key predictor of medication adherence and service engagement, as well as of clinical and functional outcomes; importance of family interventions / psychoeducation

  cultural adaptation of psychological therapies for psychosis is possible and could enhance patient engagement and outcomes

  emphasis on therapeutic alliance and engagement, personalized care, and openness to issues around identity, illness models, and worldviews

  openness to patients seeking support from nonmedical sources, such as religious or spiritual groups

- ***Community outreach*** (multilingual pamphlets in GPs' offices, posters in community centers, liaising with religious leaders etc)

- ***Interpreters and Translation Resources*** (https://www.socialstyrelsen.se/stod-i-arbetet/asylsokande-och-andra-flyktingar/samtala-genom-tolk/)

- ***Cultural Brokering*** (consultation services, cultural brokers; Cultural Formulation Interview)

Old images → New visions

Etymologi av vanföreställningar från latin: ”de lira ire” (*jumping out of the furrow*) → ”delirare” (på italienska), ”délire” (franska) → metaforiskt, att komma ur ett logiskt resonemang, att tänka på ett osammanhängande sätt

"Though we are far from being able to explain all the relationships in that obscure world, we can mantain with complete assurance that in dementia praecox ***there is no symptom which could be described as psychologically groundless or meaningless****.*

Even the most absurd things are nothing other than symbols for thoughts which are not only understandable in human terms, but dwell in every human breast. In insanity, we do not discover anything new and unknown, we are looking at the foundations of our own being, the matrix of those vital problems on which we are all engaged”

C. Jung, in Zurich public lecture (January 1908)

www.transkulturelltcentrum.se