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Transkulturelle Psychiatrie aus medizinischer Sicht

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Universitätsklinik für Psychiatrie und Psychotherapie
Universität Bern

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Überblick

- Global Burden of Disease
- Epidemiologie
- Einflussfaktoren auf Krankheitsbilder durch Migration
  - am Beispiel von Migranten aus Afrika
  - am Beispiel des Klimawandels
- Migrationsspezifische Aspekte der Diagnostik und Therapiegestaltung
- Eine kurze Übersicht über das Vorgehen in den UPD

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GLOBAL BURDEN OF DISEASE

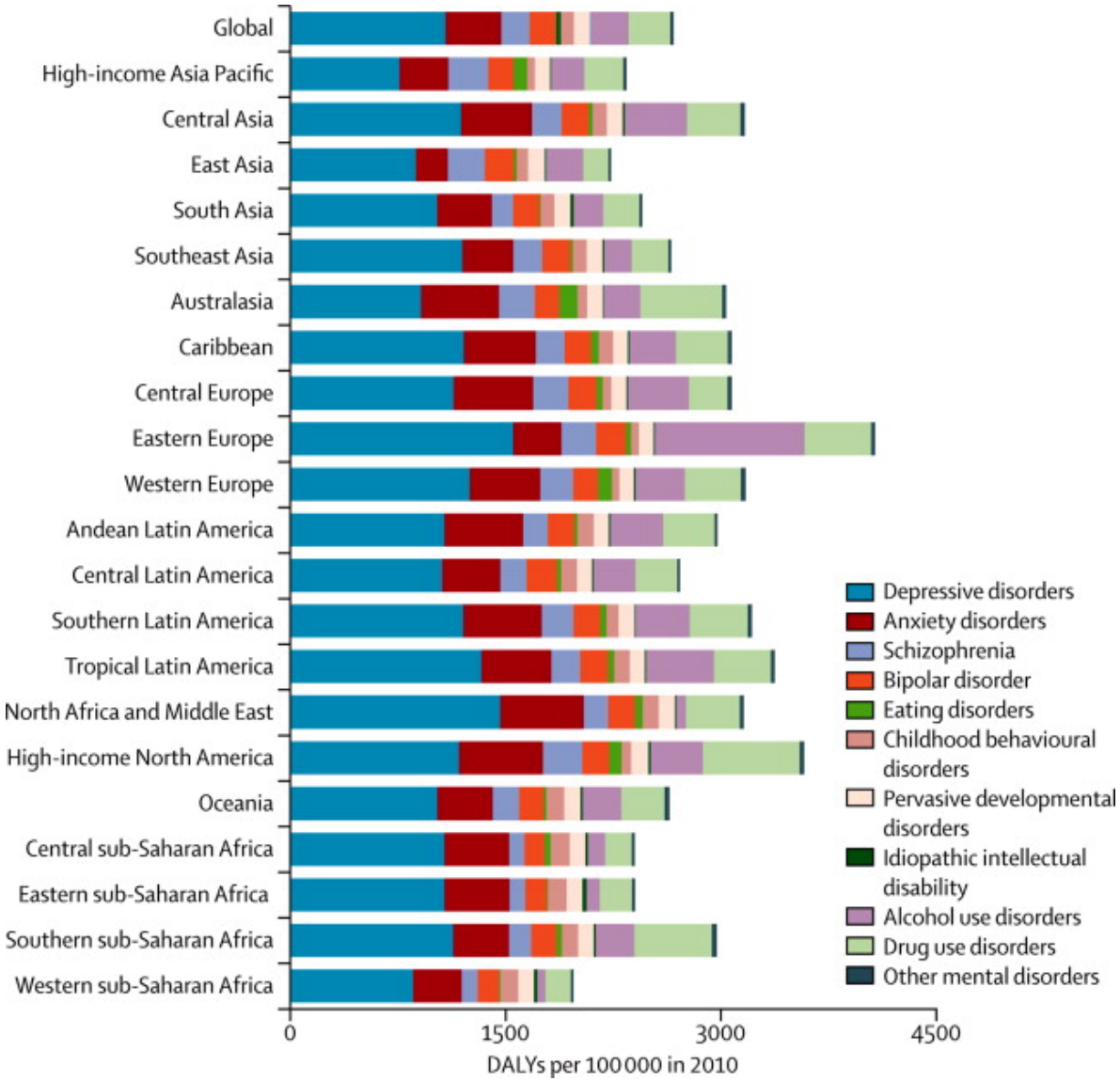

Figure 4. Rates of disability-adjusted life years (DALYs) per 100 000 individuals for mental and substance use disorders in 2010, by region

Harvey A Whiteford, Louisa Degenhardt, Jürgen Rehm, Amanda J Baxter, Alize J Ferrari, Holly E Erskine, Fiona J Charlson, Rosana E Norman, Abraham D Flaxman, Nicole Johns, Roy Burstein, Christopher JL Murray, Theo Vos

Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010

null, Volume 382, Issue 9904, 2013, 1575–1586

http://dx.doi.org/10.1016/S0140-6736(13)61611-6

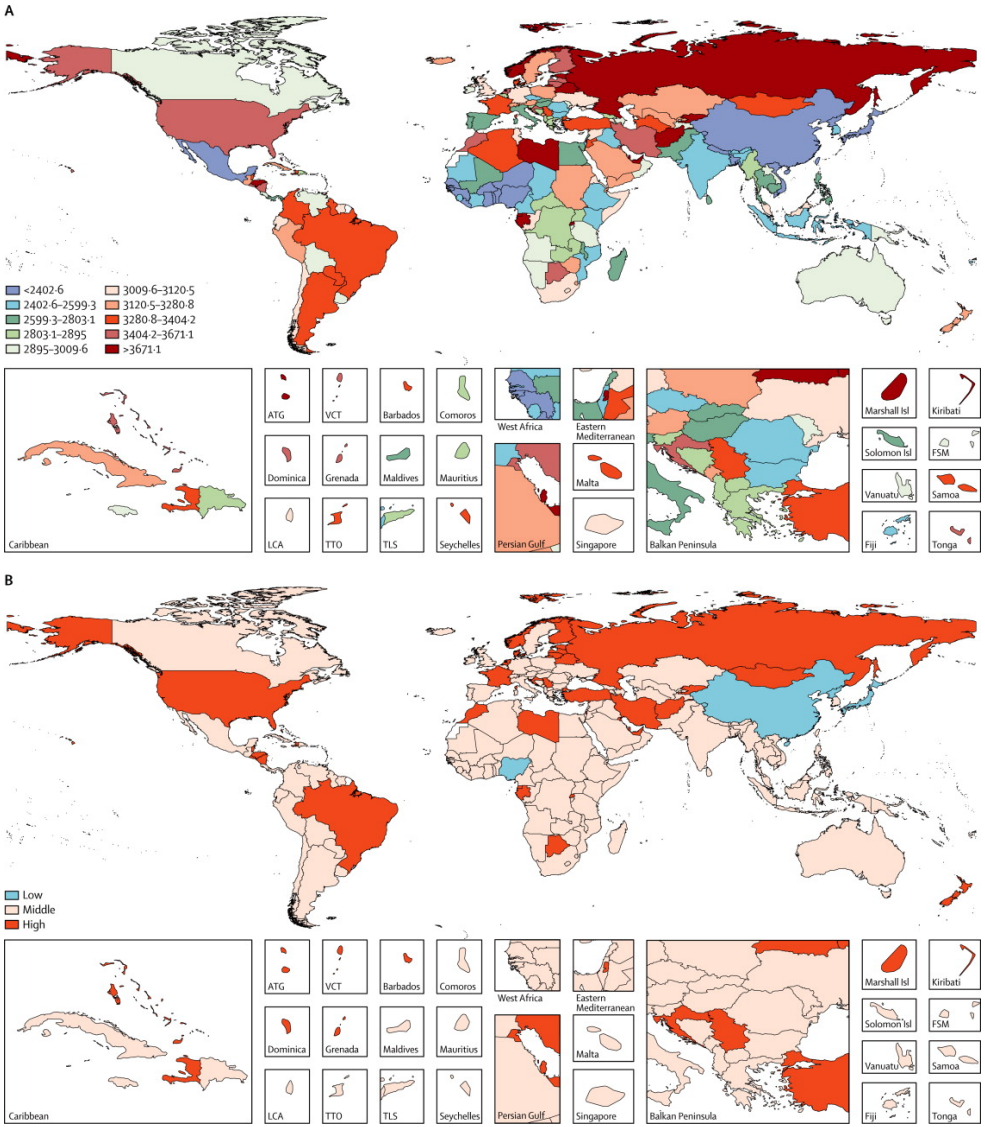

Figure 5. DALY rates per 100 000 individuals for mental and substance use disorders in 2010(A) Age-standardised DALY rates per 100 000 individuals. (B) Age-standardised DALY rates compared with the global mean. DALYs=disability-adjusted life years. Low=signifi...

Harvey A Whiteford, Louisa Degenhardt, Jürgen Rehm, Amanda J Baxter, Alize J Ferrari, Holly E Erskine, Fiona J Charlson, Rosana E Norman, Abraham D Flaxman, Nicole Johns, Roy Burstein, Christopher JL Murray, Theo Vos
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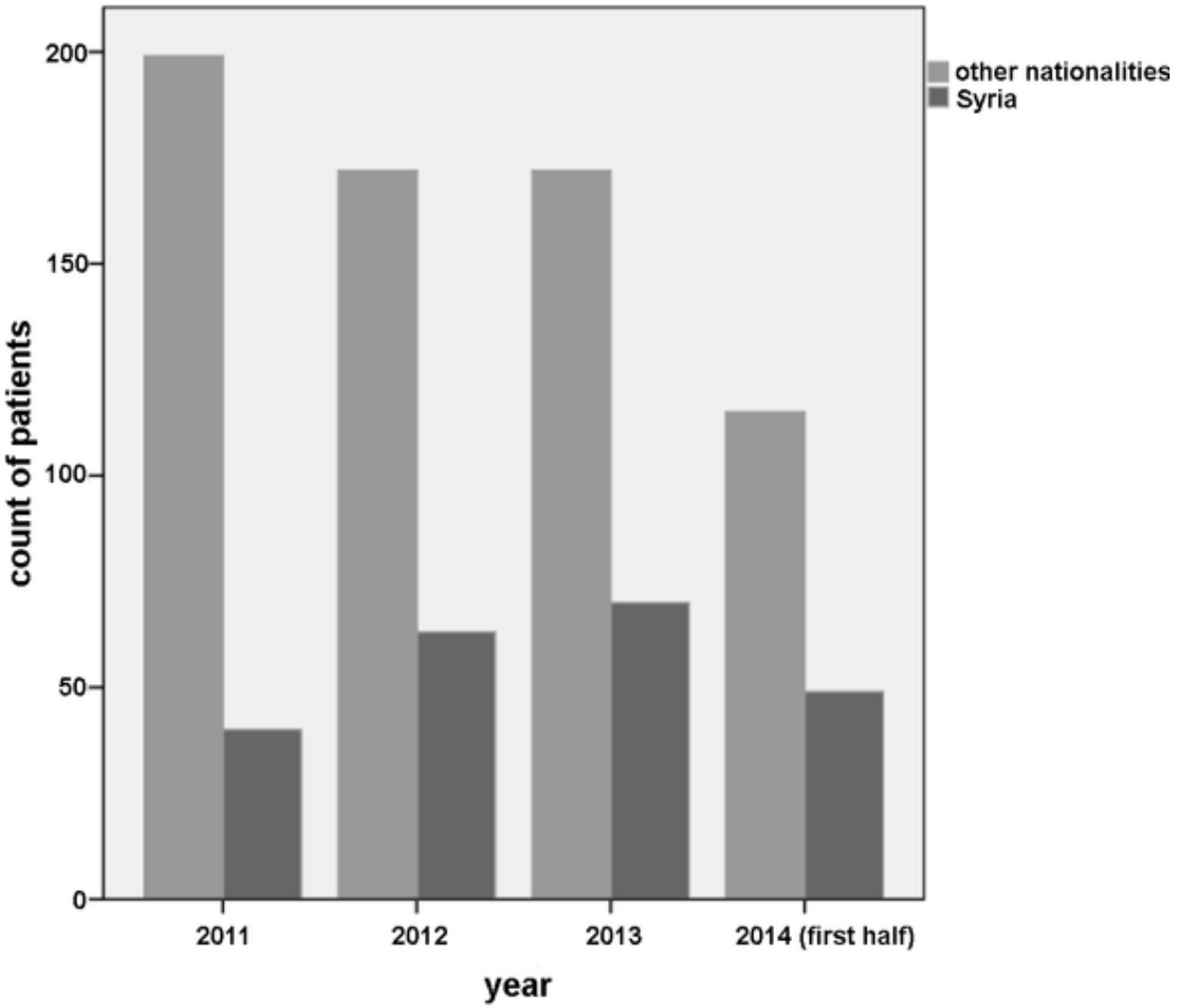
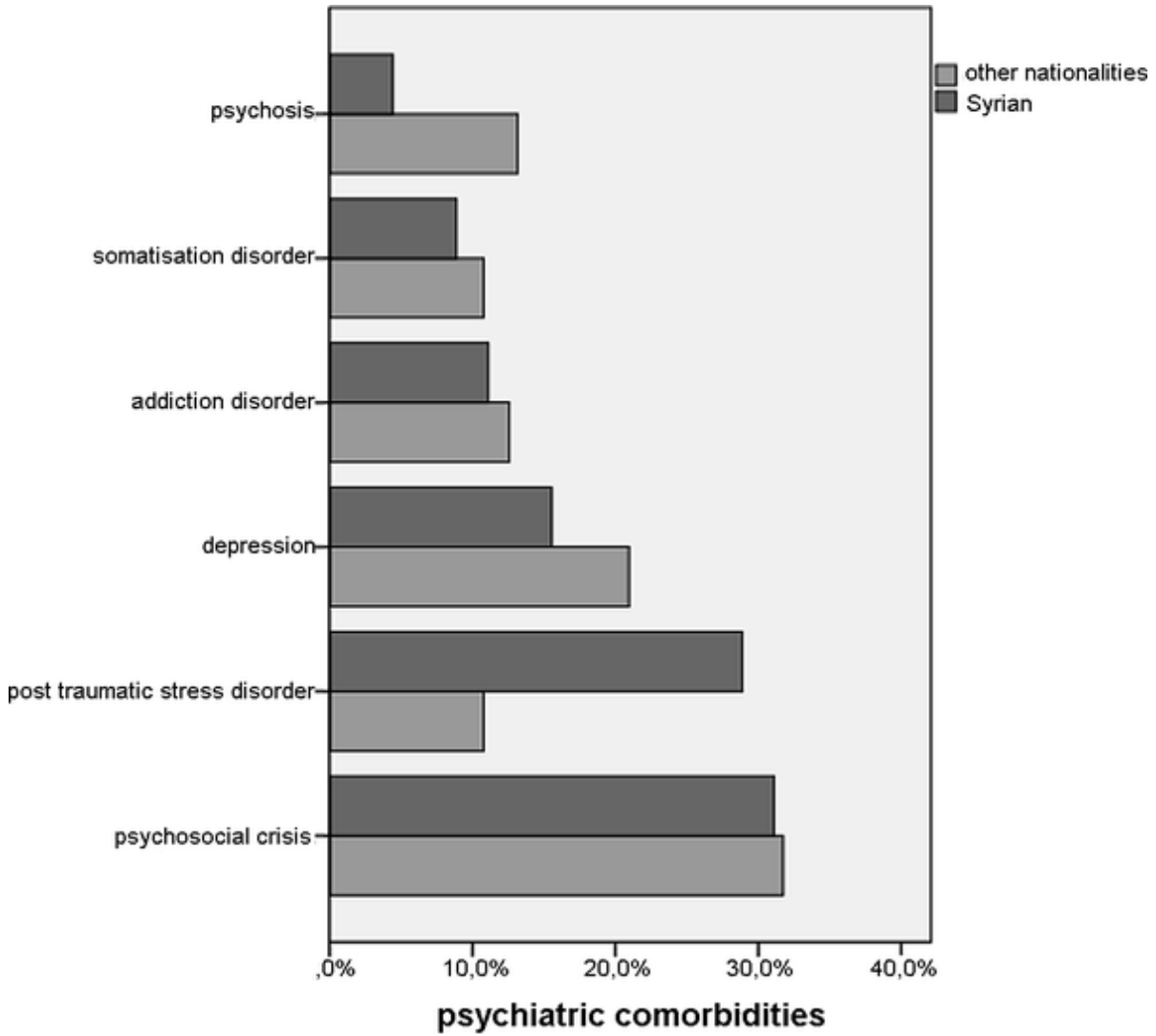
EPIDEMIOLOGIE

Fig 2. Number of patients presenting to emergency department by year and country of origin.



Pfortmueller CA, Schwetlick M, **Mueller T**, Lehmann B, Exadaktylos AK (2016) Adult Asylum Seekers from the Middle East Including Syria in Central Europe: What Are Their Health Care Problems?. PLoS ONE 11(2): e0148196. doi:10.1371/journal.pone.0148196
http://journals.plos.org/plosone/article?id=info:doi/10.1371/journal.pone.0148196

Fig 3. Overview of psychiatric co-morbidities by country of origin.



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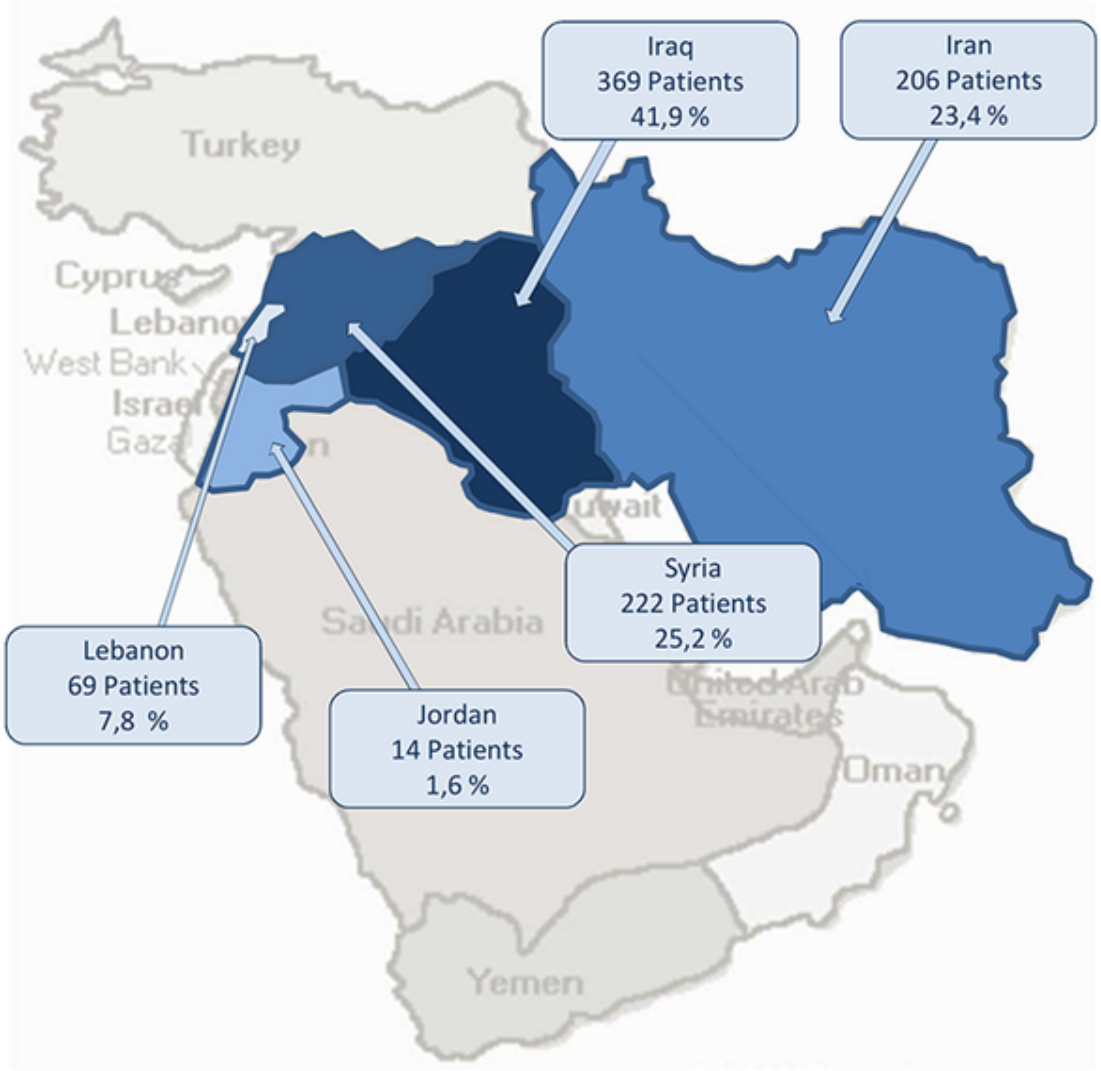
http://journals.plos.org/plosone/article?id=info:doi/10.1371/journal.pone.0148196

Fig 1. Overview of patients' origins.



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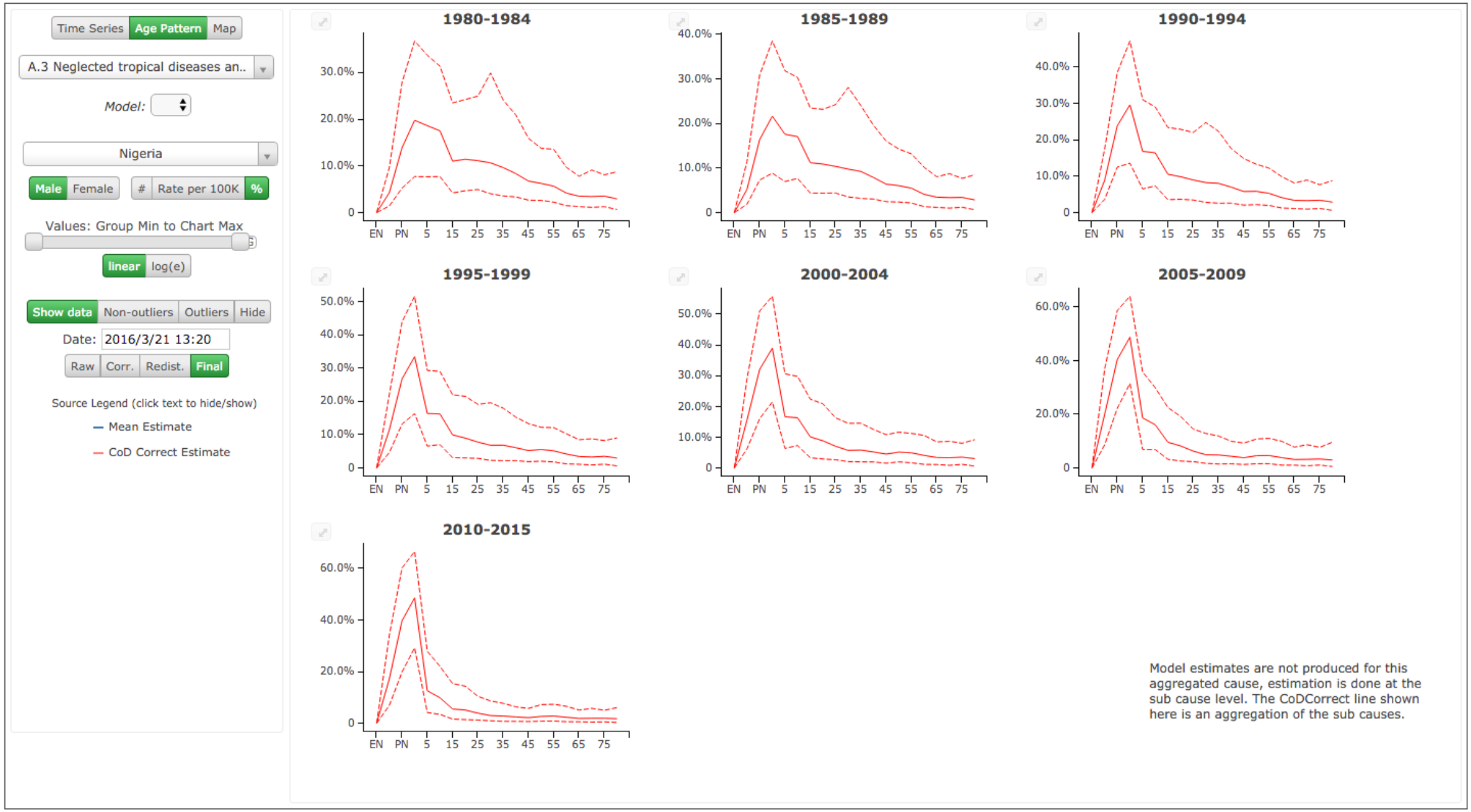
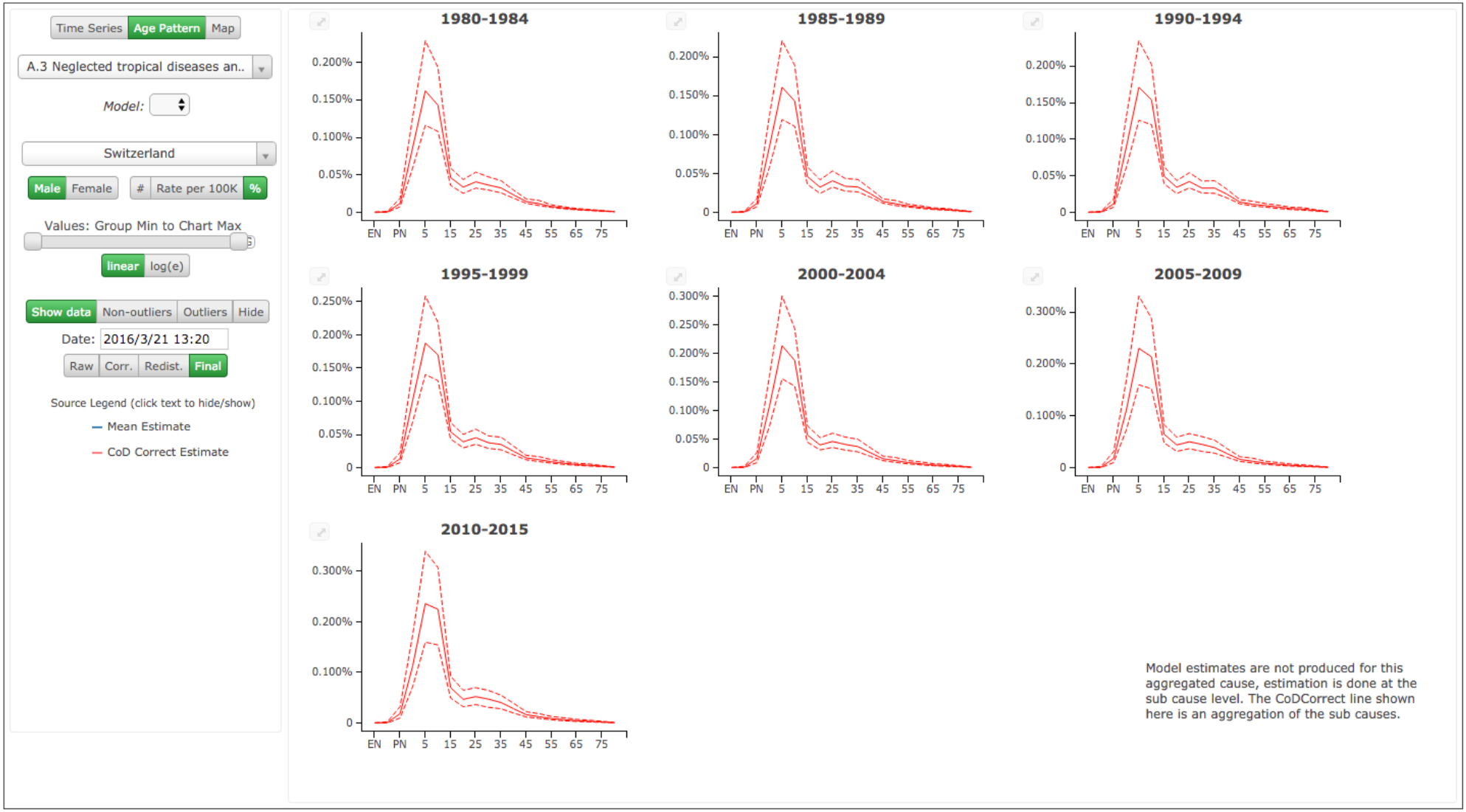
Causes of Death (COD) Visualization | Viz Hub



http://ihmeuw.org/3s9h

Causes of Death (COD) Visualization | Viz Hub



http://ihmeuw.org/3s9h

BMJ 2013;347:f7375 doi: 10.1136/bmj.f7375 (Published 10 December 2013)

FEATURE

HUMANITARIAN DISASTERS

Syria: a healthcare system on the brink of collapse

Destroyed hospitals and severe shortages of doctors and drugs are taking their toll in Syria after more than two years of civil war, which has led to more than 100 000 deaths, millions of displaced people, and the re-emergence of polio, writes **Keir Stone-Brown**

Syrian civil war in numbers

80 000—Doctors who have fled the conflict; 37 000 remain

32—Syrian Red Crescent medical volunteers killed in the conflict

>100 000—Deaths since the conflict began

60%—Polio vaccination rate (down from 90%)

10 years—Estimated time to rebuild facilities if the conflict stopped now

2.2 million—Refugees in neighbouring countries

Sources: WHO and other United Nations agencies

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KLIMAWANDEL: MOTOR DER MIGRATION UND DESSEN FOLGEN

Ältere Farmer in Australien

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> Wichtig: kurzfristige Ereignisse kaum vorhersagbar ⇒ unkontrollierbar und somit erhöhte Stresswirkung

What is already known on this subject:

- *Farming is tough but farmers are well adapted to Australia's extreme climate variability and tend to enjoy good mental health and well-being.*
- *Climate change is likely to increase climate variability, bringing more frequent, intense and prolonged weather-related disasters such as floods, storms, fires and droughts, with likely adverse impacts on agricultural livelihoods.*
- *Prolonged and multiple adversity is a risk factor for mental health problems, including among farmers. The recent Australian drought brought such adversity, compromising the health and well-being of farming families and communities.*

What this study adds:

- *Older farmers faced the same drought-related pressures as their younger peers but these pressures were compounded by the discomforts of ageing and by fighting a losing battle to cope with rapid social and agricultural change.*
- *Older farmers' mental health was compromised by these chronic, severe pressures and, above all, by an intense and pervasive sense of loss.*
- *Older farmers did not have available, or were reluctant to use, mental health services. Services would be more acceptable and accessible if offered in familiar, comfortable settings by known and trusted providers.*

Polain et al. Rapid change, climate adversity and the next 'big dry': Older farmers' mental health *Aust. J. Rural Health* (2011) **19,** 239–243

Klimaveränderungen und Landwirtschaft: psychische Folgen

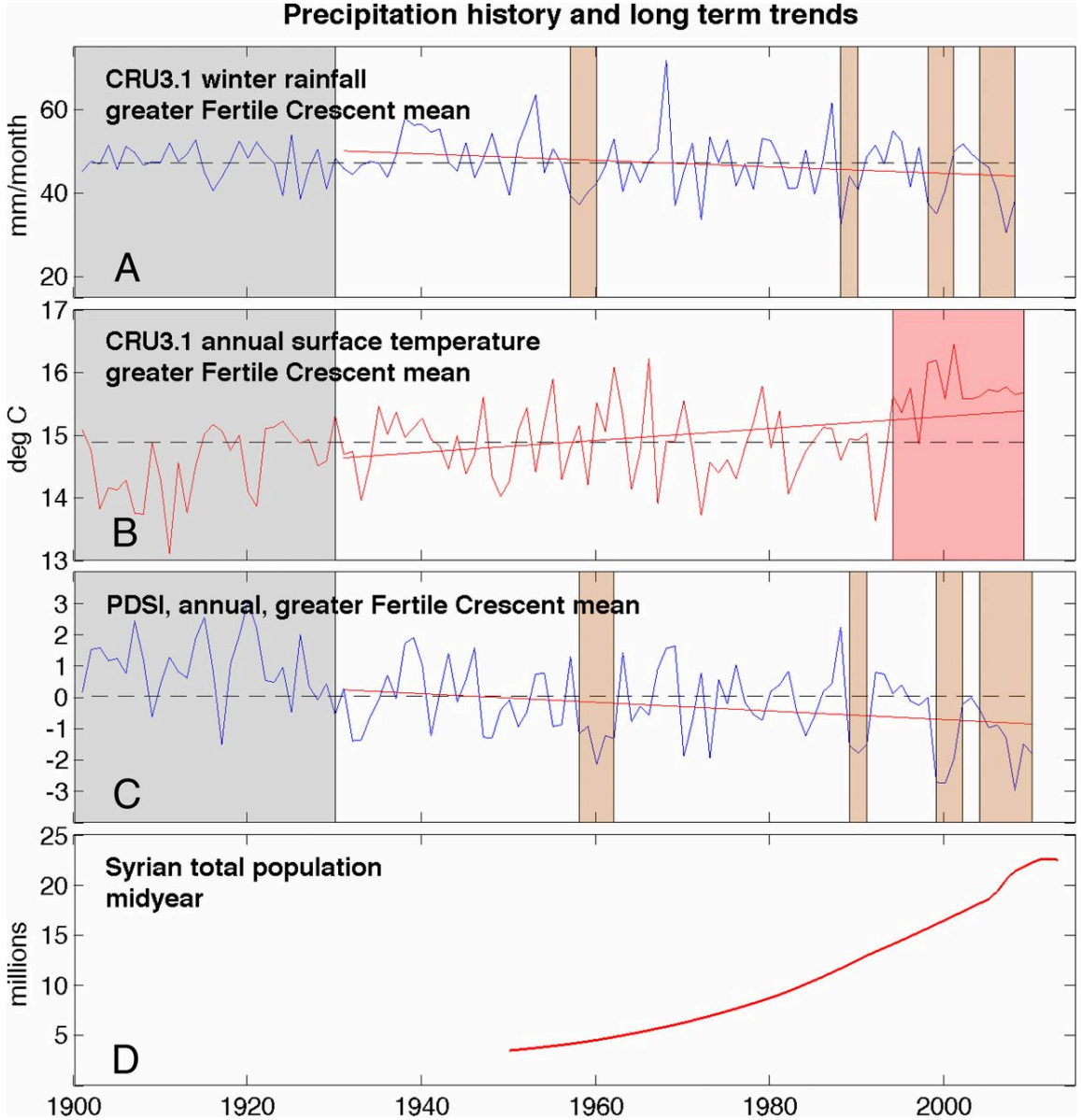
- Landwirtschaft an sich schon sehr anstrengend
- Klimawandel →
  - kurzfristige Folgen (Überschwemmungen und Dürre)
  - Langfristiger Wandel: andere Früchte, Aufgeben von Land...
- Zunahme von Suiziden bei entsprechenden Ereignissen
  - Suizidrate in Australien bei Farmern ↑ als in Normalbevölkerung
  - Suizidrate in Indien und Kenia auf Grund von Dürren bis auf das 6-fache gestiegen
- Langfristig: Landflucht mit psychischen Folgen für die Zurückgebliebenen

DAILY NEWS 2 March 2015

Droughts in Syria and California linked to climate change

Unrest may be linked to climate change
(Image: United Nation Relief and Works Agency via Getty Images)

(A) Six-month winter (November−April mean) Syria area mean precipitation, using CRU3.1 gridded data.



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BESONDERHEITEN IM UMGANG MIT MIGRANTEN

Migrationsspezifische Anamnese

Leben vor der Migration: Genaue Herkunft (Land, Region); Muttersprache, allfällige Zweit- und Drittsprachen; Herkunft und Zusammensetzung der Familie; soziale Schicht; Ethnie; Religion; Schule und Ausbildung; Beruf; Arbeitserfahrung; Militärdienst; Normen und Werte; Sitten; Erfahrungen mit dem Gesundheitswesen; Gesundheit, Krankheit, Unfälle, Traumata; Trennungen, Schicksalsschläge.

Migration: Gründe, Ursachen, Wünsche, Ziele, Verluste, Umstände der Migration, Dauer der Reise, Flucht?, Begleitpersonen, Erlebnisse auf der Reise.

Leben nach der Migration: Aufenthaltsstatus; Familie, soziales Netz; Arbeit, Beruf, Ausbildung; Spracherwerb; ökonomische Situation; Asylverfahren?; Möglichkeit zur Rückkehr ins Heimatland?, Ferien in der Heimat?, Kontakt zur Heimat; Lebensstil, Integration; Gesundheitszustand, Krankheiten, Unfälle, Erfahrungen mit dem Gesundheitswesen; Pläne, Zukunftsperspektiven?; Migrationsbilanz, Enttäuschung?

Therapeutische Umschau 2015; 72 (10): DOI 10.1024/0040-5930/a000732

Konkrete Empfehlungen zur Abklärung von Suizidalität bei Migranten

- höfliche, respektvolle Beziehungsaufnahme, Vertrauen schaffen
- bei Sprachproblemen professionellen Dolmetscher beiziehen, im Notfall Telefondolmetscher
- Thema Suizidalität offen ansprechen, Formulierungshilfen für die Kommunikation geben
- Patienten sprechen lassen, gut zuhören
- sich genügend Zeit nehmen, ggf. in Absprache mit Patient Angehörige oder andere Vertrauenspersonen des Patienten beiziehen
- offen und transparent sein zur Beurteilung und zu den fachlichen Überlegungen
- Ausführlich informieren über mögliche Massnahmen und Hilfestellungen
- Risikosituationen[1]: drohende Ausschaffung bei abgewiesenen Asylsuchenden,
  innerfamiliäre Konflikte,
  gescheitertes Migrationsprojekt

Therapeutische Umschau 2015; 72 (10): DOI 10.1024/0040-5930/a000732

Common mental health problems in immigrants and refugees: general approach in primary care

Laurence J. Kirmayer MD, Lavanya Narasiah MD MSc, Marie Munoz MD, Meb Rashid MD, Andrew G. Ryder PhD, Jaswant Guzder MD, Ghayda Hassan PhD, Cécile Rousseau MD MSc, Kevin Pottie MD MClSc; for the Canadian Collaboration for Immigrant and Refugee Health (CCIRH)

Table 1: Factors related to migration that affect mental health[12–23]

Premigration	Migration	Postmigration
Adult		
Economic, educational and occupational status in country of origin	Trajectory (route, duration)	Uncertainty about immigration or refugee status
Disruption of social support, roles and network	Exposure to harsh living conditions (e.g., refugee camps)	Unemployment or underemployment
Trauma (type, severity, perceived level of threat, number of episodes)	Exposure to violence	Loss of social status
Political involvement (commitment to a cause)	Disruption of family and community networks	Loss of family and community social supports
	Uncertainty about outcome of migration	Concern about family members left behind and possibility for reunification
		Difficulties in language learning, acculturation and adaptation (e.g., change in sex roles)
Child		
Age and developmental stage at migration	Separation from caregiver	Stresses related to family's adaptation
Disruption of education	Exposure to violence	Difficulties with education in new language
Separation from extended family and peer networks	Exposure to harsh living conditions (e.g., refugee camps)	Acculturation (e.g., ethnic and religious identity; sex role conflicts; intergenerational conflict within family)
	Poor nutrition	Discrimination and social exclusion (at school or with peers)
	Uncertainty about future	

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MIGRATION ≠ KRANKHEIT!

Common mental health problems in immigrants and refugees: general approach in primary care

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Key points

- Among immigrants, the prevalence of common mental health problems is initially lower than in the general population, but over time, it increases to become similar to that in the general population.
- Refugees who have had severe exposure to violence often have higher rates of trauma-related disorders, including post-traumatic stress disorder and chronic pain or other somatic syndromes.
- Assessment of risk for mental health problems includes consideration of premigration exposures, stresses and uncertainty during migration, and postmigration resettlement experiences that influence adaptation and health outcomes.
- Clinical assessment and treatment effectiveness can be improved with the use of trained interpreters and culture brokers when linguistic and cultural differences impede communication and mutual understanding.

> Zu Beginn niedrigere Prävalenzen psychischer Störungen bei Migranten; nach gewisser Zeit Angleichen der Raten

> Aber: höhere Raten an PTSD, chronische Schmerzsyndrome bei Opfern von Gewalt und Folter

Cultural identity
Individual's ethnic or cultural reference group
Degree of involvement with cultures of origin and host culture for immigrants and ethnic minorities
Language abilities, use, and preference
Cultural explanations of illness
Idioms of distress used to communicate symptoms or need for supports
Meaning and severity of symptoms compared to the cultural reference group
Local illness categories used by the family or group to describe symptoms
Perceived causes and explanatory models for the illness
Preferences and experiences with professional and popular sources of care
Cultural factors related to psychosocial environment and levels of functioning
Relevant interpretations of social supports, stressors, and level of functioning and disability
Stresses in the local social environment
Role of religion and kin networks in providing support
Cultural elements of the physician-patient relationship
Individual differences in culture and social status between patient and clinician
Problems these individual differences may cause in diagnosis and treatment
Overall cultural assessment for diagnosis and care
Cultural considerations that specifically influence comprehensive diagnosis and care

Source: Adapted with permission from the DSM-IV[1]

The Psychiatric Cultural Formulation: Translating Medical Anthropology into Clinical Practice.
AGGARWAL, NEIL; KRISHAN MD, MA

Journal of Psychiatric Practice. 18(2):73-85, March 2012.
Digital Object Identifier:
10.1097/01.pra.0000413273.01682.05

Table 1 Cultural Formulation Axes

Soc Psychiatry Psychiatr Epidemiol (2008) 43:507–515 DOI 10.1007/s00127-008-0333-1

ORIGINAL PAPER

Cornelis J. Laban · Ivan H. Komproe · Hajo B.P.E. Gernaat · Joop T.V.M. de Jong

The impact of a long asylum procedure on quality of life, disability and physical health in Iraqi asylum seekers in the Netherlands

Table 2 Quality of life (QoL) and disability in at random samples of Iraqi asylum seekers arrived <6 months (Group 1) and >2 years (Group 2) in the Netherlands, 2000–2001

QoL	Group 1 (n = 143) Mean (SD)	Group 2 (n = 151) Mean (SD)	Total (n = 294) Mean (SD)	P value	α[a]
Overall[b]	2.88 (0.99)	2.23 (1.14)	2.55 (1.11)	$P < 0.0005$, $Z(294) = -5.29$	
Perceived general health[b]	3.06 (1.15)	2.74 (1.27)	2.89 (1.22)	$P = 0.017$, $Z(294) = -2.39$	
Domains					
Physical health[c]	55.08 (19.72)	47.50 (20.72)	51.19 (20.58)	$P = 0.001$, $t(292) = 3.21$	0.8372
Psychological health[c]	50.00 (15.82)	45.28 (18.70)	47.58 (17.49)	$P = 0.020$, $t(292) = 2.33$	0.7446
Social relationships[c]	49.38 (22.18)	46.60 (21.51)	47.96 (21.85)	NS	0.7103
Environment[c]	43.57 (14.87)	37.17 (17.27)	40.29 (16.47)	$P = 0.001$, $t(292) = 5.26$	0.8133
Disability					
Physical and Role Disability (BDQTot)[d]	17.31 (7.43)	19.25 (6.77)	18.30 (7.15)	$P = 0.020$, $t(292) = -2.34$	0.9488
Days of disability (BDQdays)[e]	5.37 (8.24)	7.68 (9.17)	6.56 (8.80)	$P = 0.024$, $t(292) = -2.27$	

Soc Psychiatry Psychiatr Epidemiol (2008) 43:507–515 DOI 10.1007/s00127-008-0333-1

ORIGINAL PAPER

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The impact of a long asylum procedure on quality of life, disability and physical health in Iraqi asylum seekers in the Netherlands

Table 3 Perceived physical health, chronic physical complaints and physical handicaps in at random samples of Iraqi asylum seekers arrived <6 months (Group 1) and >2 years (Group 2) in the Netherlands, 2000–2001

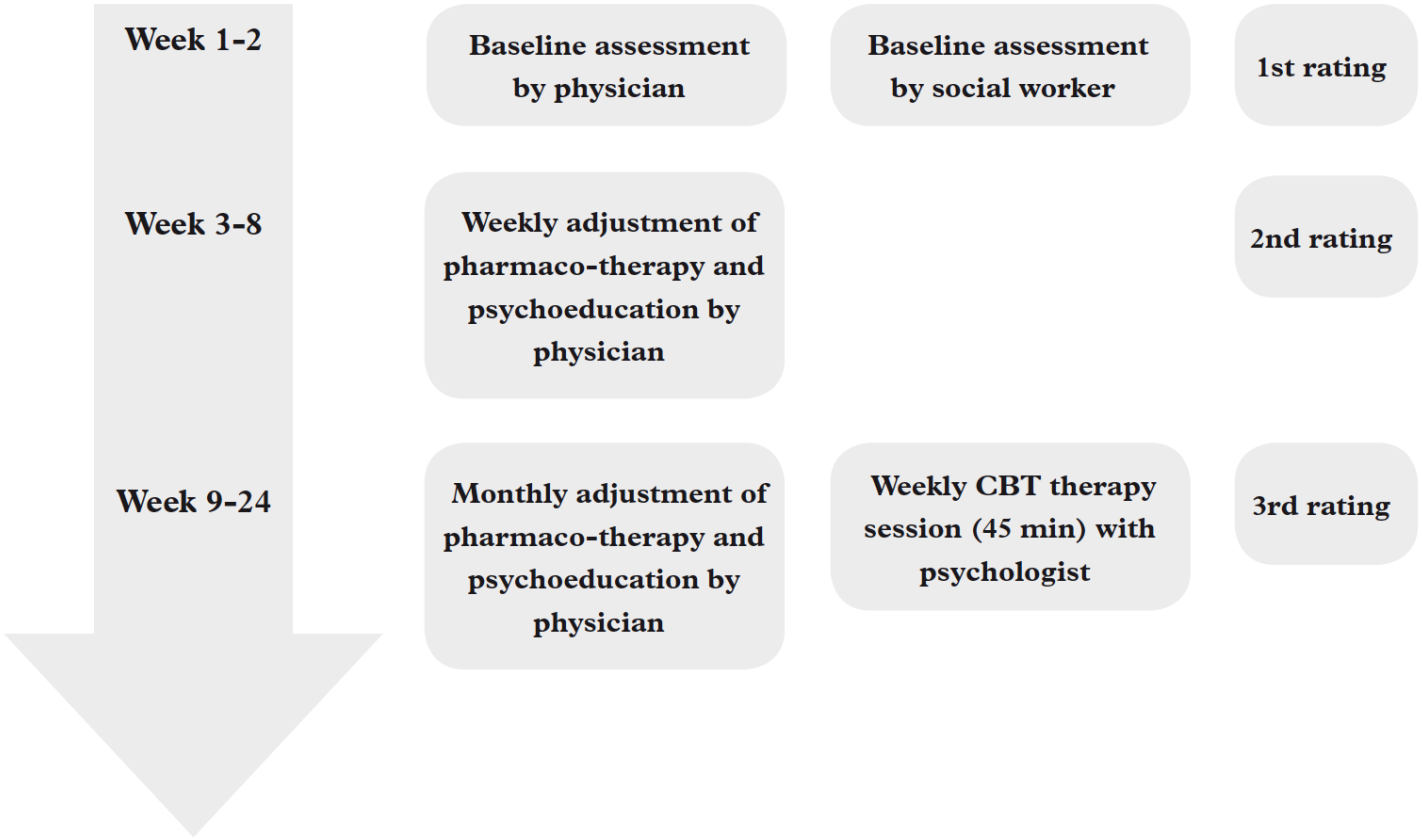
	Group 1 (n = 143)	Group 2 (n = 151)	Total (n = 294)	P value
Perceived physical health[a] (Mean, SD)	2.87 (1.21)	3.25 (1.14)	3.06 (1.19)	$P = 0.001$, $Z(292) = -3.27$
Chronic physical complaints (%)				
One or more physical complaint	38.5	66.2	52.6	$P < 0.0005$, $\chi^2(6) = 31.857$
Dizziness with falling	17.5	32.5	25.2	$P = 0.003$, $\chi^2(1) = 8.736$
Headache >3 months	15.4	33.8	24.8	$P < 0.0005$, $\chi^2(1) = 13.308$
Back problems >3 months	11.9	31.1	21.8	$P < 0.0005$, $\chi^2(1) = 15,961$
Stomach problems	14.7	27.8	21.4	$P = 0.006$, $\chi^2(1) = 7.519$
Joints problems >3 months	14.7	26.5	20.7	$P = 0.013$, $\chi^2(1) = 6.224$
Intestinal problems >3 months	9.1	9.9	9.5	NS
Physical handicap	5.6	8.0	6.8	NS

NS Not significant, $P \geq 0.05$
[a]Scale of 1 (very good)–5 (very bad)

Follow-up study of the treatment outcomes at a psychiatric trauma clinic for refugees

Cæcilie Buhmann, MD, PhD*, Erik Lykke Mortensen, MSc**, Merete Nordentoft, DrMSc***, Jasmina Ryberg, MD*, Morten Ekstrøm, MD, PhD*

Figure 1: *Standard treatment flow and ratings*



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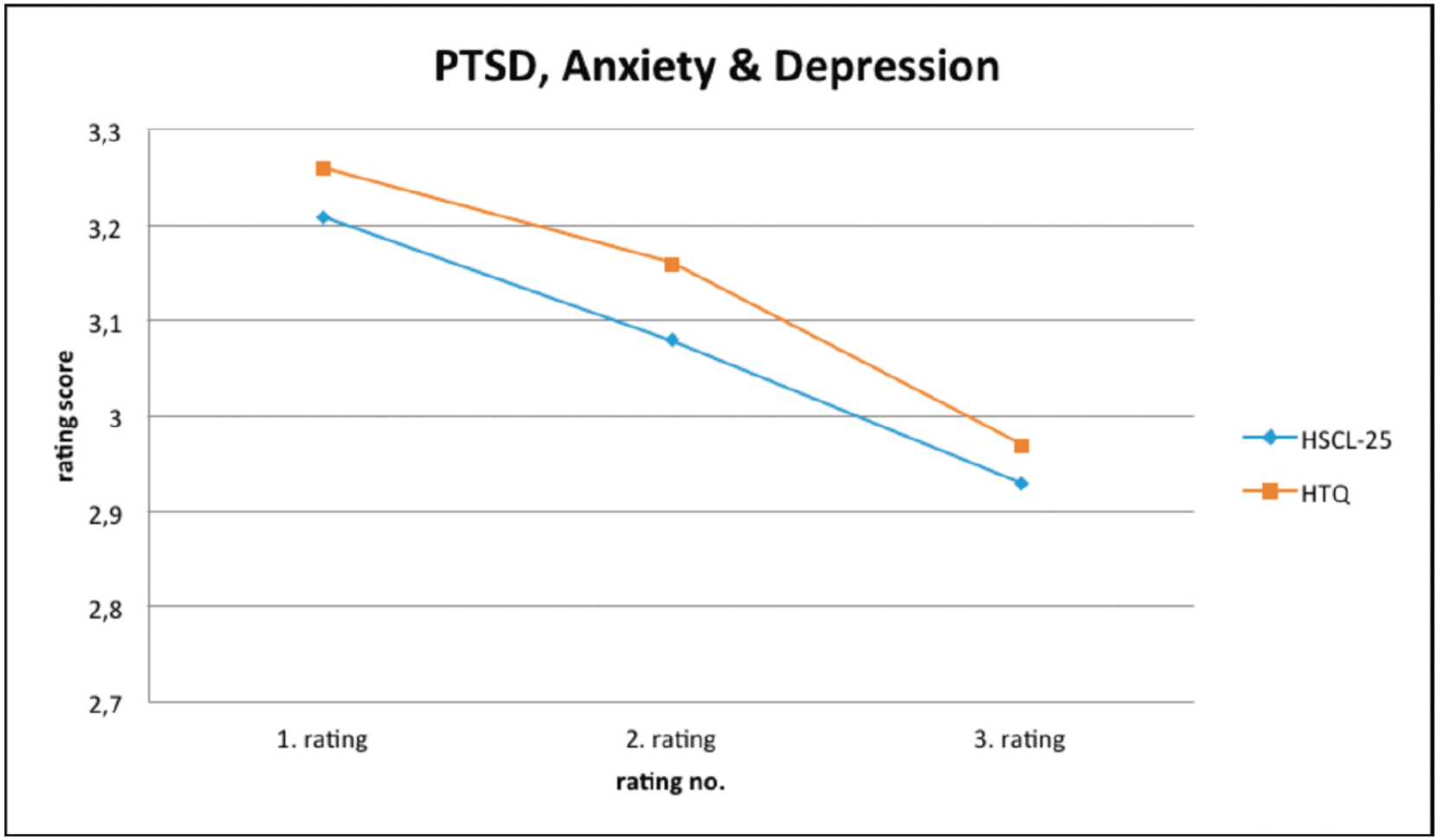

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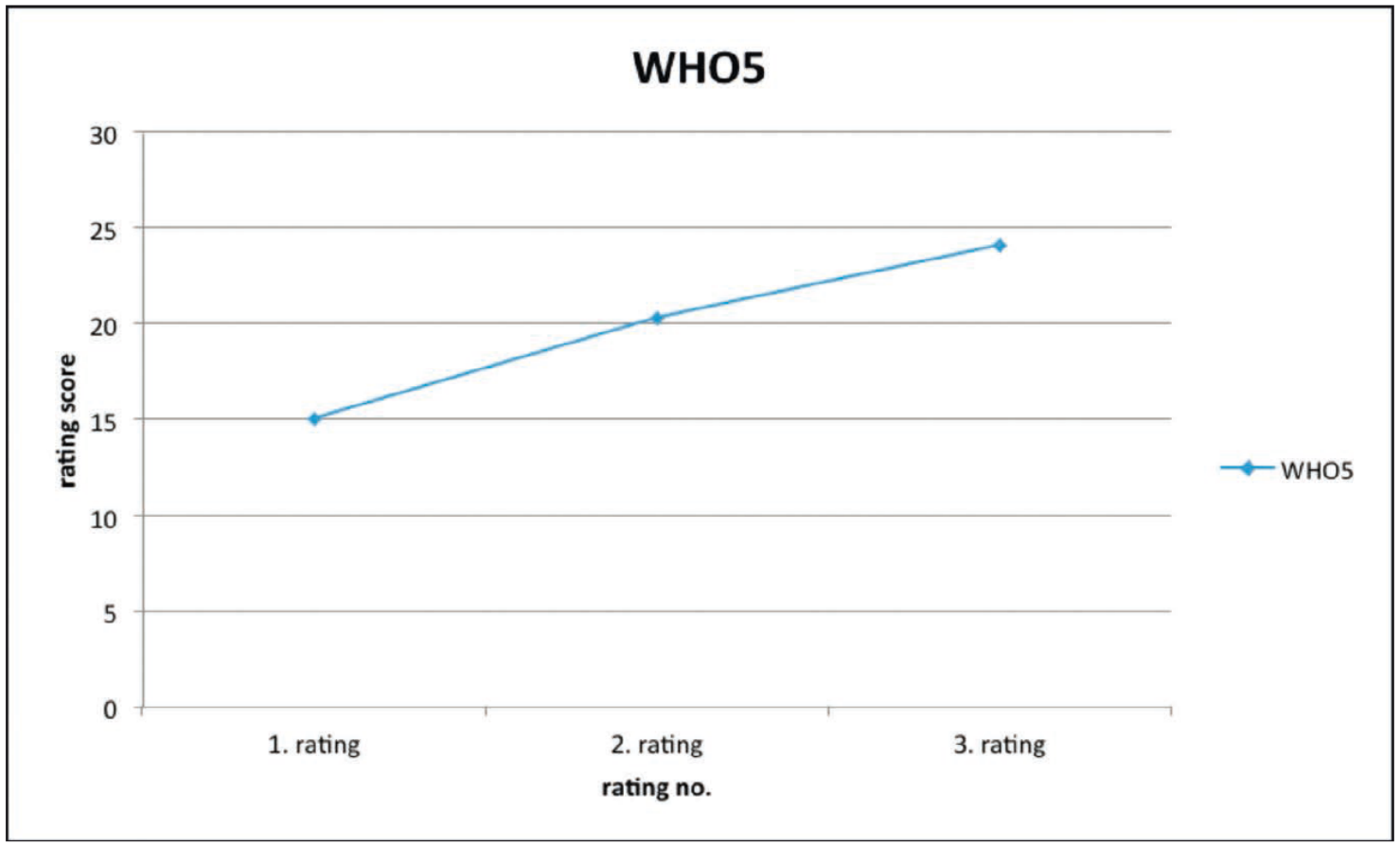
Figure 4: *Change in quality of life*



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ABLAUF IN DEN UPD

Allgemeines Vorgehen

- Vorstellung im Universitären Notfallzentrum (UNZ) des Inselspitals oder im KIZ (insbesondere ambulante Krisenintervention)
- Abklärung von somatischen und psychiatrischen Störungen

- Ggf. Zuweisung zu den fachspezifischen Angeboten
  - Insomnie
  - Angst-Zwang
  - Psychose
  - ...
  - ...
  - **Transkulturelle Psychiatrie**

Sprechstunde für Transkulturelle Psychiatrie

- multidisziplinäre Beratung und Therapie für psychisch kranke Migrantinnen und Migranten (Fokus PTSD)
- 3 Module
- Ansprechpartnerin: Dr. med. Agnes Meyer

Beratung Abklärung	Psychotherapie	Gruppentherapien
•Max. 3 Termine bei Psychologin unter Einbezug einer Psychiaterin •Bei Bedarf mit Übersetzung •Bei Bedarf Sozialberatung •Auch im Sinne von "walk in" Krisenintervention •Ziel ist Beratung mit entweder Lösung der Grundproblematik oder interne/externe Triagierung	• Spezialpsychotherapien Schwerpunkt "Traumatherapie" • Bei Bedarf mit Übersetzung	• Bewegungstherapie für Frauen • Bewegungstherapie für Männer • Ressourcenaktivierende Gruppe für Frauen • Psychoedukative Gruppe für traumatisierte Frauen • Kunsttherapiegruppe für kurdische Flüchtlinge • Teils mit einleitender Übersetzung