

**MIGRATION, PSYCHOSIS
AND COMPULSIVE
HOSPITALIZATION IN
THE POPULATION OF
LOURES – THE PATH TO
SOCIAL DEFEAT**

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MIGRATION AND THE SOCIO-DEVELOPMENTAL MODEL OF PSYCHOSIS

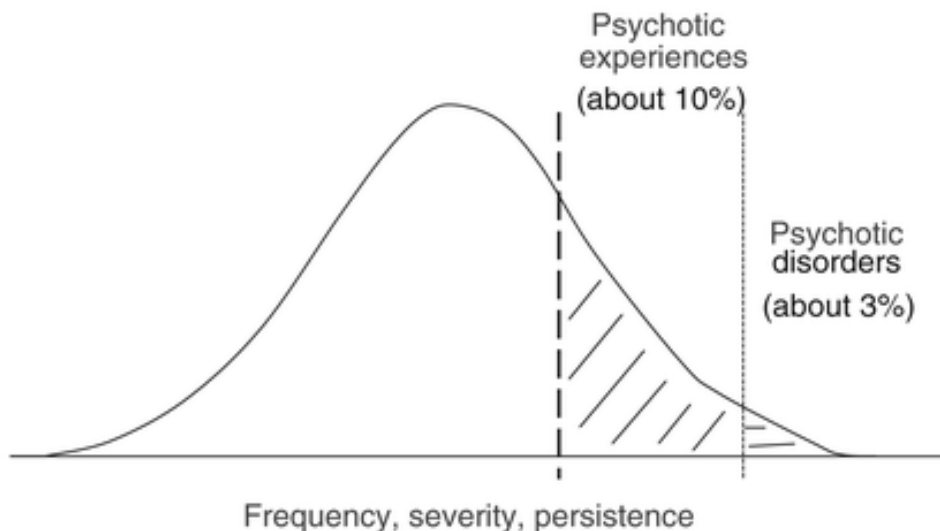
After several conceptions that have dominated over time have referred to mental disorder in an almost deterministic perspective, of causes or consequences of another physical or health condition, family or social, it is expected today that mental illness is interdependent on multiple factors, and must be observed in a holistic and systemic dimension. Society conditions and is in turn conditioned by these disorders, a perspective that has become a continuum of concern and intervention on the part of public health, in order to guarantee the conditions for the promotion of mental health. (Ministry of Health, 2015, p.154)

One aspect that characterizes the modern world is large-scale migration, within and between countries, which leads to an increase in cultural and ethnic diversity in different places. The number of international migrants worldwide was, in 2017, around 258 million, with Europe representing the second country with the highest reception of foreign nationals after Asia. India represented the country where the most people migrated, followed by Mexico, Russia, China, Bangladesh, Syria, Ukraine, Pakistan and Ukraine (UN, 2017). In addition, in 2019, in the European Union, 630,000 people were in an irregular situation, still a lower number compared to the 2.2 million people who were in the same situation in 2015 (European Parliament, 2020). There is a vast literature reporting the high rates of psychotic disorders in ethnic minority populations in developed countries. Overall, scientific reviews suggest that the incidence of psychotic disorders in all minority populations combined is approximately 1.5 – 3 times higher than in majority populations, and that these rates are most significant in black people (4 to 6 times

higher compared to majority groups) so the increase in rates in the remaining non-black minorities is almost non-existent or modest (Morgan, Knowles & Hutchinson, 2019). The relative risk of psychosis is higher in second-generation migrants (4.5), in migrants from developing countries (RR 3.3) and, above all, in migrants from countries where the majority of the population is black (4.8) (Morgan et al, 2010). Variations related to the country of origin of these people (higher risk if they come from developing countries and where most people are black) and the host country (lower risk associated with countries such as Israel and Canada) are not surprising given the different migratory histories and cultural heritages, and the different social contexts in which they live. When black migrants are studied, Afro-Caribbeans are especially affected and three variables stand out: unemployment, living alone and separation from parents during childhood (Mallet et al, 2014). The variation in risk also appears to apply to gender as well, with men, especially those from certain parts of the world (Morocco, Algeria, Libya and Tunisia) being especially affected (Ven et al, 2016). Even in the refugee population, which apparently has a higher risk than the rest of the migrant population (2.9 vs. 1.7) with regard to psychotic disorders, the incidence is higher in males (Hollander et al, 2016). However, several scholars in the area such as Selten, Vem & Termorshuizen (2019) refer that the results in the refugee population must be interpreted with caution because the quality of the available information is limited.

In the last twenty years, knowledge about the characteristics and etiology of psychoses has increased considerably. It is now clear that schizophrenia and other psychotic disorders are conditioned by a myriad of factors, including social conditions and experiences,

General population



Minority ethnic groups

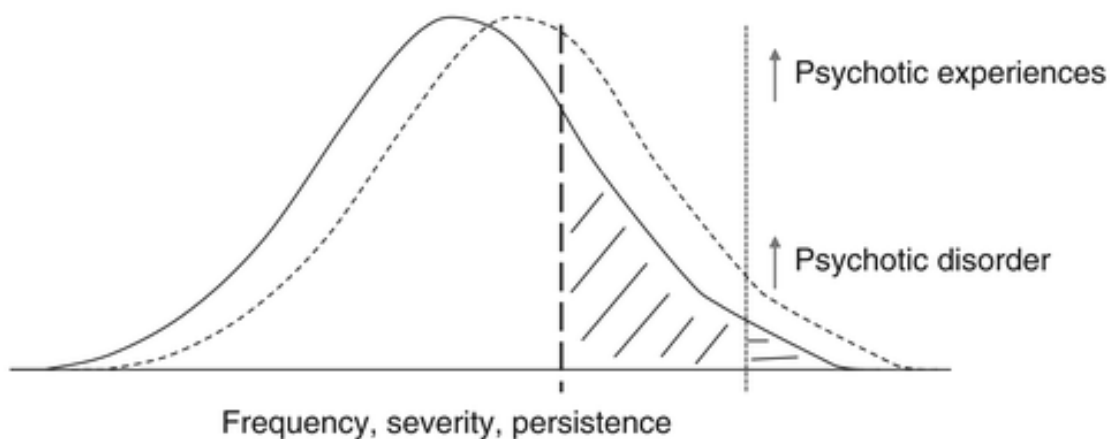


Figure 1. The functional deviation hypothesis (to the right) considering the continuum of psychosis in some ethnic minority groups.

Source: From "Migration, ethnicity and psychoses: evidence, models and future directions" de C. Morgan, G. Knowles, G. Hutchinson, 2019, *World Psychiatry*.18: p. 250. <https://onlinelibrary.wiley.com/doi/epdf/10.1002/wps.20655>.

as well as genetic factors, which interact in concert over time and can lead to increased risk. In relation to social factors, they can be individual (abuse, bullying, adverse life events, discrimination and abuse/dependence of psychoactive substances) and collective (urbanity, social fragmentation and ethnic density). This means, therefore, that the increased risk of psychosis in migrants and minority ethnicities is not due to the genetic dimension as the preponderant factor, that is, it is not simply the result of a brain dysfunction of biological etiology. If, on the one hand, one cannot ignore the results that indicate the low incidence rates of psychotic disorders in countries such as Canada and Australia in which “selection” policies are more rigorous (Vang et al, 2017 cited by Selten et al, 2019), on the other hand, poverty itself will not be directly associated with psychotic illness because, in their countries of origin, black and Asian populations show a “normal” incidence of schizophrenia (Bhugra et al, 1996 and Baxter et al, 2016 cited by Selten et al, 2019). Although cross-cultural diagnostic difficulties are recognized, there is current evidence showing that the same patients, evaluated by physicians of their own ethnicity, or a different one, receive the same diagnosis (Hickling et al, 1999). Migrant and minority populations seem to exhibit psychotic conditions in which affective symptoms and positive symptoms predominate (eg paranoid delusions and hallucinations, ie reality distortions) and less negative symptoms (eg affective blunting and social isolation) (Quattrone et al, 2019) or any other form of emotional expression of distress, and may erroneously receive the diagnosis of schizophrenia. One of the aspects commonly considered is the consumption of certain psychoactive substances, specifically cannabis and alcohol, which, being more expressive in certain minority populations, are associated with a higher incidence of schizophrenia and

other psychotic disorders. The heterogeneity in the clinical manifestations, evolution and prognosis of these disorders can be explained by a socio-developmental model in which clusters of protective and predisposing factors for the disease operate at different levels throughout life, from molecular to social. According to this model, a person’s exposure, over a long period of time, to exclusion from the majority group (“social defeat”) increases the risk of psychosis due to its effects on the dopaminergic meso-limbic system. It follows that social factors are more likely to act, not because they have a greater impact on migrant and minority groups, that is, because in these groups the reactivity to stress is higher, but rather because they are more recurrently exposed to hostility, to social disadvantage and discrimination. It is the excessive and repeated threat, at least perceived as such, that induces the sensitization of the dopaminergic system, producing a state of hopelessness (paradigm of the depression model). This does not mean that gene-environment interactions do not occur, but it is assumed that the fundamental (and differential) component, which is exposure to environmental factors, will act on a genetic risk that, in general, is similar to that of the rest of the population. Egerton et al, 2017 cited by Selten et al, 2019 references studies revealing structural changes in the brain of migrants and ethnic minorities and positron emission tomography studies showing increased stress-associated dopamine synthesis in the striatum of these patients.

The migratory process is associated with “psychological, environmental, biological, social, cultural, family, political changes, implying the psychological and social adaptation of individuals and families and different modalities of acculturation” (Ramos, 2009, p. 5). The literature indicates that the incidence of psychotic disorders is higher

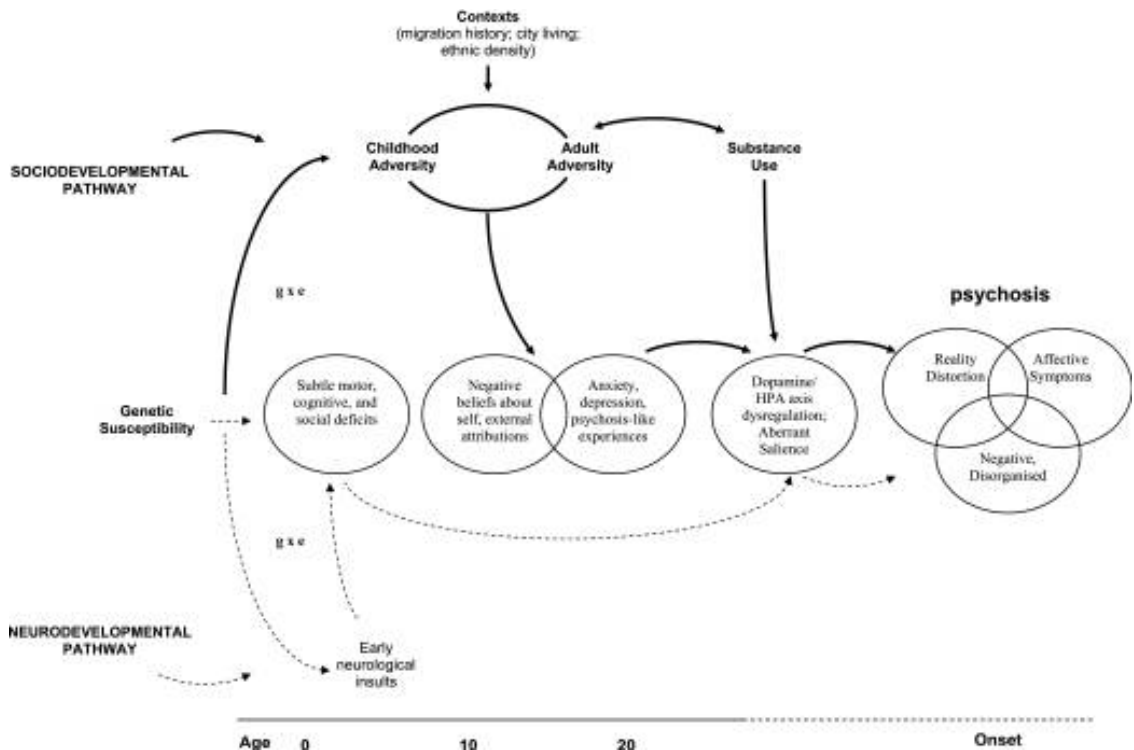


Figure 2. The neurodevelopmental hypothesis of psychosis (adapted from Murray et al: Figure 1, p. s130). Source: From “Migration, Ethnicity, and Psychosis: Toward a Sociodevelopmental Model” de C. Morgan, M. Charalambides, G. Hutchinson, R.M. Murray, 2010, *Schizophrenia Bulletin*. Vol. 36 number:4, p. 661. <https://onlinelibrary.wiley.com/doi/epdf/10.1002/wps.20655>.

in asylum-seeking populations and among refugees, which at the outset would not be surprising since they originate from contexts affected by natural disasters, wars, violence and persecution, being more subject to traumatic experiences. In addition, they have fewer resources, which makes the process of psychological and social adaptation difficult, with obvious consequences in terms of their physical and psychological health. Research in the area also reveals that while the linguistic distance (between the native’s mother tongue and the migrant’s mother tongue) has a more significant impact on the first generation of migrants, social disadvantage mainly affects the second generation of migrants and subsequent generations (Jongsma et al, 2020) regarding the incidence of first psychotic episodes. From this it can be deduced that the sociocultural experiences are different

for the new immigrants and for the minority populations already installed. These findings are supported by others that show that the younger the migrants, the greater the risk of developing psychotic illness (Veling et al, 2011). This means that, during their childhood and adolescence, they are subject to a development guided by disadvantageous and discriminatory social conditions and experiences that predispose them to risk. In any case, the social experiences associated with the acculturation process will only represent a partial explanation for the higher incidence rates in these population groups, not least because the time interval between migration and the occurrence of the first psychotic episode is, on average, of two years in the migrant refugee population and three years in the migrant non-refugee population (Hollander et al, 2016).

It is known that both “health behaviors” and “illness behaviors” are influenced by the socioeconomic and cultural context and “one of the explanations for health differences focuses on the cultural and behavioral explanation that involves class differences in behaviors that, or are destructive, or are health-promoting and, in principle, subject to individual choices” (Bäckstrom, 2009, p. 145). But are lifestyles so individually determined? Migrants, for example, face more constraints in accessing services and goods that promote well-being and prevent illness, namely health, adhering less to outpatient services and more to emergency services, including in the form of compulsory hospitalization. (Morgan et al, 2017). First of all, the needs felt by the individual are at stake, that is, the perception of the disease and then there seems to be a lack of knowledge regarding the services available and how to access them - “the lack of knowledge is one of the dimensions of the global and social” (Bäckstrom, 2009, p. 146). Aspects interfere in accessibility, which, although often ignored by clinicians, are of paramount importance: the time to spend on care (directly associated with the professional situation, usually precarious and consuming several hours a day), the geographical location of the health units and the transport network that allows reaching them, the opening hours of these institutions and the representations of the patient-health professional relationship (previous experiences). Access to social security support mechanisms is equally relevant, but without clinical follow-up, its pursuit becomes unfeasible. In fact, the difficulties experienced by these populations along the trajectory of care are all too evident, presenting themselves in the form of: abandonment due to exhaustion, failure to adhere to the first and subsequent specialist consultations and delays in hospital referral. Clandestine situations also contribute to later

and more complex diagnoses that can arise in the form of compulsive hospitalizations (absence of morbid awareness of the disease). Nutritional deficiency and migration from countries where certain diseases are endemic, such as infectious diseases, imply the diagnosis of medical comorbidities that modulate psychopathological conditions, complicating them at the time of diagnosis and treatment. In neurodevelopmental risk factors, the impact of maternal viral infections, obstetric complications and vitamin D deficiency must be taken into account (Eagles, 1991, cited by Morgan et al, 2010). Although drug and alcohol consumption affects more men than women in the general population, the relative risk of psychosis between genders is not significant and, for this reason, it will not have such a relevant weight in the psychotic etiology in migrants and minorities. ethnic groups (Selten et al, 2019).

COMPULSIVE HOSPITALIZATION AND THE ECOLOGY OF RISK IN LOURES

If it is more or less easy to determine organic and physiological normality to determine the organic and physiological normality of a human body, it is no longer so to define psychic normality, and the history of our times is tragically marked by psychiatric abuses, whether for the guarantee of dominant values (“conservatives” or allegedly “vanguardists”) against political dissent, whether in the name of supposedly scientific ideas (more or less widespread) of social hygiene, or in defense of public order and tranquility against marginality (as a factor of danger) social. (Andrade, 2000, p. 48)

The Mental Health Law (Law Number: 36/98) defines the general principles of mental health policy and regulates the compulsory internment of people with mental disorders. In medical-psychiatric and

judicial activities, the need for compulsory hospitalization for treatment arises when there is a clinical situation in which “the carrier of a serious psychic anomaly that creates, by virtue of it, a situation of danger to legal assets, of relevant value, their own or others, of a personal or patrimonial nature, and refuses to undergo the necessary medical treatment” or if “the absence of treatment significantly deteriorates their condition, not having the necessary discernment to assess the meaning and scope of consent ” (Law Number: 36/1998). Paradigm is the case of the patient with schizophrenia or another psychotic disorder with aggressive behavior, constituting a danger for himself and for others or for society in general. Compulsive internment therefore implies depriving someone of their liberty for the purpose of psychiatric treatment. State activity emerges as a “total and totalitarian therapeutic model, underlying a formal and coercive system of control” (Albuquerque & Albuquerque, 1992) but in balance with the “right to difference”, that is, to experience a psyche that is different from the man accepted as “normal”. Mistrust abounds in relation to the psychiatric authority and certain theoretical currents consider that the mentally ill person is not a true patient, but only and only a person who is socially excluded. Compulsory internment today, in democratic societies, takes special care in such a way that the deprivation of liberty respects the principles of necessity, adequacy and proportionality and, even if, in the course of the treatment, there is respect for the dignity patient staff. However, nowadays, the protection of fundamental rights needs to be updated: at stake are threats that emerge from other powers, which are structured in more diffuse social plans, and which mirror inequalities in the field of health and disease. They are basically new forms of discrimination and

exclusion that the contemporary multi and intercultural world produces (Ramos, 2009). 36/98 of July 24th, “that the law has a bad name and must be called compulsory internment, because that is what ultimately regulates and not the mental health policy” (Andrade, 2000, p. 50).

In parallel with the resurgence of the notion of Subject/Person, the notion of context that links the social and the individual in a Relational and Systemic perspective is fundamental. (Pereira, 2007, p. 78)

Hospital Beatriz Ângelo, which started operating in 2012, is the hospital unit responsible for providing assistance to around 278,000 residents in the municipalities of Loures, Odivelas, Mafra and Sobral de Monte Agraço. In relation to the municipality of Loures, it responds to the parishes of Santo António dos Cavaleiros and Frielas, São Julião do Tojal and Santo Antão, of Fanhões, Bucelas, Loures, Lousa and of Camarate, Unhos and Apelação. With regard to mental health and consulting the Health Profile and its determinants of the Lisbon and Tagus Valley Region (ARS LVT) (Ministry of Health, 2015) it appears that 27.1% of residents have probable psychological distress. In the municipality of Loures and specifically in relation to the consumption of alcohol and drugs, the indicators are close to those verified at the national level, but slightly higher when compared to those of the ARSLVT. In this county there is a deficit of doctors and even more of nurses with values below the national average with around 23% of citizens without a family doctor. The number of residents with overweight and tobacco consumption is higher than the national average and that of the Lisbon Metropolitan Area, which together with chronic alcohol abuse, are the most impacting risk factors for health.

The Lisbon and Tagus Valley Region has witnessed in recent decades a significant

immigration flow with the influx of citizens from the PALOP impelled by independence processes, civil wars and poor living conditions in these countries. First-generation migrants are affected by the most prevalent pathologies in their countries of origin, while subsequent generations mirror the most frequent medical conditions in receiving countries. The largest migrant community in the Lisbon and Tagus Valley region is made up of citizens from the PALOP and in this group there is a lack of adherence to health surveillance programs in the child and reproductive area; communicable infections (HIV, hepatitis, sexual diseases and tuberculosis) have a high incidence and prevalence, possibly due to language difficulties, situations of non-documentation or the inability to exercise active citizenship. According to data from the 2011 Census (INE, 2011), around 16,658 foreign individuals lived in the municipality of Loures, that is, 8.1% of the population of Loures, 55% of which were natives of African countries, with a predominant age group between 15 and 64 years of age and 14.8% had Brazilian nationality. However, there is a downward trend in the number of foreign residents of African origin and, conversely, an increase in the number of foreign residents from Southern European countries. Regarding the number of residents from Asian countries (China and India), they are stable, representing around 7% of the foreign population living in Loures. (Loures City Council, 2019). The fact that it is a municipality bordering Lisbon, providing more favorable conditions, financially, in terms of housing, as well as the preexistence of family nuclei living in this territory, may explain why the migratory phenomenon characterizes the municipality of Loures. The 2019 report of the Social Diagnosis of the Municipality of Loures, however, identifies difficulties with regard to the integration of

the migrant community in the Council of Loures:

Lengthy legalization process, which conditions access to the labor market and social and health services, exacerbating situations of economic insufficiency and food shortages. Difficulty in communication, due to language barriers, which limits access to services and job opportunities. Low schooling, which also affects access to the labor market and contributes to the precariousness of the work situation. (Loures City Council, 2019, p. 152)

As of December 2018, around 34.7% of the inhabitants of Loures relocated in municipal dwellings were foreigners and mostly from Cape Verde, S. Tomé and Príncipe and Angola. The Parishes Unions of Sacavém and Prior Velho and Camarate, Unhos and Apelação had the highest number of relocated individuals (28.32% and 57.46%, respectively) (Municipal Council of Loures, 2019). The opportunity for individual, social and professional development of migrants and ethnic minorities with a view to their true social inclusion with quality and well-being is only possible if they live in urban spaces with adequate infrastructure and resources. In fact, ethnic minority groups tend to inhabit densely populated, socially fragmented and excluded urban areas. In this sense, both the attitudes of the citizens of the cities that host them and the policies of governments and states are very important. In these neighborhoods, which are sometimes located in degraded areas, the populations generally have low levels of education and professional qualifications and are subject to precarious work with a lower overall level of remuneration. In a 1994 study carried out by the Center for Territorial Studies (CET/ISCTE) for the Lisbon City Council, which aimed to characterize the “social profile and housing expectations” of the population of 8 neighborhoods in the municipality of


Loures, it was found that its structuring it was associated with demographic dynamics and, more specifically, with migratory flows from the former Portuguese colonies (PALOP's and India). Households belonged mostly to the white race and to the majority black and Indian races. At the time, the author already commented: "the population residing in the surveyed neighborhoods seems to associate the low levels of education achieved with very low-skilled professions, predominantly manual" (Quedas, 1994, p. 58). Given the situation of sociocultural and ecological exclusion, immigrants only integrate Portuguese culture superficially and in a fundamentally instrumental way. "In this context, intercultural and interethnic contacts in the Municipality of Loures are, therefore, reduced to a minimum that is dictated by the need to integrate immigrants into the sphere of production" (Alves, 1994). This marginalization limits immigrants from enjoying their civic rights. In addition, during the communication process within these neighborhoods, culture often interferes in a negative way: "culture, when evoking a communicational field, is involved by a whole set of attitudes of the subjects, whose meanings of these attitudes, externalized through codes of conduct or expression, are internalized in memory during interaction and mark the difference between "us" and "others", mark a border of "recognition" and "exclusion" (Alves, 1994), being subject to the dual culture syndrome, they live in a difficult balance between what is the cultural identity of their household and that of the ethnic community reinvented in the light of new experiences. "It seems that the older ones continue to adopt traditional practices while the younger ones partially reject this tradition. This intergenerational change is common in the case of immigrant children undergoing a process of "medicalization"

as an aspect of general adoption of beliefs, practices and lifestyles of the "dominant" culture" (Bäckstrom, 2009, p. 154-155).


In these second and subsequent generations of immigrants, the lack of opportunities and expectations for a better future in the face of the cultural and social environment in which it generates identity crises, racial prejudices, multi-ethnic confrontations and deviant behaviors. Even the cultural link with the young natives of the neighborhood is made by an identity marked by adverse living conditions (dropout and failure at school, poverty, delinquency and precarious housing). However, and referring to the study by Quedas (1994, p. 60): "neighborhood relations are even more important for African and Indian ethnicities that, facing a migratory process, seem to want to recreate in their place of residence, the network of relationships lost by the alteration of geographical places". There is, therefore, a common basis for these social groups, which consists of an internal organization system capable of generating feelings of belonging and rooting and this way, facing the various adversities. From the mid-19th century to the present (Bécares, 2018) relevant scientific evidence stands out in the research produced in this area: migrants living in areas of high population density, but belonging to their ethnic minority, are more protected from risk in develop psychotic disorders ("buffer effect") and, conversely, in those who live in areas where their community is underrepresented, the risk is increased as there will be greater exposure to racism and discrimination and the social support available will be less. There seem to be different clusters of causes as the effects of ethnic density are felt mainly in minority populations already settled and not in first-generation migrants (Schofield et al, 2018).

In two studies carried out by the author that evaluated one and two years of compulsory hospitalizations (2012 – 2014) in the Department of Psychiatry and Mental Health of Hospital Beatriz Ângelo (Loures) (J. S. Ferreira, personal communication, 2014) (Ferreira, 2013) revealed that the rate of compulsive admissions was 13.3%, a very significant figure, with Caucasian patients being the most affected (82%), followed by black patients (13%). These were men (49%) and women (51%) aged between 35-49 years old, unemployed, unoccupied, single and living in densely populated areas. Previously hospitalized patients represented 51% and, in second position, were patients without previous assistance in the department,

representing 13% of the sample. A very interesting piece of data that needed reflection was the realization that 71% of patients admitted involuntarily had previous contact with the judicial system. Patients manifested self-injurious behaviors (men and women). On the other hand, hetero-injurious behaviors characterized mainly the behavioral changes of male individuals. Alcohol abuse/dependence and the consumption of cannabinoids were strongly implicated in psychopathological conditions (88% and 81%, respectively), which, in their overwhelming majority, were schizophrenic. The duration of hospitalization was, on average, approximately three weeks. The conclusions of this study can be found on the following slide.



CONCLUSIONS
**“The Things that We Love Tell Us
 What We are”** (Thomas Aquinas)



Social inequalities in mental health – Factors seem to be associated to an increased compulsory admissions (Saint Thomas Aquinas 1225-1274)

- ! Being younger
- ! Unemployed - **Combat the poverty and illiteracy !**
- ! Disabled/Retired
- ! Living in urban settings - **Combat the exclusion and marginalization !**
- ! Previous contact with the criminal justice system – **New models of collaboration between criminal justice and mental health system !**
- ! Previous contact with the health system (including mental health system) – **Specialized Interventions !**
- ! Psychotic disorders
- ! Lack of motivation for treatment – **Psychoeducation !**
- ! Those who pose relatively danger to others – **Attention to the “invisible” ones !**

Figure 3. Work conclusions: Psychiatric compulsory admissions at Beatriz Ângelo Hospital – A report from two year’s experience.

Source: From “Psychiatric compulsory admissions at Beatriz Ângelo Hospital – A report from two year’s experience.” de J.S. Ferreira, comunicação pessoal, 19 de maio de 2014.

The report “Compulsory Admission and Involuntary Treatment of Mentally Ill Patients- Legislation and Practice in EU-Member States” (Salize, Drebing & Peitz, 2002) indicated percentages of 2.8% of compulsory admissions for Portugal (and 3.2% in relation to the total number of admissions), low values that probably also did not reflect the reality of the care provided in 2002. In a study of 497 compulsory admissions carried out at Hospital Júlio de Matos, from January 1, 2005 to December 31, 2006, the authors Brissos, Carita & Vieira (2007) present the profile of the inmate – male, middle-aged, age, unmarried, diagnosed with schizophrenia and without comorbidities with the consumption of psychoactive substances, having been taken to the hospital with aggressive or violent behavior and remaining hospitalized for about 3 weeks. Madeira et al, 2010 in a review of the casuistry of the Hospitals of the University of Coimbra and the Hospital Infante Pedro establishes a typical profile of patients submitted to compulsory hospitalization: “man between 30 and 49 years old, single, working inactive (unemployed or retired)”, Almeida and Molodynski (2016) in a review article on compulsory admissions in Portugal refer that the biggest challenge in complying with the Mental Health Law is the transfer of care to the community. In another study carried out at the psychiatry department of the Fernando da Fonseca Hospital (Amadora-Sintra) (Alexandre, Ribeiro & Cardoso, 2010) which aimed to comparatively assess the care burden of black and white patients, it was found that 19, 6% of the patients treated were of black race, a higher percentage than the inhabitants of this race, in the municipality of Amadora, with the majority receiving the diagnosis of schizophrenia. These ethnic/racial aspects may somehow explain the differences in the percentages of compulsory admissions at Hospital Magalhães Lemos

(7.2% - 2007) compared to those recorded at Hospital Júlio de Matos (15.31% -2007) (Almeida et al, 2008) What is documented in all the literature consulted is a worrying trend of an increase in the number of compulsively hospitalized patients in Portugal (9-10%), similar to what happens in other parts of the world, and which deserves monitoring by the Commission for Monitoring the Execution of the Legal Regime of Compulsory Internment created by the Ministries of Justice and Health (2020).

International studies relating race/ethnicity to compulsive psychiatric admissions identify the “break in contact” (Bhui et al, 2003) of black individuals (the most subject to this type of admissions) with outpatient services that ensure continuity of care, which includes specialist consultations, as one of the reasons for a higher incidence of compulsive psychiatric admissions in this population. Another explanation is the symptomatology of psychotic conditions, as symptoms such as aggression and paranoia predominate (Morgan et al, 2010), which imply the adoption of coercive behavioral restraint measures. The literature has also shown that the racism perceived by black patients leads to lower medication adherence (Mann, Fischer & Johnson, 2014). These patients are subject to longer hospitalizations due to the severity of the conditions they manifest and the loss of contact with the outside reality can lead to the so-called “institutional neurosis” characterized by loss of individuality, inactivity, apathy, submission and disruption of activities of daily living. Patients also often suffer from the so-called “revolving door syndrome”, not least because compulsory hospitalization is a strong predictor of future involuntary admissions; they enter and leave the hospital recurrently, being subject to greater clinical deterioration and socio-family exclusion. A

longitudinal study that followed African-American and Afro-Caribbean patients for 10 years showed that the course of their psychotic illness is marked by persistently negative contacts with services, namely more hospitalizations and involuntary admissions, involvement of police authorities and longer periods of hospitalization, when compared to white patients (Morgan et al, 2017). The ethnically diverse Asian population, on the other hand, shows to adopt, in acute situations, “help-seeking behaviors”, such as the voluntary visit to emergency services (Morgan et al, 2010). According to Thomson et al. (2015), migrant status may be associated with involuntary admissions due to difficulties in navigating the health system (access conditioned by economic, language and knowledge barriers), while the effect of ethnicity in this association may be due to barriers cultural (representations of mental illness, adequacy of services and racial discrimination). Barnett et al. (2019) draw attention to important aspects to be taken into account in the process of compulsive hospitalization:

Decision-making processes in psychiatric detention, which exclude patient and family input to risk management, must be examined because their interaction with situational factors, such as available alternative treatment and under-resourced services, might reflect area deprivation experienced by BAME communities. (Barnett et al, p. 314)

TO FACE SOCIAL DEFEAT

The second European Union survey on Minorities and Discrimination (“Being Black in the EU”) (2018) which was based on data from 25,500 people of immigrant or ethnic minority origin living in the 28 Member States of the European Union, although it indicated that Portugal has a low rate of

racially motivated violence and victimization compared to other countries (2%) highlights glaring disadvantages: “38% of people of African descent living in Portugal find it very difficult to pay their bills, more than double than what happens in the Portuguese population in general (17%), and more than a fifth (21%) show difficulties in accessing housing” (EU, 2018).

The effects that adverse life events have on an individual’s mental health are already well known. In this sense, family breakdown, more prevalent in certain ethnic minority communities (Morgan et al, 2007), when associated with discord and family instability and financial difficulties, makes people vulnerable to the development of psychosis. Another factor already identified in extensive literature as implicated in the high incidence rates of psychosis is the perceived level of discrimination (Pearce et al, 2019). The 2019 Eurobarometer (EU, 2019) data on perceptions of discrimination in the European Union show that discrimination based on ethnic origin is 67%, with Portugal ranking seventh in the European Union, out of 28 countries, where the average is 59%. In relation to the previous year, there was an increase. Regarding the “knowledge of rights in terms of discrimination”, around 42% of respondents claim to know their rights, however, there is a significant percentage of individuals who say they do not know where to report such a situation (Oliveira & Gomes, 2019). (.). Everything indicates that the combination of trauma, namely associated with migration history, family dysfunction and perceived social disadvantage and discrimination implies an increased risk of psychosis (Patino, Selten, Van Engeland et al, 2005). The literature indicates that these adverse social experiences, either in childhood or in adulthood, do not concretely translate into common emotional and mental

disorders and, therefore, into depression, as in the majority groups, which suggests lower levels of internalization. Persecution delusions, on the other hand, seem to be more frequent in immigrant ethnic minorities since “social defeat” induces negative cognitive distortions, with an external locus of control, generating anxiety and anticipation and precipitating misinterpretations that are at the base of paranoid psychotic activity (Li, Law & Anderson, 2012).

A favorable perspective regarding the experiences of migrant and ethnic minority children in social ghettos is described as follows by Papalia & Olds:

By and large, ethnic minority children are encouraged to cooperate, share and develop an interdependence with others – values that contrast sharply with western ideals of competition, autonomy, individualism, and self-reliance [...] Older siblings assume more responsibilities for younger ones, adults more often share breadwinning (often out of economic need), and alternative family arrangements are more common (often because of a perceived, or real, awareness of inadequate support systems in the larger society). The parents of well-motivated, achieving African American children emphasize ethnic pride and self-development, while acknowledging the existence of racial barriers. (Papalia & Olds, 1995, p.319)

In relation to the dynamics of these social networks, reality reveals something very different. Children, adolescents and young people, especially from the second and third generations of migrants, live with family and professional instability of their parents, with recurring phenomena of crime, delinquency and violence, experience school failure and dropout and gender inequalities, organizing themselves in gangs that potentiate antisocial attitudes and that aggravate stigmatization and tensions and intolerance, between these groups and

the indigenous population, progressively reinforcing the perceived discrimination. Social networks do not, therefore, act as containment and security, but rather exacerbate the segregation and stress levels to which migrant and minority populations are subject. There are, however, studies that show that group cohesion, that is, in which social networks are reinforced and not the breaking of ties, may be associated with more favorable results in the incidence of schizophrenia. In fact, everything indicates that negative ethnic identity, that is, the lack of affinity with one’s own ethnic group, implies a greater risk of developing psychosis (Veling et al, 2010). Bhugra et al. (2010) compared the incidence of schizophrenia in the United Kingdom among African, Caribbean and Asian immigrants, concluding that the incidence was lower in migrants of Asian origin considered “more traditional”, in which the socio-family structure acts as a “buffer”.

CONCLUSION

However, *More Than Just Race* develops a framework for understanding the formation and maintenance of racial inequality and racial group outcomes that integrates cultural factors with two types of structural factors – those that directly reflect racial bias – those that do not, including interpersonal macroeconomic forces and political forces that reinforce long-standing forms of racial stratification. (Wilson, 2011, p.14)

Migratory flows have led to an increase in contacts between cultures and to the cohabitation of different ethnic-cultural groups, often in highly urbanized contexts, generating new and complex challenges for the management of intercultural communication and reflecting in the inefficiency of public health policies, housing and the social sector. Even not being available to accept it, the psychiatrist plays a political role, and this role

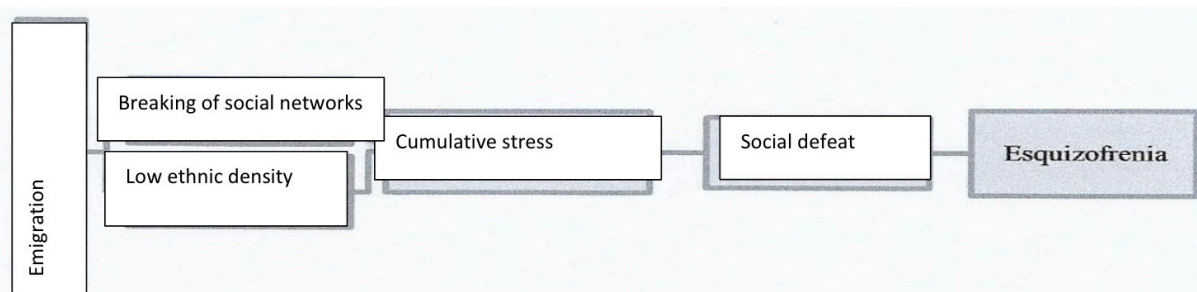


Figure 4. Chain of social factors associated with emigration influencing schizophrenia.

Source: From “Cultural aspects in the diagnosis of schizophrenia” A.B.C. Medeiros, n.d, p.37. <https://eg.uc.pt/bitstream/10316/37410/1/Aspetos%20culturais%20no%20diagnostico%20da%20esquizofrenia.pdf>

has relevant social and ethical consequences. From a care point of view, this role implies alerting policy makers to the consequences of untreated psychosis, which is associated with a worse prognosis, that is, the importance of adopting early intervention models that focus on the so-called “critical period”, aimed at strategic audiences, heavily discriminated against. It is also important to point out that social inequalities are manifested upstream of compulsory internments, which, being a common final path, in certain populations, with serious difficulties in their care path, thus find themselves victims of a hiatus in treatment for the disease, the which places them even more in a fragile situation. Psychiatrists are also in a privileged position to contribute to the conceptualization of migrant integration policies. I list a few by way of example: the strengthening of support structures for immigrants in the municipalities/parishes (in addition to linguistic, food and access to employment support, they must include clinical services); to work with the national media, but above all the regional ones, in order to increase the literacy of the populations in relation to migration and this way, contributing to an improvement in the quality of the relations between natives and migrants; intervene with the wider school community and, specifically in this matter, as

well as with regard to housing policies, adjust these interventions to scientific evidence related to the concept of ethnic density (protective effect mitigating the impact of discrimination, isolation and disadvantage); still at school level, develop systematic actions on discrimination, although not specifically associating them with mental illness, but including topics such as bullying, problems associated with gender differences, moral harassment, violence (verbal and physical) or guidance sexual; finally, at the medical level, despite the intervention in other areas, such as sexual and reproductive life, it suggested an assertive longitudinal intervention regarding the consumption of drugs and alcohol, once again supported by the literature on substances psychoactive drugs, and in particular cannabis-oriented.

The reflection on racial/ethnic inequalities in the context of compulsory internment and migratory phenomena aims to contribute to raising attention to the importance of developing social policies, community initiatives and mental health services in order to address an important public health problem. which is a context of deprivation of liberty even for treatment. New forms of discrimination and social exclusion, or even racism, are at stake, as well as threats to the inclusion, well-being and quality of life of these populations.

The high rates of psychosis in migrants and ethnic minorities can be explained by the social exposure, throughout the life cycle, to threat, hostility (including discrimination) and violence, especially in contexts of poverty and disadvantage and isolation (such as are areas of low ethnic density). The effects of social inequalities persist, also influencing the prognosis of the disease (Morgan, 2017) denouncing that these risks are socially structured. Exposure to adversity and trauma (particularly during childhood and/or during the migratory process), in the absence of protective and buffering factors, will interact with the underlying genetic risk and impact neurobiological development (in particular the stress response and dopaminergic system and hypothalamic-pituitary gland) creating a lasting predisposition to psychosis (expressed, for example, by mild psychotic experiences). This predisposition becomes apparent in the form of frank psychotic episodes (phenomenologically in the form of positive and affective symptoms) if there are cumulative stressors and/or consumption of psychoactive substances, such as high potency cannabis.

In the problem of compulsory hospitalization, the lack of knowledge about the existing health services, the difficulties in adhering to them and the difficulties in accessing social support systems increase the psychotic risk, although they could act as psychosocial buffers. Bad experiences in contact with hospital admissions, namely in the form of compulsory hospitalization, contribute to alienation from psychiatric services and, consequently, to a worsening of the underlying psychotic patient with the adoption of less “health behaviors”. For this reason, there is an increased risk, in the future, of more coercive interventions associated with different phenomenologies in their psychopathological presentation

(changes in behavior in black patients as opposed to subjective suffering in white patients). Mental health services are essentially oriented towards the disease, that is, towards the treatment of individuals and their symptoms, so the experiences and social conditions of their patients are, in most cases, marginal in the clinical evaluation, although intrinsically involved in the etiology and clinical course of patients. It is urgent to provide a psychosocial context that, instead of aggravating the vulnerabilities of the migrant and minority population, is rather a buffer against risk. This means that special attention is needed to the socio-economic and political conditions of host societies, preventing phenomena of verbal abuse, xenophobia, racism, prejudice and discrimination, particularly in the workplace, which, from a neurodevelopmental and ecological perspective, are organized in a psychotic path.

A holistic approach to the paths to social defeat needs explanatory models and comprehensive ecological-cultural models; at stake is also the epistemological, political and methodological reformulation in terms of prevention and treatment in mental health. The study of these subjects is, therefore, a unique opportunity to explore the knowledge about the etiology of psychotic illness. In addition to the particular responsibility of physicians and the country’s judicial system, there is also a constitutional responsibility of all citizens. One cannot ignore the so-called “structural violence” (Galtung, 1969), that is, the way in which social structures and institutions damage the health of populations by creating barriers to resources that allow access to fundamental needs to achieve a harmonious development. Perceptions of racial and ethnic discrimination also depend on the origins of migrants, as there are certain ethnic groups more likely to suffer discrimination

in European countries than others, it also depends on migratory experiences in the host country and the representation of this population in the same. The absence of robust epidemiological data in Portugal, especially of the longitudinal type, and preferably multisectoral, represents a serious constraint that makes any attempt at a more targeted approach difficult. Health professionals also need to be researched as aspects such as stigma and racism can influence the provision

of care. It is urgent to use all the evidence produced by the social and health sciences in relation to these patients, specifically, at a social disadvantage, to produce social policies, public health interventions and mental health services capable of dealing with the highest rates of psychotic disorders, with the prognoses tending to be unfavorable for these conditions and with the worst hospital experiences, such as the use of coercive methods and deprivation of liberty in particular.

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