PSYCHOSIS AND IMMIGRATION

G. I. TEWFIK, M.D., D.P.M.

Consultant Psychiatrist, Powick Hospital, Worcester.

A. OKASHA, M.D., M.R.C.P., D.P.M.

Lecturer in Psychiatry, Ainshams University, Cairo

THE BRITISH doctor will have been trained to recognise a classical picture of disease which has arisen in a European culture and has therefore been described in Western terms. It is too often assumed that this is the normal pattern for other peoples in other lands. This assumption is far from correct. The frequency, symptomatology, and sometimes even the presence of an illness in a community depend to a considerable extent on the environment in which it arises. The climate, the standard of nutrition, the presence or absence of infecting organisms and the habits of the people are factors of considerable variety which impose an equal variety of illness patterns upon differing cultures.

If Uganda is taken for example, Burkitt, Nelson and Williams (1963) have shown that not only has East Africa in general a different illness pattern than Britain, but great differences can be observed in East Africa and even within Uganda itself. Atherosclerosis, pulmonary embolism, post-operative venous thrombosis and coronary artery disease are rare. Cancer of the breast, lung, bowel and stomach are rare; whereas cancer of the skin and penis are common. Gallstones and urinary stones are very rare. Although tuberculosis of the bones and lungs are common, genito-urinary disease is almost unknown. As a surgical emergency, strangulated hernias in Uganda are infinitely more common than appendicitis or peptic ulcer perforation. Ulcerative colitis is rare and tears to the cartilage of the knee joints are almost unknown. (Burkitt, 1965).

The pattern of psychiatric illness in Africa is equally determined by culture. Tooth (1950) writing about Ghana Africans, stated that—

“One is forced to the conclusion that there are real differences in the quality of psychotic reactions in different racial and cultural backgrounds which make it impossible to fit them into an accepted nosological framework.”

Tewfik (1958) has shown that in tribal agricul-

tural areas of Uganda the incidence of psychosis is low, but with internal migration, industrialisation and the breakdown of traditional authority, the frequency of mental illness rises sharply. From a population of six million, 500 patients were admitted to the Mental Hospital in 1955, 1,000 in 1960 and 1,500 in 1963. This increase cannot be explained by the readmission rate which has kept fairly constant at about 10%. There has also been an increase in admissions to the General Hospital, but this has not been in any way comparable to the increase in the Mental Hospital.

Statistics on mental illness which have been gathered from community studies and mental hospital populations throughout Africa show the incidence of mental illness in the male is 50% in excess of that of the female. Patients are most frequently admitted between the ages of 20-40 years, but this can largely be explained by a difference in the age of the population.

There is a very different pattern of psychosis in Uganda. A minority of patients have classical illnesses which would be identified throughout the world. Mania, general paralysis of the insane, epilepsy and chronic schizophrenia can be easily recognized. Most writers are agreed that depression is rare in Africa. Suicide rates in Africa vary considerably in the different territories according to the tribal attitudes towards suicide, but in general they are low. The majority of admissions to mental hospitals are diagnosed as schizophrenia, e.g., de Wet (1957) diagnosed 84% of African new admissions as suffering from schizophrenia. However in many ways this illness is unlike that seen in Britain. It is usually an illness of sudden onset with a rapidly changing clinical picture. Excitement alternates with stupor and elation with depression. The majority of cases are confused and this state may be of sufficient intensity to render them unable to recognise their relatives or the food that is placed before them. Persecutory delusions and auditory hallucinations

contribute to the excitement and distress of the condition. In the acute stage of the illness the incidence of violence is very high. The majority of patients are brought into hospital because of violent behaviour such as the burning of huts or for having beaten other people. In a hospital of 600 patients, for example, 86 were committed under criminal procedure. Many of the latter, having committed murder, had recovered and been well for some considerable time. When an uneducated African feels that his security is threatened either by environmental misfortune, or from a loss of his faculties as a result of a toxic illness, he may attribute this to witchcraft and become so overwhelmed with terror that he is provoked into killing his own kinsmen, or even the children whom he loves.

As public health measures soften the hostility of the environment and education removes some of the irrationality of fear, the expectation of life improves, and the more violent forms of frenzy occur less frequently.

Despite the severity of the psychotic symptoms, within three months 83% of the patients had been discharged and able to return to the work they were doing prior to their illness. A minority of patients remained dull and sleepy for varying periods and in a smaller number the illness went on to a picture of chronic schizophrenia such as is seen elsewhere in the world.

Hypochondriasis and hysterical conversion reactions are frequently seen. They are usually ascribed to bewitchment, and treated quite successfully by local traditional means either individually or by group exorcism.

This illness pattern mentioned above is common in unsophisticated people in many parts of the world and particularly occurs in a culture where there is a belief in witchcraft and animistic religions. It is as if the difficulties of life instead of being attributed to personal failure are projected into culturally determined external channels.

In discussing the psychosis of immigrant peoples and a comparison of their breakdown rates relative to those of the host community, there are several points that need to be considered.

(1) The immigrant tends to respond to stress according to the culture of his childhood environment.

(2) The host community may attract a positive or negative selection of the immigrants according to the circumstances prompting embarkation.

(3) The response of the host and immigrant to each other depends upon their mutual regard. Frequently the host looks upon the newcomer as a social and occupational threat and responds by varying degrees of discriminatory practices.

(4) Where the host itself has no majority society, for instance as in Switzerland, integration is much more rapid.

(5) As the immigrant becomes adapted to the culture of the host their differing illness patterns merge, but achievement of this may well take more than one generation, according to their mutual acceptance and the cultural differences separating the two peoples concerned.

Weinstock (1964) in a study of Hungarian refugees abstracted the factors which helped the person to integrate with the host society and summarised his findings as follows:—

"A composite portrait of the highly acculturated Hungarian appears to be the following: his religion is either Protestant or Jewish; his father's occupation was non-manual in Hungary; he comes from the middle class in Hungary; after getting into the school of his choice under communism his occupation was in the upper half of the occupational-prestige scale; he had at least a gymnasium education; his family suffered deprivations under communism but he, himself, did not suffer economically. On coming to the United States, he got a job in the upper half of the occupational-prestige scale, is generally satisfied with his job and feels that he has had a greater chance of succeeding here than in pro-communist Hungary. It is likely that his occupation requires some retraining and he therefore takes some school courses. He has not changed residence more than two or three times during the past three years, and he lives either alone or with his family. In his food habits, he shows a preference for American food and though he has some favourite Hungarian dishes, his diet is predominantly American. He has some close friends, most of whom he has met in the United States. He has most probably participated in one or two anti-communist picketings but has not joined any Hungarian organisations. He goes to the movies rather frequently, and his main sources of information are the American press and books in English. He makes no special effort to follow developments in Hungary. He wants to settle in the United States permanently and would not go back to Hungary except for a visit

provided the political situation there had changed. Acquisitiveness and personal enjoyment are the central concerns of his existence, with a lesser emphasis on enjoying the company of family and friends. He speaks English fairly fluently, and thinks in English most of the time. As to his personality, he is an ambitious and highly cynical person, but not specially authoritarian."

Paranoid feelings are particularly common in the symptomatology of mental illness of migrants. It would have been thought that naivety rather than cynicism would have been a protective factor against this type of breakdown.

Eitinger (1960), discussing the plight of the immigrant says:

"The first and immediate feeling in a strange milieu will usually be this particular feeling of loneliness and rejection. The manifold external expressions do not create any feelings of solidarity, of an understanding of the situation or of the inner meaning of the impressions, and first and foremost, no understanding of the individual's position in the whole of this unknown and overwhelming system. It is precisely this lack of ability to receive, to understand, to develop and to react to the surroundings which causes this apparent but none-the-less very familiar paradox of feeling isolated, of being totally alone as Lilly's experimental persons in the water-tank, while one is actually surrounded by masses of talking, laughing, active fellow-beings, be it on Karl Johan Street in Oslo, on Piccadilly Circus in London, or on Fifth Avenue, New York.

We have thus two different mechanisms which cause psychotic reactions. The primitive, unabsorbed feeling of being overwhelmed by outside impressions and stimuli which cannot be digested, and thus lead to confusion, and in addition to this the reaction to the feeling of loneliness which is first and foremost marked by insecurity. The feeling of 'not belonging' of not being able to take a role in some form or other, of not knowing what is expected of one, add insecurity to isolation."

Eitinger noted that the incidence of psychoses among the refugees in Norway is, for all diagnoses, five times higher than would be expected when compared with the matched Norwegian population. The symptoms which appear to be of special importance among refugees were persecutory delusions, disturbances of consciousness, conversion symptoms and ideas of jealousy. Somatic conversions occurred in

nearly half of Eitinger's patients and were much more frequent in his refugee material than in the controls that he used. He was struck by the difficulty that the patients had in talking about their psychic symptoms, while they had no such difficulty in recounting their somatic complaints. These patients feel that the doctor will not be able to sympathise or comprehend their attempts to speak of their nervous distress and they thus mention only their bodily pains.

Students from abroad are particularly likely to be brought to the attention of the psychiatrist as they frequently suffer from psychological distress. A well recognised syndrome which is seen frequently in students coming from India and Africa is described under the title 'The Brain Fag Syndrome' by Prince (1960). The symptoms commence during a period of intense reading or study prior to examinations. The symptoms are intellectual impairment, special sensory impairment, particularly visual, and somatic complaints, usually pain of a burning character in the head and neck. It is commonly observed in adult unmarried males between the ages of 15 and 30 who are students at university or teachers or government clerks who are studying in their spare time to raise their educational level. The patients find they are unable to comprehend what they have just read or to follow what is given in a lecture. When they attempt to study there is a burning sensation over the skull and the eyes seem strained or the lids seem to close compulsively. There is also a general weakness of the body, difficulty in getting up in the mornings, and a tendency to sleep during the day. The patients lose interest in their families and their girl friends and the syndrome is often accompanied by impotence. Often the patients are the rather spoilt sons of wealthy parents who have sent their sons to this country at considerable expense but sometimes not at the recommendation of the university in the home country. The patients become apprehensive that they will fail their examinations and they tend to study until very late in the evenings, with resulting withdrawal from social contacts. They are afraid to face the disgrace of a return to the family home without the necessary qualification, and avoid the final examinations by changing curriculae and thus tend to become chronic students.

An example of a culturally acceptable people, mainly of comparatively high occupational status, who have settled quite well following migration is given by Malzberg (1964).

He compared the breakdown rates of English-born people coming to New York state with those of the native-born population. When corrected for age differential, the rate of the English-born was 84% of the native-born. However, this advantage was lost in the second generation, that is, of New York born people of English parentage.

An example of a vulnerable migrant group is given by Malzberg (1956), who studied the mental illnesses of the Spanish-speaking Puerto Ricans living in New York City. The migration was prompted by a desire to escape from the poverty of the islands to find greater occupational opportunities elsewhere. In coming to New York their poverty restricted them to living in the slum areas. Their low occupational status and the language barrier offered them very little opportunity for advancement. When the ages of the two populations were standardised, the admission rate for Puerto Ricans to a mental hospital was 239.3 per hundred thousand, that is 262.7 for males and 214.9 for females; whereas for non-Puerto Ricans figures were 185.5, that is 183.4 for males and 180.7 for females. Both populations differ from the British norm in that the males are more frequently admitted. Half of the Puerto Rican patients were under 25 years of age and only 2% were over 65, the median age being 24.5 years. When the two populations were standardised for age, a Puerto Rican was twice as likely to be admitted for schizophrenia as a native-born person from New York. In the island psychiatric hospital in Puerto Rico, 160 patients were admitted each year from a population of approximately two million whereas in New York from a population of 355,000 the annual average admission rate was 400 per year. No doubt the facilities for the local psychiatric hospital were very inadequate, but this enormous difference in admission rate must be due to a considerable extent to the stress of migration.

Migrations to Britain

Tristan da Cunha. Rawnsley and Loudon (1964) reviewed the mental health of Tristan da Cunha immigrants to Britain during their stay here from November 1961 to October 1963. The total community of 293 members came to this country.

The members of this community descended from a small number of settlers from Britain, the Netherlands, Italy and North America with a mixed European Afro-Asian stock from St.

Helena and S. Africa. The majority of the population were active members of the Church of England. They live a mainly agricultural life, growing potatoes, fishing and caring for cattle, sheep and poultry. The small size of the population, the physical proximity of the houses and the universal inter-relatedness of the individuals and the nature of their economy has meant that there is a great deal of sharing in most of their life's activities. The effect has been to produce a notable degree of homogeneity in the values and attitudes prevailing among the population and also a very low tolerance for departures from a generally accepted standard of behaviour. In Rawnsley's study of the adult population, four cases of psychotic disorder were found; in three, at over the age of 60 years, there was clear evidence of organic dementia; and another woman aged 65 had a resolving depression of moderate severity. In addition six adults were thought to have markedly subnormal intelligence.

There were two minor neurotic disorders which were carefully studied: epidemic hysteria and headache associated with anxiety.

Hysteria

An epidemic of hysteria which occurred in 1937-1938 has been carefully recorded by the Norwegian group who were conducting a sociological survey on the island at the time. Twenty-one islanders were affected by hysteria. The first occasion occurred during a dance in the school in August. A young girl fainted and went into a series of violent convulsions, while apparently in a state of unconsciousness. She had several further attacks of convulsions on the same day, and occasional attacks occurred over the next few months, after which they gradually subsided. Two days later another young girl had similar spells and this spread rapidly. During the course of September and October, 16 women had similar attacks. There were three main forms of attack. Firstly "Sleeping Spells" in which the women swooned and lay unconscious for a considerable time. Secondly "Fighting Spells"; these attacks starting with fainting and then turning into convulsions. The women struck out with their arms in all directions, kicked with their legs and bent their bodies. On occasions four strong men were needed to hold them to prevent them hurting themselves. A third main type was a "Choking Spell"; during the spell the women were conscious and complained of a feeling of choking and they made violent

movements to get air. When these women were together in the same room, e.g. a church or school, where an attack began in one of the women, the others became affected. Sporadic attacks of spells have occurred since 1938 and during the period of immigration to England three women have manifested spells in this country.

Rawnsley and Loudon noticed that the patients who had spells in their own country were more likely to seek medical attention here than their compatriots. The spells occurred more frequently in those of a high social position. Of 23 women married to leaders 10 had spells, compared with only 3 from an age-matched control group. It was thought that the spells were due to sexual rivalry, jealousy and domestic quarrels in the setting of the rather isolated monotonous life which they had been forced to lead. Yap (1951) speaking of psychic contagions, said:

"These hysterical contagions were frequent in medieval societies and are still to be found now and then in closed fervently religious communities like nunneries, where belief in possession by external agencies exists, or in small, compact communities of easily excitable and emotional people such as girls' boarding schools."

Headache

The 1937 Norwegian survey of the island also recorded a high incidence of headaches. It was noted that the sufferers were accustomed to having them every week or two, but usually they did not interfere with their normal activities. The headaches were provoked by exposure to wind or bright sunshine, menses, or worry. No less than 66% of the women and 52% of the males complained of recurrent headache. In patients who headaches were precipitated by anxiety, it was noted that they had a high incidence of medical consultations for a variety of other complaints; and again the leaders' wives were particularly vulnerable. There is also an association between epidemic hysteria of 1937 and headache in 1962.

Asthma

Another illness which is very prevalent among the Tristan da Cunha is bronchial asthma. Twenty-two per cent of the adult population suffer from this condition. Again, probably emotional factors are partly responsible. The publicity that the migration received in the press evoked a warm-hearted response among the people of Britain, and although the first few weeks were spent in some discomfort

in an Army Camp the immigrants were soon transferred to more permanent homes. The men and women without family responsibilities soon obtained work within the locality. Throughout their stay they were eager to return home and only 14 of the islanders elected to remain in this country. As far as can be judged from this survey their pattern of neurosis did not alter during their stay in Britain.

The Hungarian Migration to Britain. Mezey, (1960 a and b) pointed out that for many years there has been a considerable migration from Hungary to the Western countries. Between the two World Wars the host countries imposed quota laws which considerably checked this migration. Since the second World War, the Hungarian Government has made it very difficult for the population to leave the country. These barriers were temporarily removed during the Hungarian Revolution and about 20,000 Hungarians came to Britain. Probably more than 50% of these had contemplated migration before the revolution. Eighty-four per cent were aged between 18 and 40 years. Mezey studied 82 consecutive refugees who were referred for psychiatric illness. Seventy-five per cent were males, and partly owing to their young age group half were single; however, the other half were comprised of equal numbers of married and divorced people with a small number who were widowed. The high number of divorced people which amounted to a figure of 4 times in excess of a similarly aged group of English patients does suggest that there has been a considerable social maladjustment among the section of referred patients. Forty per cent had a broken home in childhood. One half had a history of mental illness in Hungary and slightly more than half had previously migrated from one district of Hungary to another. Fifty-five per cent gave an economic, social or personal reason for leaving Hungary while only 28% migrated for political reasons. Twenty-six patients were diagnosed as suffering from neurosis, 23 from affective disorders, 15 from abnormal personality and 14 from schizophrenia. The most frequent method of presentation was of somatic manifestations of anxiety and depression, or a hysterical disorder of function. The abnormal behaviour took the form of aggression or wandering, and 9 patients had made suicidal attempts. The majority of schizophrenics presented with paranoid delusions, often of being persecuted by communist agents. Patients with neurotic or affective disorders had often deteriorated in their social

and occupational adjustment from their standard in Hungary. The patients with personality disorders were mostly referred within six months of their arrival in this country as they were unable to make the first step in adjustment to their new environment. The social adaption of the schizophrenic patients had not deteriorated following their migration. They were a very vulnerable selection of the population and their previous adjustment in Hungary was described as 'marginal.'

West Indian Migrants. For many years unemployment, over-population and lack of educational opportunity had prompted large numbers of West Indians to emigrate. Their usual destination in the past has been the Panama Canal, Cuba, Venezuela, and the United States. The McCarran Act of 1952 prohibited further immigration to the United States and the West Indians were then attracted to the full employment conditions appertaining in Britain in the post war years. Sheila Patterson (1962) gave the following information. The numbers of West Indians in Great Britain rose from 40,000 in 1955 to 120,000 in 1960 and 300,000 in 1962, after which legislation barred further legal entry. The majority came from a fairly low social status. Only two per cent of migrants had received secondary education. For all practical purposes there is no effective apprenticeship in the West Indies. Thirty-four per cent of migrants had been unemployed for over a year prior to migration. The Labour Exchange rated them as skilled 13%, semi-skilled 22% and unskilled 65%. There is no doubt that the West Indians would have rated themselves very differently. The majority came to England initially to acquire money and skills prior to their return home. Most have found and kept jobs, even if they did not command the status and wage that had been expected. The employment recession of 1956-58 necessitated a higher standard of endeavour at work and previous criticisms against the West Indians about their unpunctuality and lack of effort are not now heard so frequently. These West Indians are rarely promoted, except to work involving the supervision of other immigrants.

The housing problem has been temporarily solved by the buying up of large dilapidated short lease properties which are considered undesirable and uneconomic by the local population. The majority pay rents which are higher than the local average and out of proportion to their income, necessitating living pre-

dominantly in one family room. As the West Indians come into a district the white people have generally moved out of the neighbourhood. Although this has reduced the chances of community friction it may also have delayed integration.

Marital status. The West Indian in Britain, at home, often does not form stable sexual unions. Marriage is the norm for upper and middle class West Indians, but few of these people have come to Britain. Marriage is an expensive social occasion which few young men are able to afford, but nevertheless fairly permanent unions are contracted and later when the children come, often the union proceeds to marriage. More unstable, masculine-dominated unions are formed in which the woman has more the status of a servant or housekeeper. There is an increasing tendency for the successful female employee to form female-dominated unions. She and her family form a unit into which temporary male partners become included. In Jamaica 70% of children were born to women in some form of stable union. Unions between West Indians and the British are rare but some unsuccessful rejection. English women have formed relationships with West Indian males.

Mental Illness in West Indians in the Caribbean

A census of the Mental hospitals in the Caribbean was carried out in 1960. It showed that the sex ratio of patients in their first admission, who had been in hospital less than a year, was 59.4% for males and 40.6% for females. However, the females tended to remain in hospital longer than the males; and the sex ratio of those remaining in hospital over one year had almost equalised; 50.7% for males and 49.3% for females.

Fifty-seven per cent of all admissions were diagnosed as suffering from schizophrenia, 9.5% manic depressive psychosis of which nearly half were cases of mania; and 20% suffered from organic reactions. Patients with neurotic disorders were rarely admitted to hospital. 71% of male patients and 57% of female patients were not in a stable sexual union at the time of their admission to hospital.

Ari Kiev (1963), showed that the delusions of West Indian patients suffering from psychoses were closely associated with their magico-mystical beliefs. Devil possession (known to the West Indians as 'Obeah') is at the core of their beliefs in ghosts and supernatural insanity.

West Indians have local names for the

types of psychoses which include 'brain madness' and 'mind madness'. These states are similar and are characterised by inappropriate behaviour, confusion and increased psychomotor activity. They are thought to have a supernatural cause which is usually attributed to the 'Obeah', the violent and disturbing behaviour being taken as evidence that a ghost has entered into or is pursuing his victim. In fundamentalist sects the mental illness is attributed to the work of the devil rather than to the 'Obeah'.

Psychoses of West Indians in Great Britain.

In a personal study 124 patients, 74 males and 50 females were reviewed. In the catchment areas for the hospital in the 1961 census a sex ratio of the West Indian population was 1.1 males to 1 female, whereas the sex ratio of our patients was 1.5 males to 1 female; a ratio which corresponds closely with that of the Carribean survey. It is quite unlike the sex ratio of the patients admitted from the local population in which the ratio is 1.5 females to 1 male.

Housing. If it is considered that where three people of the same family live in one room is an adequate standard of housing, then 40% of our patients were adequately housed. 27% had very inadequate accommodation and 32% were living in lodgings and hostels.

Employment. Only 7% of our patients were unemployed, although 38% had more than four jobs since their arrival to this country. The majority of the West Indian women were employed and only two said they were just housewives.

The patients gave the following reasons for leaving home; 41% for financial gain, 15% for travelling and adventure, 15% for study and 21% followed their families, while 6% could give no adequate reason.

Precipitating factors. The illness was preceded in 37% by some form of physical stress, e.g., childbirth, anaemia, drugs, fevers or post-operative states. 29% had some form of psychological stress, such as employment, domestic disturbance or difficulties in adaptation. We could find no adequate evidence for either physical or psychological stress in 34%. After recovery, 52% of the patients contemplated returning to their home in the West Indies.

Symptomatology. 15% of patients could be diagnosed as suffering from an illness which was typical of those seen in Britain; half of these suffered from mania and half from chronic hebephrenic schizophrenia. The other

patients, that is 85%, had an illness resembling schizophrenia and in 65 of these cases the presenting symptoms were as follows:—

Behaviour					Total
Withdrawn/Retarded/Negativistic/Stuporous	...	...	...	...	38
Aggressive/Excited	...	...	...	...	11
Noisy	...	...	...	...	3
Bizarre/Manneristic/Unpredictable	...	...	...	...	10
Co-operative	...	...	...	...	3
					65
Mood					
Depressed	...	...	...	...	32
Elated/Talkative	...	...	...	...	5
Incongruous	...	...	...	...	16
Mute/Slow	...	...	...	...	12
					65
Delusions					
Paranoid/Persecutory/Reference/Influence	...	...	...	...	36
Grandiose	...	...	...	...	7
Jealousy	...	...	...	...	1
Nihilistic/Guilt	...	...	...	...	3
					47
Hallucinations					
Visual/Auditory	...	...	...	...	2
Auditory	...	...	...	...	21
					23
Confusion-Clouding of Consciousness					27
Hypochondriasis					27

In the early stages, the clinical picture changed rapidly. 58% showed catatonic symptoms with retardation, withdrawal, mutism, and catatonic stupor. This phase was often interrupted by outbursts of excitement, in which the patient reacted to auditory and visual hallucinations. It was often very difficult to get these patients to talk, eat, or drink. 55% also showed paranoid symptoms with vivid delusions of a persecutory nature, coloured by ideas of reference and influence. In cases where the paranoid element predominated, the confusion and catatonic features were not so pronounced. 40% of these patients suffered from hypochondriasis and described bizarre hypochondriacal symptoms amounting to somatic hallucinations e.g., waves of heat inside their body, insects running under their skin, pepper running in their blood, and snakes in the abdomen. Hypochondriasis was seen with equal frequency among the catatonic and the paranoid patients. 40% of patients were confused to a degree amounting to disorientation in time and space. In the majority of patients there was a mixture of disturbed mood, disturbed behaviour, hallucinations, delusions and confusion.

The illness can best be seen as a continuum. At one end were illnesses with predominantly paranoid symptoms, whereas at the other end of the continuum were patients with predominantly confusional symptomatology. Disturbances of behaviour were nearer to the confusional end of the scale whereas disturbances of mood were nearer to the paranoid end of the scale. Hallucinations and hypochondriasis took up a broad central position. Patients whose illness tended towards the confusional end of the scale were of good prognosis and often improved without specific treatment; whereas patients on the paranoid end of the scale, particularly if this were associated with depression, often required electrical treatment. The latter illnesses tended to be longer lasting and after recovery the patients found more difficulty in social adjustment.

In some patients it was clear that the illness was precipitated by social factors e.g., if during weekend leave an upset occurred, the mental state of the patient might relapse to its previous condition, despite the continuation of psychotropic drugs which were thought to have been responsible for the improvement that had been achieved.

If this type of reaction occurred in a European patient most psychiatrists would feel that some genetically determined biochemical disturbance had occurred in the brain, and that a prolonged course of electrical treatment and phenothiazine drugs would be indicated.

However, the West Indian patients frequently respond to distress by dissociation into a condition resembling schizophrenia. Several patients were accustomed to attending Pentecostal churches, such as the Church of God. In the course of this kind of service, it is expected that some of the congregation will respond to the Holy Spirit by excitement, stupor and 'talking in tongues'; that is uttering words of praise to God in a language or languages unknown to the patient.

Progress. 77% of our patients were able to return to their previous employment; of these 43% appeared to have recovered completely, while 34% were much improved; 18.5% had some residual symptoms of retardation or a remnant of their previous paranoid attitude; and 4.5% had not improved at the time of discharge. Of the male patients, 65% had recovered or improved, whilst of the female patients, 90% had recovered or improved. It may well be that the better prognosis amongst the female patients was due to the fact that they were able to obtain employment more

easily. Thus the picture of mental illness in West Indian immigrants is much the same as that described in the Caribbean census and is similar to that occurring in unsophisticated peoples of the world. The illness may occur more frequently following migration, but it does not seem to alter in character. Lamborn (1955) has shown that with education, the amorphous confusional states among Nigerians become less frequent.

Indian Immigrants

For many years the Indian people have migrated to many countries including most of those which were under British rule. They were recruited by the Colonial Governments and the East India Company to satisfy the labour needs of the developing colonies.

The migrants mostly come from specific regions in India and they tend to retain the culture, language and kinship of their parent country even when they are away for long periods. Like the West Indians they were attracted to the occupational opportunities in post-war Britain. In 1952 it was estimated that there were 10,700 Indians in this country. This figure rose to between 70 and 100 thousands in 1960 (Desai, 1963). The large majority came from Punjab and Gujarat districts from people who traditionally encourage immigration. The majority who leave are young married males who are later joined by their wives and children. All the Gujarati and the majority of the Punjabi males are literate although the educational standard of the females is lower. Very few can speak English with any competence although many have had some tuition in English at school. In this country, apart from the head-dress and beard of the Sikh, the males adopt European dress although the women continue to wear traditional clothing. A large majority retain Indian habits of eating. There are three language groups, Punjabi, Gujarati and Eastern Bengali. Hardly any immigrant is able to speak in an Indian language other than his own. Indian caste barriers are relaxed in this country; all may eat together and caste no longer restricts employment. Kinship in India is threatened if marriage occurs outside the caste or religion, or where personal and financial allegiance with their caste members in this country and at home is not maintained.

A recently arrived immigrant will usually be offered hospitality by a relative or kinsman who helps him to find accommodation and employment and his life in England is arranged

extension of his life in India. A sense of community does not extend outside his kinship group. There are strict laws governing sexual behaviour and married people will behave formally before others and particularly before children.

In this country most households are run on the Indian pattern of a joint family system in which the house owner takes the place of the senior male as the patriarch for the residents. Community living, sharing of domestic equipment and often of food is usual and guests are entertained in the joint lounge rather than privately. Quarrels are settled through the senior community members and the police are only called in exceptional circumstances. Gaitonde (1964) speaking of socio-cultural attitudes in India says—

"The early development influences to which an Indian child is exposed emphasize a sense of belongingness to the family and a sense of responsibility toward the family members, leading, in turn, to the formation of a super-ego, which has more a social than personal character. The religious outlook which emphasizes that a person's existence is only a moment on the infinite scale of life's cycle enables him to tolerate frustration with tranquillity and minimises the urgency of personal initiative to change things and make life more bearable. Respect for the elderly makes it possible to grow old in Indian society with grace and equanimity. The social, religious, and family organization promotes the development of basic personality pattern in which personal initiative is replaced by a sense of conformity, in which responsibility is exercised without personal authority, in which security is associated with a sense of dependence and self-respect with a sense of helplessness, but in which opportunities for isolation and acute anxiety are minimised."

This rather passive attitude may well account for a syndrome which is described by Carstairs (1958) under the title of 'Jiryan', which he believes is the commonest form of anxiety neurosis amongst the males in the Indian communities he knew. The sufferer believes that he is continuously losing semen into his urinary tract. He may bring a specimen of urine to the doctor showing perhaps a deposit of phosphates or urates and assert that this contains semen. He attributes his symptoms of exhaustion, inertia and a wasting-away of the bodily tissues to this seminal loss. Many have been victimised by sex specialists in India who offer treatment for impotence which they diagnose even

in the presence of regular successful sexual intercourse. No matter how frequently the sufferer has intercourse the specialist would suggest that he should be having it more frequently.

Personal experience of Indian patients in Kampala shows that many young males, particularly those who have been educated in England, find it difficult to adjust to a joint family system in which they will have no authority until they reach middle age or even later in life.

We were unable to find any literature concerning mental illness occurring in Indians in Britain.

From our experience depression is quite common. On occasions symptoms of retardation and withdrawal may sufficiently dominate the clinical picture for the case to be mistaken for organic confusion.

Mania occurs with comparative frequency and all forms of schizophrenia are commonly seen. Of the neuroses, maladjustment, anxiety states, hypochondria and the Brain Fag syndrome are frequently seen.

Mayer-Gross, Cross, Harrington and Sreenivasan (1958) surveyed the mental hospital population in Bangalore, which is, admittedly, far from the Punjab and Gujerat districts which have been discussed. He found that the sex ratio for the inmates was three males to two females. This has also been our experience in England. The Indian males are much more frequently referred for both psychoses and neuroses than the females. There is probably some family reluctance for the females to be referred to a non-Indian doctor.

Although witchcraft and possession are a part of the culture of many districts in India, they did not play a dominant part in the symptomatology of the mental illnesses we were seeing. Attitudes of passivity, non-violence and morbid introspection caused mental breakdowns to be directed inwardly rather than to be projected upon the environment.

Summary

Mental and physical illness patterns vary in differing cultures.

The immigrant tends to respond to stress according to the cultures of his childhood environment.

The host community may attract a positive or negative selection of the immigrants according to the circumstances prompting migration.

The difficulties that the immigrant finds in his new environment frequently result in an in-

creased frequency of mental illness, with a relative excess of paranoid and somatic symptomatology.

These points are illustrated by examples of immigration to Britain of peoples from Tristan da Cunha, Hungary, the West Indies and India.

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