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Psychiatric Disorders in Selected Immigrant Groups in Camberwell

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Summary. This paper reports on psychiatric disorder amongst West Indians and Irish-born residents of Camberwell in South London. National figures suggest high rates of severe functional disorders in West Indians with relatively few minor disorders. Among the Irish, however, mania is rare, schizophrenia shows high rates in women but not in men and the milder affective disorders are more common than in the native born (Cochrane 1977). The current study uses both hospital-based data from the Camberwell registrar and data from a community survey and essentially substantiates these findings. It is suggested that these persistent opposing patterns in these two groups of immigrants could be in large part explained by culturally determined patterns of response to adversity.

The psychiatric health and social performance of immigrants has been an issue for a very long time. Ødegård (1932) has provided an excellent summary of the early literature. Sanua (1969) reviewed a wide selection of studies on the mental health of immigrants – all over the world immigrant groups have higher rates of disorder, especially schizophrenia. However, as Malzberg (1969) has shown, control for age, sex and other factors likely to influence rates either reduces or completely eliminates the rate discrepancy. This was indeed known although sometimes forgotten from some very early American work (Ødegård 1932).

There are three possible explanations for true high rates of mental disorder in immigrants (Murphy 1973) of which two adduce a constitutional and one a social basis. Firstly there may be national or racial differences which may account for these differences. Secondly, pre-existing abnormalities might lie behind the impulse to emigrate (the selection hypothesis). Finally, immigrants may be more likely to break down because of the special stresses of the immigration. There is, of course, no reason for these hypotheses to be mutually exclusive (Krupinski 1967).

As Bagley (1975) emphasised, immigrations differ. The immigrating group may be conquerors, refugees or economic opportunists. They may have the intention of remaining separate or of adopting completely the ways of their hosts. They may have various similarities with and differences from the host population. Examples of widely differing types of immigrations include the European Jews in Israel, the British in India and the British in Australia. There is little doubt that assimilation even in favourable circumstances takes years.

Bagley (1975) has been particularly interested in the situation of West Indian and Asian immigrants in Britain. This has led him to emphasise the poles of assimilation and plural accommodation. Both of these processes involve an acceptance of many of the social values of the host nation; in the case of plural accommodation however many elements of traditional immigrant culture are retained.

Since the last war there has been a large immigration into the U. K. from the so-called New Commonwealth countries, especially from the West Indies and from the Indian subcontinent. West Indians have emigrated for many years because of under-employment, over-population and poor economic opportunity. In the past they moved to other Caribbean countries and to the United States. However, the passing of the McCarran Act of 1952 in that country prohibited further immigration of West Indians. In the immediate post-war years there was full employment in Britain which attracted both West Indian and Asian groups to this country. At that time Britain was

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Table 1. Admission rates to mental hospitals in England and Wales by country of birth [native-born = 100], (adapted from Cochrane 1977)

Country of birth	Crude admission rates		Age adjusted rates	
	Men	Women	Men	Women
Scotland	171	123	164	123
Irish Republic	267	219	245	209
West Indies	170	188	103	113
India	135	118	85	79
Pakistan	123	126	68	68

Table 2. Admission rates to mental hospitals in England and Wales by country of birth, by selected diagnoses. [native-born = 100], (adapted from Cochrane 1977)

Country of birth	Schizophrenia		Affective disorders		Neuroses	
	Men	Women	Men	Women	Men	Women
Scotland	103	111	93	108	117	126
Irish Republic	95	292	153	189	183	188
West Indies	333	371	67	99	40	76
India	162	161	69	62	69	73
Pakistan	182	118	49	41	75	117

almost alone amongst the independent members of the Commonwealth in allowing free and unlimited entry and residence for all British subjects or Commonwealth citizens. This period of immigration extended throughout the 1950s and 1960s until progressively curtailed by the Immigration Acts of 1962, 1968 and 1971 (Evans 1976).

At the time of the 1971 Census 313,000 Indians, 136,000 Pakistanis and 236,000 West Indians were resident in England and Wales. Only 31% of Indians and West Indians and 17% of Pakistanis had entered the country before 1960.

Ireland provides another large group of more local immigrants to Britain. Northern Ireland is, of course, part of the United Kingdom and there are no restrictions on entry to Britain upon persons from that region. In addition, there has always been a free flow of people from the Irish Republic to Britain, a situation which is made possible by the unusual British nationality laws concerning the Irish (Dummett 1976). Irish citizens are not British citizens but may be British subjects with voting rights. They are not aliens although Ireland has not been a member of the Commonwealth since 1948. In 1971, 676,000 people born in the Irish republic were resident in England and Wales and a further 216,000 born in Northern Ireland.

The situations of the Irish and of immigrants from the New Commonwealth are very different. Bagley (1975) describes the position of the West Indians in Britain in terms of failed assimilation and that of the Asians in terms of failed plural accommodation: in both cases he regards the failure as having arisen because of discrimination.

The extent of discrimination against Asian and West Indians in the United Kingdom is well documented and is prominent in both the housing (Deakin 1970) and employment sectors (Daniel 1968; McIntosh and Smith 1974). As in the United States, prejudice is based upon colour, not culture. It may therefore be that, as Bagley (1975) suggested, the same problems of low self-esteem and of Mertonian disjunction between aspiration and means applies to coloured immigrant groups in Britain as in the United States (Parker and Kleiner 1966). Bagley (1971) himself presents some evidence of an association between high 'goal striving' and schizophrenic breakdown in West Indians. It seems reasonable to suppose that if immigration is a stressor, it is most likely to be so where the fusion process is relatively a failure and especially where it is failed assimilation. This argument would suggest high rates of psychiatric disorder in general in West Indians, and relatively low rates in the Irish, whereas in Asian groups, if it is true that their immigration has resulted in failed plural accommodation, group cohesiveness may actually be increased and therefore protective.

However, the situation becomes more complicated if the contingencies of actual immigration are examined. One variable likely to affect the 'selection hypothesis' is the ease of immigration. Where the barriers to immigration are strongest and the process in other ways difficult, there may well be selection for good mental health. Where immigration is easy, there may well be a larger proportion of drifters, some of whom may be mentally ill or developing an illness. Cochrane (1977) for instance has used this argument to explain the high rates of mental hospital admissions amongst the Scots and Irish in England and Wales. In the 1950's and 1960's immigration was also particularly easy for West Indians: there were, for instance, recruiting compaigns in the West Indies mounted by London Transport at that time.

There is a moderate literature purporting to document high admission rates amongst West Indian immigrants in Britain (Giggs 1973a and b; Hemsi 1967, 1968). These showed particularly high rates of schizophrenia. The special features of this disorder in West Indians have been described by Kiev (1963) and Tewfik and Okasha (1965). Cochrane (1977) criticises these early studies because they did not standardise for age and sex. In his study of admission

rates of hospitals in England and Wales, Cochrane (1977) did make this correction. Table 1 gives rates relative to the native born based on his data and it can be seen that the correction makes a large difference. Overall rates in the Irish and West Indian groups remain higher than in those who were born in England and Wales. Rates for Asians are consistently below the native born. Cochrane also presents rates broken down by diagnostic category. This results in numbers too small to give an age standardisation. Table 2 contains a selective presentation of his results. It seems likely from a consideration of the size of the change brought about by the age correction for all disorders that West Indians have about twice the expected admission rates for schizophrenia, that a smaller excess remains in the Asian group and that there are very low admission rates in both groups for affective disorders and neurosis. Low rates for these categories are the rule in hospital-based studies of West Indians and Asians. An exception is Hemsi (1967) who did not control for the sociodemographic characteristics of the immigrant population but did find high rates of affective disorder in West Indians. Cochrane's uncorrected figures (1977) suggest high rates of schizophrenia in Irish women, but in the men, if anything, the rate is less than that of the British-born. Both sexes show high rates of both affective disorder and neuroses.

Until recently only two general practice and no community surveys have looked at the psychiatric health of immigrants. Pinsent (1963) in his Birmingham practice claimed to observe twice the rate of mental disorder in West Indian females compared with his English patients, although there were no differences in the men. Kiev (1965) mounted a six-month morbidity survey in a Brixton practice. The West Indians showed 38% more 'conspicuous psychiatric morbidity' after age-matching, compared with the British born. However, this difference, in contrast to Pinsent's findings, was significant for men but not for women. Brewin (1980), in Oxford, found that overall G. P. consultation rates were the same for Asians and suggested that G. P. s might have difficulty in recognising psychiatric disorders in this group.

Recently Cochrane and Stopes-Roe (1979, 1980) have conducted community surveys in Britain. There are difficulties in such community surveys as no available sampling frame in Britain carries information about country of birth. One way round this is the 'random walk' technique used by Cochrane and Stopes-Roe. However, in order for it to be economic, it has to be conducted in areas of high immigrant density which may of itself lead to an unrepresentative sample.

In both these studies, Cochrane and Stopes-Roe used trained interviewers to administer a battery of schedules including the Langner Scale. This was used to produce a continuous scale of undifferentiated psychiatric morbidity. In the first study (Cochrane and Stopes-Roe 1979) 200 Irish immigrants in large English cities were compared with 200 native English and 200 native Irish in Dublin. The immigrants had better mental health than the native Irish who in turn scored less than the native English. A similar study (Cochrane and Stopes-Roe 1980) on 240 English, 200 Indian and 200 Pakistan-born subjects in Birmingham showed low rates amongst the Indians, whilst the Pakistanis showed similar rates to the English.

Any study seeking to provide a theoretical explanation for any association found between immigration and psychiatric disorder must take account of the many relevant aspects of the immigration process, i. e. which persons of which race, from which culture, for what reasons and with what intentions, move to which country, with what effect? Moreover, it must also account for differential association with type of disorder. As social explanations for the suceptibility to different disorders are in any case inadequate, and as we seldom have comparable data of rates of disorders in the host country and the country of origin, it can be argued that theoretical explanations of the psychiatric susceptibilities of immigrants are premature. Such explanations are often premature on the further grounds that they have been put forward on the basis of inadequately analysed data.

The opportunity for the current report arose because of the availability of two sources of data for Camberwell, a predominantly working class region of South London which serves as the catchment area for the Maudsley Hospital. The first was the Camberwell Psychiatric Case Register (Wing and Hailey 1972) and the second a community psychiatric survey carried out by the authors (Bebbington et al. 1980). Camberwell has two major immigrant groups of West Indian and Irish origin. It is not possible to make a crucial test of the three hypotheses in the West Indian group as insufficient is known of the rates of disorder in the West Indies. If immigration acts as a stressor, it is more likely to do so in the West Indian group who come from a different culture and are subject to considerable discrimination. On these grounds they are likely to have an overall increase in rates of psychiatric disorder. On the other hand, immigration is likely to be much less stressful for the Irish. However, national rates for schizophrenia in Ireland are very high, particularly in the West (O'Hare et al. 1980) and this together with the selection hypothesis might lead to an expectation of high

Table 3. Population of Camberwell, 1971 by age and country of birth (estimated from the 10% sample of Southwark and using the known number by sex of U. K., West Indian and Irish-born residents in Camberwell)

Age	U. K.		West Indies		Ireland	
	Male	Female	Male	Female	Male	Female
15–24	9754	9471	686	841	198	326
25–34	5799	5931	823	1113	660	751
35–44	6111	6543	1105	929	691	702
45–64	16383	18204	639	433	921	838
Total	38047	40149	3248	3316	2476	2617

rates of schizophrenia in Irish immigrants. These speculations do not readily fit in with Cochrane's results (1977). A further purpose of the current study is to attempt a replication of these results on a population subject to relatively uniform diagnostic practices.

Method

(a) The Register Study

In this section we use data from the Camberwell register to establish rates of new episodes, prevalence and admissions for the native-born, Irish-born and West Indian born. This register had been described in detail elsewhere (Wing and Hailey 1972). It is designed to record all admissions to hospital, and (until 1978) all new episodes of mental disorder leading to contact with psychiatric services in the area. It covers persons living in the Maudsley Hospital catchment area which coincides with the former borough of Camberwell in South London. In addition, a census of Camberwell patients in contact with services in the area is conducted on 31st December each year. Although Camberwell no longer exists in administrative terms it can still be defined in terms of polling districts and so population figures can be derived for it.

Because we wished to take account of the age and sex distribution amongst persons born in different countries, it was necessary to have a breakdown of the population by age, sex and country of origin. In 1971, a total census by sex and age was taken and a 10% sample of the London Borough of Southwark was used for a fuller enquiry which gave figures by age, sex and country of origin. From this it was possible to derive estimates by sex, age and country of origin for the Camberwell area, which constitutes the southern two-thirds of the Borough of Southwark. This assumes that immigrants are uniformly distributed throughout Southwark. As a check on this assumption we used our estimates to reconstruct the total population of Camberwell, aged 15–64. This taillied to within 0.4% with the actual enumerated population between these ages. In Table 3 we give the Camberwell population who were born in Britain, the West Indies or Ireland. There are relatively few (892) Asian immigrants in Camberwell and we therefore do not present findings for this group.

In this paper we present two sets of tables of data from the Camberwell register. In the first three (Tables 4–6) we give figures for prevalence, new episodes and admissions by country of origin for the diagnostic categories schizophrenia, all affective disorders and neuroses for the year 1971. The category 'all affective disorders' includes mania, severe depression and moderate depression. The neuroses include anxiety states and other categories of neurosis in the International Classification of Disease (WHO, 1978), but exclude affective disorders.

In these tables we give both uncorrected rates and rates corrected for age. Age correction was carried out by breaking down the populations into ten-year age groups and correcting for discrepancies in distribution between the populations taking the British-born as standard. However, as figures vary appreciably from year to year, we have regarded the actual values with caution. They do, however, represent a best correction for the age distribution and serve to show the change in rates which arises through this correction.

Because of our reservations, we also present prevalence and admission rates which are the mean of eight years figures and rates of new episodes which are the mean of seven years. We also include data on mania (Tables 7–9). The advantage of this is counterbalanced, however, by the fact that the declining population of Camberwell has to be taken into account in calculating rates. It is probable that this decline has affected persons of different country of origin to a different extent. It is unlikely, for instance, that the West Indian population has declined to the same extent as the native-born. Moreover, the age structure of those too young to be enumerated in our selected age band in 1971 also varies by country of origin, with an over-representation of West Indians. For these reasons, the base population estimates for this group are probably too low and the age structure misrepresented. The two sets of tables must, therefore, be regarded as complementary.

(b) The Population Survey

The details of the method of this study are presented elsewhere (Bebbington et al. 1980; Hurry et al. 1980; Sturt et al. 1980).

Table 4. Point prevalence per 100,000 (31st Dec. 1970) by sex and country of birth of persons aged 15–64 resident in Camberwell and in contact with psychiatric services, Camberwell Register data

(a) Raw Data Place of birth	Sex	Schizophrenia	All affective disorders	Neuroses
United Kingdom	Male	200	168	81
	Female	147	463	82
West Indies	Male	339	62	0
	Female	332	241	0
Ireland	Male	162	323	81
	Female	153	535	38
(b) Corrected for Age				
West Indies	Male	244	56	0
	Female	269	322	0
Ireland	Male	199	279	46
	Female	135	507	43

Table 5. Rate per 100,000 (1971) by sex and country of birth of new episodes of psychiatric disorder bringing persons aged 15–64 resident in Camberwell in contact with psychiatric services, Camberwell Register data

(a) Raw Data Place of birth	Sex	Schizophrenia	All affective disorders	Neuroses
United Kingdom	Male	110	365	168
	Female	87	780	152
West Indies	Male	154	339	123
	Female	452	784	151
Ireland	Male	81	687	202
	Female	38	917	76
(b) Corrected for Age				
West Indies	Male	85	270	210
	Female	253	893	192
Ireland	Male	46	510	245
	Female	54	774	74

Table 6. Admission rate per 100,000 (1971) by sex and country of birth of persons aged 15–64 resident in Camberwell, Camberwell Register data

(a) Raw Data Place of birth	Sex	Schizophrenia	All affective disorders	Neuroses
United Kingdom	Male	97	118	29
	Female	70	257	32
West Indies	Male	216	277	0
	Female	392	151	0
Ireland	Male	81	283	40
	Female	115	267	38
(b) Corrected for Age				
West Indies	Male	120	192	0
	Female	417	196	0
Ireland	Male	153	185	129
	Female	146	239	54

Table 7. Mean point prevalence per 100,000 (31st Dec. 1970–1977 inclusive) by sex and country of birth of persons aged 15–64 resident in Camberwell and in contact with psychiatric services, Camberwell Register data

(a) Raw Data Place of birth	Sex	Schizophrenia	Mania	All affective disorders	Neuroses
United Kingdom	Male	173.5	17.4	172.7	65.1
	Female	122.4	19.1	417.9	93.6
West Indies	Male	328.7	76.8	136.6	17.1
	Female	464.8	29.1	344.5	16.6
Ireland	Male	105.6	5.6	227.8	105.6
	Female	208.8	10.4	490.6	104.4
(b) Corrected for Age					
West Indies	Male	285.0	60.5	143.0	28.5
	Female	501.7	38.3	469.9	44.2
Ireland	Male	86.5	6.3	204.6	107.3
	Female	244.2	5.7	514.9	79.9

A random sample of 800 subjects aged 18–64 in the former borough of Camberwell, in London, was interviewed by professional interviewers from a reputable Social Survey Agency using a 40-item version of the Present State Examination and a questionnaire eliciting basic social facts about the subject. A further and longer interview four weeks later was sought with all cases and a random sample of non-cases. This included the administration of the full PSE by members of the MRC Social Psychiatry Unit. Cases were defined as those of level 5 and above on the Index of Definition (Wing et al. 1978). Of the initial 800 interviewers, 611 were British born and 69 either West Indians or of West Indian origin. The remainder were made up of a fairly large group of Irish-born (n = 32), and smaller groups from the Indian sub-continent, Africa, the Mediterranean and other places. Persons other than British or West

Table 8. Mean rate per 100,000 (1971–1977 inc.) by sex and country of birth of new episodes of psychiatric disorder bringing persons aged 15–64 resident in Camberwell in contact with psychiatric services, Camberwell Register data

(a) Raw Data Place of birth	Sex	Schizophrenia	Mania	All affective disorders	Neuroses
United Kingdom	Male	117.8	20.3	366.5	149.5
	Female	101.6	13.0	704.9	193.7
West Indies	Male	331.8	58.6	283.0	92.7
	Female	483.8	61.7	792.1	156.5
Ireland	Male	82.5	19.1	628.6	336.5
	Female	232.6	6.0	1193.0	322.1
(b) Corrected for Age					
West Indies	Male	346.0	70.1	275.5	115.2
	Female	720.7	52.0	898.1	165.3
Ireland	Male	57.3	21.7	457.6	404.4
	Female	270.7	3.3	1129.7	305.4

Table 9. Mean admission rates per 100,000 (1971–1978 inclusive) by sex and country of birth of persons aged 15–64 resident in Camberwell, Camberwell Register data

(a) Raw Data Place of birth	Sex	Schizophrenia	Mania	All affective disorders	Neuroses
United Kingdom	Male	106.9	18.3	123.2	23.2
	Female	78.3	18.7	288.1	40.9
West Indies	Male	292.7	87.8	214.7	24.4
	Female	447.4	89.5	435.4	23.9
Ireland	Male	38.1	6.4	215.9	88.9
	Female	155.1	17.9	405.6	71.6
(b) Corrected for Age					
West Indies	Male	252.9	64.4	190.6	35.1
	Female	426.2	54.7	337.2	25.0
Ireland	Male	37.8	3.6	183.4	104.7
	Female	181.8	9.8	413.3	60.0

Indians are too small in number for us to draw any but tentative inferences and so we will concentrate on the West Indian group. Of the 310 persons successfully re-interviewed, 31 were West Indians and 233 were British-born. In drawing conclusions from our data we take account of the lower reliability of the agency interviewers (Sturt et al. 1980) as against the smaller numbers of interviews conducted by the MRC team.

Results

(a) The Register Study

The results of this investigation are presented in Tables 4–9. Certain trends can be seen in these tables, some definite, some less so. The effect of age correction is more apparent in the 1971 figures than in the pooled data: we take this to mean that more effective age correction makes a bigger difference to the values, although this is not always in the direction expected. In general, the effect is more prominent in the figures for schizophrenia in West Indians, tending to reduce the rates by a large degree. Even here, however, the effect of age corrections on admission rates in 1971 for female West Indians was to increase an already high rate.

Nevertheless, the most striking finding in our tables is of high rates of schizophrenia in West Indians. This persists in females in all the tables, even after age correction, and in males the only exception to the trend is that in the 1971 figures of incidence there is a low rate compared with the native-born after age correction. It seems likely that, even after allowance for under-estimation of the base population and possible inaccuracies of age-correction in our pooled data, our figures reflect a true increased rate of this disorder amongst persons born in the West Indies.

The number of cases of schizophrenia amongst the Irish-born was relatively small and the results for the single year 1971 are inconsistent, with the prevalence being equal to, incidence less than, and admissions higher than in the native-born. In the pooled figures, however, a consistent and interesting trend emerges. Irish males show half, and Irish females over twice, the rates of schizophrenia in the native-born.

West Indians also show very high rates of mania although there were insufficient numbers of this relatively rare disorder to give results for the single year 1971. This is in marked contrast to the consistently *low* rates in the Irish-born.

When we turn to affective disorders, trends in the West Indian figures are less discernible although it is possible that there is a greater difference between the sexes than in people born in Britain. Moreover, although we do not give the detailied figures, a consistently higher proportion of affective disorders in West Indians were manias and severe depressions. Amongst those born in Ireland it is reasonable to conclude that there is in general a higher rate for these disorders.

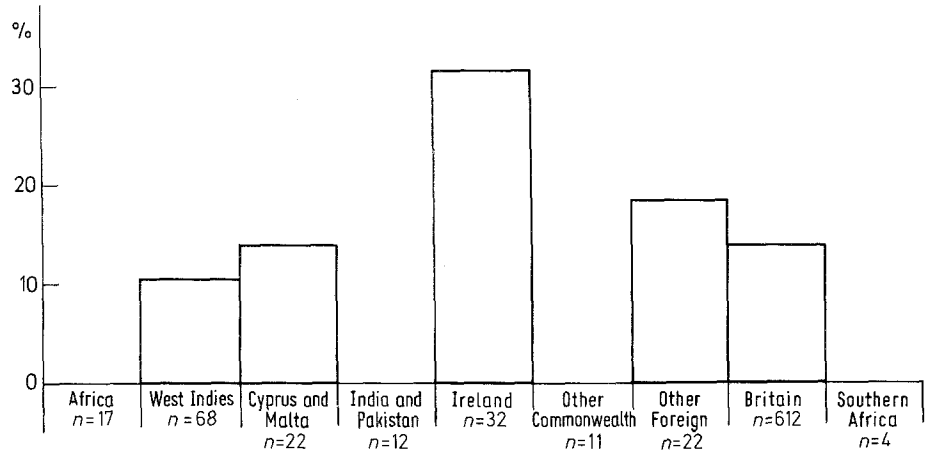

Fig. 1. Percent prevalence of psychiatric disorders of ID5 or above by country of birth agency interviews

Table 10. Prevalence of disorders (ID5 and above) in the Camberwell population: by country of birth

(a) Agency Interviews[a]

Country of birth	Total	Males		Total	Females	
		No. of cases	% of cases		No. of cases	% of cases
Britain	296	26	8.8	315	57	18.1
West Indies	31	1	3.2	38	7	18.4
X^2 (ldf)		0.53			0.03	
p		N. S.			N. S.	
For both sexes: X^2 (ldf)			0.07			
p			N. S.			

(b) MRC Interviews[b]

Country of birth	Total	Males		Total	Females	
		No. of cases	% of cases		No. of cases	% of cases
Britain	100	10	6.2	133	32	14.7%
West Indies	15	–	0.0	16	2	10.9%
X^2 (ldf)		0.63			0.53	
p		N. S.			N. S.	
For both sexes: X^2 (ldf)			1.87			
p			N. S.			

[a] 40 item PSE
[b] Full PSE

Finally, West Indians seem on balance less prone to contact with neurotic disorders and the Irish may have higher rates in these categories, perhaps most marked in men.

(b) The Population Survey

It can be seen from Figure 1 that, for the Agency interviewers, the prevalence of disorder at threshold level and above varied considerably between groups of different origin. There were no cases at all from Africa, the Indian sub-continent or the Old Commonwealth, whilst the highest rate was in the Irish-born. Overall, however, these differences were within the bounds of chance. Table 10 shows prevalence for those born in Britain and the West Indies. The figures from the MRC interviews are weighted to give an unbiased estimate of prevalence for the whole sample. These data suggest, if anything, lower rates for the West Indian group, most marked amongst men.

In general, we found that the socio-demographic character of the West Indian group is different from the indigenous population. In the whole group of

subjects at first interview we found that the West Indians had a significantly different age structure, with fewer in the age group 55–64 and a relative excess of those aged 35–44, people who were young adults at the time of greatest immigration in the 1960's. Controlling for age did not lead to a significant association between origin and disorder.

The social class findings were interesting. Using the split employed by Brown and Harris (1978) to divide the Goldthorpe and Hope Classification into middle and working class groups, we find that West Indians are significantly more likely ($p < 0.02$) to be working class, even in the predominantly working class area of Camberwell. Only 36% of West Indians as opposed to 52% of native British were middle class. However, 61% of the West Indian males were in skilled manual occupations, compared with only 42% of native British, and relatively fewer of them were in the lowest two occupational classes. The same percentages of West Indian and British men were in employment. It appears from this that the West Indian subjects in our sample were not notably disadvantaged.

West Indian women differed significantly from those born in Britain in that two-thirds were in full-time employment compared with less than half the British. Characteristically they were employed in more menial jobs, equivalent to the lowest socio-economic group. Controlling for social class made no difference to the findings regarding prevalence. It is of interest that although being at work reduces risk of disorder in the British born (Bebbington et al. 1980), this does not apply to the West Indian group. This may reflect a different meaning of employment for this group, specially to the large percentage of West Indian wives engaged in menial tasks.

Discussion

One disadvantage of Cochrane's (1977) national study is that it is quite apparent that the phenomenological classification of psychosis in West Indians poses some difficulties for the British psychiatrist (Gordon 1965; Rwegellera 1970, 1977). In presenting our results from the Camberwell register, we hoped that relatively uniform diagnostic practices amongst psychiatrists from the Maudsley and the other hospitals in the area would increase comparability between groups. In fact, the figures presented in this paper are consistent with the national ones. We agree in showing high rates of schizophrenia in West Indians and in Irish females and a relatively low rate in Irish males. We also show similar high rates of affective disorder and neurosis in the Irish and a low rate of neurosis in the West Indians. Our findings regarding affective disorders in West Indians are more tentative but the suggestion that there may be an increased sex difference in this group agrees with Cochrane's data (1977).

The very high rate of mania amongst West Indians in Camberwell has been noted before (Leff et al. 1976). There was an abnormally low rate in the Irish.

There is no direct way of knowing if the high rates of schizophrenia in West Indians are the result of racial differences as little is known of rates in the source countries. Royes (1961) does provide prevalence figures for the island of Jamaica, but these are likely to reflect service availability rather than to offer a basis for comparison. The selection hypothesis may not be of major importance in explaining high rates in British West Indians as breakdown appears to occur some years after entry to Britain (Gordon 1965). This finding also suggests that if the breakdown is stress related, it is not the immediate stress of relocation but the more drawn-out process of acculturation which is responsible.

Hospital admission rates have drawbacks in the assessment of the mental health of immigrants. Figures refer to immigrant-host differences within a given catchment area. Even so, there may be differences in the way the referring and admitting doctos respond to disorders in immigrants. Moreover, immigrants may use lay healers as alternatives: there are more than 200 hakims in Britain. By and large this is likely to have an effect only upon the more minor disorders as the majority of schizophrenics end up in hospital at some stage, through one channel or another. Brewin (1980) has recently suggested that rates of disorder in Asian immigrants represent under-utilisation rather than relatively good mental health.

The findings from our community survey, admittedly only based on small numbers of immigrants, are inconsistent with the general practice studies of Pinsent (1963), Kiev (1965) and Brewin (1980). We also are at variance with the community survey of Cochrane and Stopes-Roe (1980) showing relatively low rates in Irish immigrants in Britain. Our community data are, however, in broad agreement with the hospital figures from the Camberwell register which show that West Indians have low rates and the Irish have high rates of minor depression and anxiety. As most disorders in the community are of this type, *overall* rates of disorder in the general population should be low amongst West Indians and high amongst the Irish.

The differences in the pattern of disorder between the West Indians and Irish immigrants and the

British born in Camberwell seems to be real ones. They are in rough agreement with the national figures. It is difficult to explain the findings in West Indians in terms either of selection or of the stress of immigration. The establishment of accurate psychiatric hospital statistics in the West Indies could do much to clarify the issue. In interviewing British West Indians in the community we were left with a distinct and persistent clinical impression that they respond to adversity with cheery denial. We speculate that it might be possible to explain the apparent proneness of West Indians to major psychiatric disorder and their relative immunity to minor disorder in terms of this cultural characteristic – the Irish citizens of Camberwell seemed much more readily aware when things were going badly.

Any understanding of the patterns of disorder in these two groups must account for the specificity of those patterns. An account in terms of culturally specific responses to adversity could fulfil this requirement and seems worthy of further investigation.

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