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Psychiatric Morbidity of West Indian Immigrants

A Study of First Admissions in London *

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Summary. A study has been made of West Indian and native first admissions for 1961, Census year, from the Metropolitan Boroughs of Camberwell and Lambeth. Only patients in the age range 15 to 54 were considered. — The results show considerably higher total first admission rates for West Indians than for the local population. Organic psychosyndromes, alcoholism and drug dependence were absent in the West Indians and rare in the native population. For both the major functional psychoses and for the personality and neurotic disorders, the West Indians showed much higher rates than the native population. The percentage distribution for these conditions was broadly similar in the two national groups though psychoses were more, and personality disorders less, prominent in the West Indians. The timing of the migration in relation to the mental illness was also examined. — The differences between these findings and those of other authors concerned with West Indians in Britain are discussed; they may be due to a different selection of patients and to differing diagnostic criteria.

Résumé. Lors du recensement de 1961, une étude a été faite sur les premières admissions antillaises et indigènes dans les centres urbains de Camberwell et de Lambeth. Seuls ont été pris en considération les patients âgés de 15 à 54 ans. — Les résultats montrent un taux d'admission considérablement plus élevé pour les antillais que pour la population locale. Les syndromes psycho-organiques, alcooliques et toxicomaniaques étaient absents chez les antillais et rares parmi la population indigène. En revanche, on trouvait chez les immigrants des taux des deux principales psychoses fonctionnelles et de troubles de la personnalité et névrotiques beaucoup plus grands que chez les autochtones. Le pourcentage de répartition de ces états était assez similaire dans les deux groupes nationaux quoique les psychoses fussent plus importantes et les troubles de la personnalité moindres chez les antillais. Les rapports entre la date de la migration et la maladie mentale furent également étudiés. — Les différences entre ces résultats et ceux d'autres auteurs concernant les antillais en Grande Bretagne sont discutées; elles peuvent être dues à une sélection différente des patients ou à l'établissement de critères diagnostiques divergents.

Zusammenfassung. Es wurden die psychiatrischen Erstaufnahmen zweier Londoner Stadtviertel (Camberwell und Lambeth) des Jahres 1961 im Hinblick auf indische Immigranten und die ansässige Bevölkerung untersucht. Dabei wurden nur Patienten der Altersspanne 15—54 berücksichtigt. — Die Anzahl der Erstaufnahmen lag bei den Indern beträchtlich höher als bei der lokalen Population. Organische Psychosyndrome, Alkoholismus und Suchten fehlten bei den Indern und waren auch bei der einheimischen Bevölkerung selten. Psychosen und neurotisch-psychopathische Störungen waren bei den Indern häufiger als bei der einheimischen Bevölkerung. Die prozentuale Verteilung dieser Zustände zeigte in beiden Bevölkerungsgruppen Ähnlichkeit, wiewohl bei der indischen Population die Psychosen relativ häufiger waren als die Persönlichkeitsstörungen. In dieser Untersuchung wurde auch der Migrationstermin in Beziehung zur seelischen Erkrankung gesetzt. — Unterschiedliche Ergebnisse im Vergleich zu anderen Untersuchungen, die sich mit indischen Einwanderern in Britannien beschäftigten, werden auf Selektionseinflüsse und unterschiedliche diagnostische Kriterien bezogen.

Introduction

The Census of 1961 (General Register Office, 1963) revealed that the large migration of the 1950's and early 1960's had made the West Indians the most numerous single ethnic group of overseas immigrants in Britain. Yet until that census was taken no accurate statistics existed to describe the demographic aspects of this migration nor the dispersal within Britain of West Indians after they had landed in the country.

This lack of statistical information restricted studies of psychiatric morbidity to that part of it which is reflected by attendances in general practice. Such studies depended upon the identification of West Indians and of native patients on the lists of general practitioners, followed by the determination of the rates of attendance and patterns of illness disclosed by the consultations. Thus Pinsent (1963) examined all items of service carried out in general practice in Birmingham for 127 West Indian and 127 native patients over a period of 4 years. He found a higher rate of attendance for mental disorders among English, as compared with West Indian men, but the reverse obtained for women, with Jamaican women showing rates of consultation twice those of English women. Kiev (1965), on the other hand, in a six month psychiatric morbidity survey in a Brixton general practice, found higher prevalence rates in West Indians of both sexes, though only for the men did the differences achieve statistical significance. Both these investigations laboured under the difficulties inherent in the collection of psychiatric data in general practice, and they naturally covered only that part of the spectrum of psychiatric illness which is mild in degree, and whose evaluation is particularly difficult and open to doubt, especially in a transcultural study.

Studies of the morbidity for more serious conditions — those requiring hospitalisation — had to

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await the publication of the census, as only then did it become possible to relate hospitalised patients to the populations from which they were drawn.

The aim of the present investigation was to study and compare the incidence, for the census year 1961, of mental disorder among the West Indian and native populations of two Metropolitan Boroughs, using first admission rates to psychiatric hospital beds as the measure of incidence.

Method

1. The Base Populations

The census showed that the population born in the West Indies and resident in England and Wales numbered 171,796 in 1961. Of these 101,000 lived in the Greater London area and 70,523 in the County of London. Within London the West Indians were scattered over many boroughs. The two South London boroughs of Camberwell and Lambeth, which includes Brixton, were selected for study.

The published census data classify the populations by birth-place and sex, but do not break the groups further by age. The West Indians have been known to have a quite different age structure from the rest of the population, and for the purposes of this investigation, it was clearly essential to obtain the exact composition of the two populations. This was done by a special extraction from the census.

Table 1. *Base Populations Classified by Nativity and by Age (Metropolitan Boroughs of Camberwell and Lambeth, 1961)*

Age	West Indian		Native	
	Number	%	Number	%
Under 15	1,050	7.4	83,510	22.3
15—54	12,843	90.7	199,465	53.3
55 and over	264	1.9	91,425	24.4
Total	14,157	100	374,400	100

Table 1 shows the West Indian and native populations in three age groups: under 15, 15 to 54 and 55 and over. It confirms the striking difference in the age structure of the West Indian and native populations. The former is composed of young and middle-aged adults with few children and fewer old people still; thus the age groups 15 to 54 include 90.7% of the West Indians, as compared with only 53.3% of the native population. Conversely only 7.4% of the West Indians were under 15 in contrast to the percentage of 22.3 for the native population. Similarly 1.9% of the West Indians were over 55 whereas over 24% of the native population were above that age. The many children born to West Indians in Britain would of course be classified in the census as being natives of the British Isles.

The study was confined to the population falling in the age groups between 15 and 54 years, as the West Indians outside those limits were too few to consider. The children born in Britain to West Indian parents would also be excluded as hardly any would have reached the age of 15 by 1961.

The native population was not entirely homogeneous for migrant status. It was constituted by all those persons born in the British Isles, including Eire. It thus included an unknown number of internal migrants who, from previous studies (ODEGAARD, 1945; MALZBERG and LEE, 1956) would be expected to have a higher morbidity than non-migrants in the native population. It was not possible to exclude such internal migrants as they could not be enumerated from the census, nor did native patients usually have their birthplaces stated in hospital records.

The base populations from which the cases were drawn were thus 12,843 West Indians and 199,465 native persons. Of the West Indians 53.8% (6,914) were men and 46.2% (5,929) women, whereas for the native populations 50.5% (100,708) were women and 49.5% (98,757) men.

2. The Patients

The boroughs of Camberwell and Lambeth were served by seven psychiatric hospitals. The case records were scrutinised of all patients admitted for the first time in 1961 to one of these hospitals from an address in Camberwell and Lambeth. All patients with a history of previous psychiatric hospital admissions were excluded; so were those with a birthplace known to be outside the British Isles or the British West Indies. The remaining patients were then classified as native or West Indian; the latter were always easy to identify from the records — the birthplace or origin being named in the clinical notes. For each patient, on the basis of the information available in the records, a diagnosis was made by the author from one of five categories defined by operational criteria as follows:

1. *Schizophrenia:* a history of change of personality towards autism; shallow or incongruous affect; primary delusions; systematised paranoid delusions; hallucinations in clear consciousness in the absence of a clear-cut underlying mood change; catatonic abnormalities of posture where explicitly described.

Thought disorder was rarely, if ever, adequately described and was not, therefore, accepted. Mere unsupported statements that it was present were ignored.

2. *Affective Disorder* was diagnosed where there was a primary alteration of mood — depressed, euphoric, irritable or anxious. States of excitement were difficult to categorise in the initial phase, but a careful history — where such was available — or the mood once the excitement had subsided, usually made the diagnosis possible.

3. *Character and Psychoneurotic Disorders* included patients with depressive symptoms where, however, the main abnormality was a longstanding personality disorder. In such cases the depression

was mild, variable, and often related to environmental difficulties.

4. *Organic Syndromes.*
5. *Alcoholism and Drug dependence.*

Results

1. The First Admission Rates

The rates for first admissions for all diagnoses are considerably higher among West Indians than among the native population (Table 2). For men the rates are 31.8 for the West Indians and 9.5 for the native population, while for the women the rates are 30.4 and 12.2 respectively (per 10,000 population). The rates are slightly higher among the West Indian men than among the West Indian women, but this sex incidence is reversed among the native population. The differences between the sexes do not attain the 5% level of significance.

Table 2. *First Admission Rates per 10,000 Population All Diagnoses*

Sex	West Indian			Native		
	Cases	Population	Rate	Cases	Population	Rate
Male	94	98,757	9.5	22	6,914	31.8
Female	123	100,708	12.2	18	5,929	30.4
Total	217	199,465	10.9	40	12,843	31.1

2. Diagnostic Distribution

Tables 3 and 4 show the numbers and percentages of patients in the five diagnostic groups as well as the rates of first admissions for each diagnosis by ethnic group and sex.

The figures show that none of the West Indian patients was suffering from an organic mental illness, nor from alcoholism or drug dependence; for the native population the incidence of these conditions was very low and indeed alcoholism and drug dependence was non-existent among the native women.

Table 3. *First Admission Rates per 10,000 by National Group, Sex and Diagnosis*

Diagnosis	Native		West Indian		Total	
	Male	Female	Male	Female	Native	West Indian
Schizophrenia	2.7	2.0	13.1	5.1	2.4	9.1
Affective	2.6	5.3	11.5	16.8	3.9	14.2
Character Disorders	2.8	4.7	7.2	8.5	3.9	7.8
Organic	0.2	0.2	0	0	0.1	0
Alcoholism	1.2	0	0	0	0.6	0
Total	9.5	12.2	31.8	30.4	10.9	31.1

The great bulk of the patients suffered from schizophrenia, an affective disorder or a personality disorder. For each of these three conditions the West Indians had considerably higher than the native population, (Table 3), though the extent of the excess varied as between the sexes and according to the diagnosis. Among the West Indian men schizophrenia predominated, the rate being 13.1 as compared with only 2.7 for the native men and 5.1 for the West Indian women. The affective disorders had an extremely high incidence among the West Indians: for the sexes combined the rate was 14.2 per 10,000 as compared with 3.9 per 10,000 for the native population. In both ethnic groups the women had a much higher rate of affective disorder than the men. For the West Indians the rates were 16.8 and 11.5 respectively, as compared with 5.3 and 2.6 for the native women and men. Finally the character and neurotic disorders: the West Indian women had a rate of 8.5 as compared to a rate of 4.7 for the native women; the rate for the West Indian men also was greatly in excess of the rate for the native men — 7.2 and 2.8 respectively.

Table 4. *Number of Cases and Percentages by Sex and Ethnic Group*

Diagnosis	Native			West Indian		
	Men	Women	Men and Women	Men	Women	Men and Women
Schizophrenia	27 (28.7%)	20 (16.3%)	47 (22.5%)	9 (40.9%)	3 (16.7%)	12 (30%)
Affective	26 (27.8%)	53 (43.1%)	79 (35.5%)	8 (36.4%)	10 (55.6%)	18 (45%)
Character Disorders	28 (29.7%)	48 (39%)	76 (34.4%)	5 (22.7%)	5 (27.7%)	10 (25%)
Organic	2 (2.1%)	2 (1.6%)	4 (1.8%)	0 (0%)	0 (0%)	0 (0%)
Alcoholism and Drugs	11 (11.7%)	0 (0%)	11 (5.8%)	0 (0%)	0 (0%)	0 (0%)
Total	94 (100%)	123 (100%)	217 (100%)	22 (100%)	18 (100%)	40 (100%)

Despite the high incidence rate among the West Indians there were only 40 West Indian patients in all, as the base population was comparatively small. When this number is broken down by sex and by diagnosis the number of cases is correspondingly further reduced. Conclusions drawn must therefore be tentative, bearing in mind the limitations following from the small size of the material.

Thus the pattern which emerges in the age group under consideration is a high incidence among the West Indians for both the major functional psychoses and for the personality and neurotic disorders. Schizophrenia is particularly prominent among the West Indian men, and the affective disorders among the West Indian women. However, West Indian patients of both sexes show a substantial rate for the neurotic and personality disorders which account for 25% of the total morbidity. This proportion is smaller than for the native patients, for whom it is 34.4%. The West Indians differ from the native population not only in having higher rates, but also in having a somewhat different diagnostic distribution, with a larger proportion of affective and schizophrenic illnesses and a lower one of character disorders, organic psychiatric syndromes and drug or alcohol dependence.

3. *Timing of Migration in Relation to Illness*

For 4 of the 40 West Indians the inadequacy of the information made it impossible to date the onset of symptoms. In the remaining 36 the symptoms anteceded the migration in 4 and started within 3 months in another 6. Thus 27% of the patients from the West Indies first admitted in 1961, and for whom the time of onset of symptoms could be established, were ill on arrival or very soon after. A further 9 patients (25%) became ill within 2 years but 17 patients (47%) showed no sign at all of illness until two or more years had elapsed after migration. Indeed, 10 patients (27%) had been in the country for over 4 years before any sign of mental illness occurred.

Table 5. *Interval Between Migration and Onset of Symptoms*

Interval	Number	Percentage
Present on arrival	4	10
Less than one month	1	2.5
1— 3 months	5	12.5
3— 6 months	0	0
6—12 months	3	7.5
1— 2 years	6	15
2— 3 years	4	10
3— 4 years	3	7.5
4— 5 years	5	12.5
Over 5 years	5	12.5
Not known	4	10
Total	40	100

Discussion

The measurement of incidence attempted in this paper is subject to important limitations. First is the very use of the first admission rate as the index of incidence. This is well known to have serious deficiencies as a measure of total incidence (Reid, 1960; Lin and Standley, 1962). Indeed it can be used to determine only a well-defined but incomplete part of the spectrum of psychiatric illness and, if a full picture is to emerge, needs to be complemented by studies in general practice (e. g. Kiev, 1965; Pinsent, 1963) and of out-patients.

A further limitation of first admission rates as a measure of incidence may be present in that it is possible that the West Indians and the native population use the psychiatric services in different ways. Thus discrepant attitudes to psychiatry and different pressures in the two communities might lead to the situation in which sick members of one community might be hospitalised, where equally sick members of the other would not be. Thus true differences in incidence might be masked, or spurious differences introduced, to an extent impossible to determine. Kiev (1965) found that the West Indian and native populations in Brixton used the services of general practice in the same way. An examination of the records in the present series suggested that different social pressures did not account for the excess of admissions among West Indians.

The second major limitation follows from the small size of the material and the fact that only one year's admissions were taken into consideration; for this there are two reasons. In the first place the West Indians were scattered over the whole of London, and when hospitalised went to a very large number of hospitals. In the absence of central returns, the only way of tracing West Indian patients was by studying all in-patient records. For a single part-time worker this perforce necessitated restriction of the study to a manageable size. The investigation had to be confined to one year, as the West Indian population was not numerically stable until after the coming into force, in July 1962, of the Commonwealth Immigrants Act. Until then it was rising all the time and by the time it did stabilise, in 1962, the census was some 18 months out of date, and the number and distribution in the country of the West Indian immigrants was again not completely known. For these reasons it was felt that only the census year 1961 could be studied, and even so it is realised that the base population at each end of the year 1961 was probably substantially different from the population on census night, in April 1961.

A further imponderable lies in the extent to which the base populations included individuals who moved in and out of Camberwell and Lambeth. If the mobility in and out of the boroughs was large, then again the denominator might be very different from the census figure, i. e. the patients might be drawn from a larger pool, with many transients. However, an examination which I carried out of the changes in domicile for another series of West Indian patients admitted from Lambeth, showed that while moves within Lambeth were common, changes over a larger distance involving different boroughs were uncommon. This particular source of error is thus unlikely to be important.

Less certain is the effect of possible differences in the accuracy with which the census enumerated the two populations. Thus part of the discrepancies

in the rates for the two populations might be accounted for by an underenumeration of the West Indians. This is speculative and is not amenable to verification on the basis of the data available.

The results confirm the findings of numerous previous investigators (e. g. ODEGAARD, 1932; MALZBERG and LEE, 1956; EITINGER, 1959; MURPHY, 1955) that migrant populations have a higher rate of psychiatric morbidity than non-migrants. The excess for West Indians over the native population is certainly very great, even greater than was the case for the European voluntary workers (MURPHY, 1955) the only previous immigrant community in Britain whose psychiatric admission rates have been determined. The fact that the native population included internal migrants likely to have a higher morbidity than non-migrant native subjects, further highlights the discrepancy between the West Indian and native populations.

How far does the incidence of mental disorder in these immigrants differ from that in their non-migrant countrymen? Comparisons are hard to make in view of differences in the availability of psychiatric services in the two countries, the possibly more protective role in the West Indies of the extended family and, in particular, the scarcity of the data about psychiatric morbidity in the West Indies. The only study of first admission rates in the West Indies (ROYES, 1961) referred only to psychoses. ROYES found an incidence of 450 per 100,000 in 12 years or 3.75 per 10,000 per annum. This compares with 23.3 for psychoses in the present study; despite the difficulties in the way of accepting such a comparison at its face value, the differences are so great as to suggest that West Indian migrants, like the Norwegian migrants studied by ODEGAARD (1932), have a higher morbidity than their fellow-countrymen who do not migrate.

The causal relationship, if any, between the migration and the mental illness cannot of course be elucidated in a study such as this, except insofar as a wide separation in time between the two would suggest that they have little direct connection. An examination of this time relation shows that 10 of the patients (25%) were ill on arrival or within 3 months. For them there is presumptive evidence that the two events were connected though the manner of this connection cannot emerge from the data. For 17 patients (over 40%) more than 2 years separated the illness and the migration, which are therefore in all probability independent of each other. This percentage is almost identical with that found by GORDON (1965) for an interval greater than 2 years between the migration and the first admission.

The pattern of diagnoses revealed by this study is of an absence of organic syndromes and of alcoholism or drug addiction in the West Indians — at least such as to require admission to hospital; the incidence for these conditions was also very low in the native population. This is not unexpected for first admissions from the age groups under consideration.

Taking the remaining three diagnostic categories — schizophrenia, affective illness and personality and neurotic disorders — the pattern is broadly similar in the two groups. True, the West Indians show a higher proportion of functional psychoses and a lesser one of personality disorders, but the differences are not great and indeed the latter account for 25% of the West Indian patients; this contrasts sharply with GORDON's series of mentally ill West Indians (GORDON, 1965) only 6.2% of whom fell in that category. Again, in this series, while the West Indian men show a very high percentage of schizophrenia (41%) much in excess of the native men (28%), the West Indian women have the same percentage as the native women. The women of both cultural groups show considerably more affective disorder than the men. In fact there is less difference in diagnostic distribution between the cultural groups than between the sexes in each group.

The clinical features of mental illness in West Indians hospitalised in this country have been reviewed in two large series (GORDON, 1965; TEWFIK and OKASHA, 1965). Both stress the atypical nature of psychoses seen in these patients. TEWFIK and OKASHA found that 85% of their 124 psychotic patients had an illness resembling schizophrenia. GORDON diagnosed an affective illness in only 19.6% of his patients, whereas schizophrenia occurred in 38.4%, schizo-affective illness in 26.8% and an acute schizophreniform illness in 2.7%. These findings contrast with the comparative infrequency of diagnosed schizophrenia among the patients in this study.

There are probably two reasons for this. In the first place this study was confined to first admissions whereas the other covered all admissions. If schizophrenia is commoner among readmissions than among first admissions, part of the discrepancy would thereby be explained. However, the main reason for the differences lies almost certainly in different diagnostic criteria. The present series included a number of West Indians with atypical psychoses; they were classified on the basis of the operational definitions given above. A retrospective study such as the present one lacks the detail which is provided by the personal examination of patients at the time of the illness. But a close examination of other West Indians at such a time has led me to conclude that such atypical psychoses can be entered into one or other of the Kraepelinian diagnostic categories and that they often derive in an understandable fashion, given the cultural background, from a primary affective change.

The present findings differ not only from those of other authors in this country studying West Indian patients: they also disagree with those of ODE-

GAARD (1932) and of MALZBERG and LEE (1956) that it is schizophrenic and senile psychoses which largely account for the high morbidity of immigrant groups. The suggestion in the present, admittedly limited, study is that the West Indian migrants show higher morbidity for both the major functional psychoses and the personality and neurotic disorders.

Much work remains to be done on the psychiatric problems of West Indian migrants, especially as they are likely to form a substantial and permanent part of the population of Great Britain. It would be of interest to carry out a follow-up study of in-patients, particularly those with atypical psychoses, although the tracing of patients may be difficult in view of their housing conditions and great mobility, even within a small area. Self poisoning in this community appears uncommon and nothing is known of suicide among these immigrants. Again, an investigation of West Indians who return to their homelands after a psychiatric illness in Britain, may allow of a better evaluation of the respective roles of individual predisposition and of external difficulties in leading to illness in those migrants.

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Studien zur „unsichtbaren Schranke" bei psychisch Kranken

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Summary. The article reviews the results of some research studies on the image of the mentally ill. It reports some of the techniques for measuring the knowledge and the attitudes of the general public on this subject. The criteria which the public employs in identifying someone as "mentally ill" are interpreted as being the converse of certain functional prerequisites of social relations in general.

Résumé. Les auteurs présentent les résultats de quelques études empiriques sur l'image qu'on se fait du malade mental. Ils font état de quelques-unes des techniques utilisées pour mesurer les connaissances et les attitudes du grand public sur ce sujet. Les critères que le public emploie pour identifier quelqu'un comme „malade mental" se rapportent surtout à un bouleversement de certaines conditions formelles dans les relations sociales.

Zusammenfassung. Es wird eine Übersicht geboten über die Ergebnisse einiger empirischer Untersuchungen über das Image des Geisteskranken. Einige Meßverfahren zur Feststellung des Wissens und der Einstellung des allgemeinen Publikums werden kurz referiert. Die Kriterien, die das Publikum zur Identifizierung eines „Geisteskranken" anwendet, werden gedeutet als Umkehrung von bestimmten formalen Voraussetzungen sozialer Beziehungen überhaupt.

I.

Dieser Beitrag ist gedacht als eine vorläufige Mitteilung über eine empirisch-soziologische Untersuchung: eine Meinungsumfrage über das Bild, das sich die Bremer Bevölkerung vom Geisteskranken und von der Nervenklinik macht. Da noch keine endgültigen Ergebnisse vorgelegt werden können, sollen zunächst

a) die Resultate und Techniken einiger früherer Untersuchungen über das Image des Geisteskranken referiert und

b) einige Überlegungen, die in unsere Untersuchung eingegangen sind, dargelegt werden, Überlegungen vor allem zu der Frage danach, worin die Ablehnung gründet, die die Geisteskranken durch die Durchschnittsbevölkerung erfahren.