Psychiatric Disorders In Egyptian Immigrants

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ABSTRACT

This study was conducted with the aim of exploring some demographic and clinical characteristics of psychiatric disorders among Egyptian immigrants. Psychobiograms of 103 immigrant patients admitted to a psychiatric hospital in Cairo over a period of 6 years were assessed for relevant demographic and clinical data. The results revealed a preponderance of males with a mean age of 31. 2 years. Married and single patients were almost equally represented and the level of education showed a peak representation of middle level group followed by higher and lower levels. The majority of patients were temporary immigrants to Arab-oil countries and most of them exhibited their disorder during the first immigration attempt. Clinically, schizophrenia paranoid type was the most frequent diagnosis (39. 8%) followed by affective disorders (24. 7%) and paranoid states (22. 4%) . (47. 5%) showed prominent paranoid symptoms while depressive symptoms were marked in about one fourth of the cases (26. 3%) . The diagnostic categories were compared with a corresponding sample of non-immigrants frequenting the same hospital. Positive past and family histories were detected in a substantial percentage of the sample.

Findings were discussed, particularly in relation to social selection and social causation hypotheses and inferences point to a complex interplay of aetiological factors rather than a simple explanation.

INTRODUCTION

A significant association has long been observed between migration and mental illness. The term"culture shock" has been coined to describe the stressful process which immigrants generally go through in their adaptation to the new change (Oberg, 1954) . The first "Honeymoon phase" in whcih the new change with its promising potentials is welcomed with excitement is soon followed by a "disenchantment phase" in which the immigrant becomes realistically aware of the problems of the new environment and looks back with nostalgia to his own culture and former life. As a result of separation and loss of social and intrapsychic supports, feelings of anxiety, irritability and depression become prominent. In the "resolution phase" he starts to seek patterns of behavior appropriate to the new setting and if successful he moves to an "effective function phase" in which he works through his loss to reestablish his self-esteem. He may even experience a reverse culture shock on returning back home (Oberg, 1954; Brink and Saunders, 1976) . This process is regarded as a normal psychological adjustment similar to that observed in relation to mourning or bereavement (Cox, 1977) . However, it portrays a considerable emotional stress from which more morbid psychiatric disturbances may arise in susceptible persons.

Studies conducted on several immigrant populations in different parts of the world have indicated that migration is associated with increased rates of psychiatric disorders (Eitinger, 1960; Murphy, 1977; Carpenter and Brockington, 1980; London, 1986) . The first major study in this respect was conducted by Odegaard in the 1930s (Cox, 1977) . Odegaard (1932) found that Norwegian-born immigrants in Minnesota have a higher admission rate of mental illness than either the local native born or the population in Norway. Among the disorders encountered, the rate of schizophrenia was particularly high.

Recently later studies on psychiatric disorders among immigrants, which were mostly based on admission rates, have consistently demonstrated that schizophrenia was the commonest diagnosis (Gordon, 1965; Rwegellera, 1977;

Carpenter and Rotkington, 1980; London, 1986) . Affective disorders, particularly mania, were found to be relatively common in some studies (London, 1986) , while in more than average, the frequency of schizoaffective disorders and acute schizophreniform reactions were reported by Gordon (1965) . Other studies (e. g. Tewfik and Okasha, 1965) have drawn attention to an increased rate of atypical psychotic disorders.

Among the features of psychotic breakdown in immigrants, paranoid symptoms seem to be particularly prominent (Kiev, 1972; Murphy, 1979; London, 1986) . This is probably explainable in relation to the nature of migration stresses including social isolation and in security which provide a fertile land for paranoia (Eitinger, 1960).

Compared to psychotic disorders, reports as regards neurotic and personality disorders among immigrants are inconsistent and do not indicate conclusive results (Murphy, 1977; London, 1986) . However, psychosomatic or stress disorders seem to be prominent. This may be understandable in relation to the unusual stresses which call for high adaptive efforts (Kiev, 1972; Murphy, 1977).

Attempts at explaining the relationship between immigration and mental illness have revolved around two principal hypotheses (Murphy, 1977; Cox, 1977, and London, 1986) :

1. a social selection hypothesis suggesting that persons suffering from or predisposed to psychiatric disorder are more prone to migrate, and

2. a social causation hypothesis suggesting that the explanation lies in the stresses associated with migration and resettlement.

However, Murphy (1977) believes that the issue is more complex and involves several factors, some arise from the society of origin including the degree of predisposition and pattern of disorder while others are related to the circumstances of migration or conditions in the society of resettlement.

The social selection hypothesis mainly applies to schizophrenia and was suggested since the early works of Odegaard (1932) who came to the conclusion that during the early or incipient phases of the illness, the likelihood of migration

is increased because of failing attachment of interpersonal relations. Most other studies supporting this hypothesis were focused on psychotic disorders (Murphy, 1977).

On the other hand, the social causation hypothesis is based on studies and observations of the different psychosocial stresses encountered during migration. There is little doubt immigrants experience a stressful life event and are subjected to certain distinctive social pressures (Cox, 1977). They are culturally disoriented persons subject to special strains that intensify conflicts and at the same time bereft of cultural means of reducing tensions (Kiev, 1972). The sudden and sharp change itself is a remarkable stress and source of disturbance. In addition, they may face various problems of employment, discrimination in work and housing, split families, sexual problems for the single as well as possible religious and value conflicts. Lack of familiar social support systems deprive them of vital help in facing and resolving tensions, moreover the social isolation and insecurity provide a fertile land for the emergence of psychopathology (Eitinger, 1960; London, 1986).

Until recent years immigration had never been a remarkable phenomenon in the life of Egyptians, who - as agricultural people - were well known for their close attachment to their homeland. Quite the contrary, and since ancient times, Egypt had always attracted and accommodated several waves of immigrants and settling invaders. Immigration from Egypt was usually limited to small numbers of adventurers, political exiles or students temporarily seeking education overseas. However, this situation has started to change rather dramatically over the last two decades. Due to economic disadvantages and overpopulation on one hand and the emergent demand for man - power particularly in Arab-oil-countries on the other, an increasing number of Egyptians started to immigrate. However, for the great majority, this immigration is typically temporary and return back home is usually foreseen after variable periods of time. Among the consequences of this phenomenon Egyptian psychiatrists started to receive an increasing number of

these immigrants suffering from psychiatric disorders that are apparently related to or associated with the immigration process.

This study is a preliminary attempt to examine some demographic and clinical characteristics of psychiatric disorders in a group of those patients admitted to a psychiatric center in Cairo over the last few years.

MATERIAL AND METHOD

Records of inpatients admitted to a psychiatric center in Cairo[1] were surveyed for cases in which psychiatric disorder was associated with immigration. The survey period was 6,5 years starting January 15st 1980 through June 30th 1986 when the study was commenced; a period probably representing a peak for the immigration phenomenon in Egypt. Most of the encountered cases fitted the criterion of first time onset of psychiatric disorder during immigration or within six months after return. However, patients with a history of psychiatric disorder before immigration who were admitted for recurrent episodes or exacerbation of disorder during immigration or within six months after return were also included. The psycho-biograms of these immigrant patients were examined as regards:

1. Demographic characteristics including age, sex, marital status and level of education.

2. Clinical characteristics including diagnosis, premorbid personality traits, time of onset as well as past and family history data. Other relevant data regarding country of resettlement, frequency of travels and duration of stay abroad were also examined.

Diagnosis of cases was made in accordance with DMP-I (Egyptian Psychiatr Association, 1975) . As part of the hospital's system, diagnosis of cases had been established after discussion in the regular meeting attended by the hospital's psychiatric staff including at least three senior psychiatrists.

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1 Dar Al-Mokatam for Mental Health.

A parallel sample was chosen, for comparing diagnostic categories. It represents admission of non-immigrants to the same hospital over the same period.

RESULTS

Patients in whom psychiatric disorder was associated with immigration were 103, representing 2. 5% of total admissions to the hospital during the study period (6. 5 yrs) .

Table (1) illustrates demographic characteristics of the sample. Except for two females, the rest of the sample (98. 1%) were males. The number of married patients (43. 7%) was very close to that of single patients (45. 6%) while a minor percentage were divorced or widowed. As regards the educational level, four groups may be differentiated : The illiterate group, a lower level group (can read and write and primary school) , a middle level group (preparatory and secondary group levels) and a higher level group (higher education and post graduate degree levels). As can be estimated from table (I) their percentages are : 14.5%, 23.3%,. 36.9% and 25.3% and 25.3% respectively.

Table (I)

Data	No	%
Sex:		
- Male	101	98.1
- Female	2	1.9
Marital status:		
- Single	47	45 6
- Married	45	43 7
- Divorced	10	9 7
- Widowed	1	1 0
Educational level:		
- Illiterate	15	14 5
- Literate	17	16 5
- Primary school	7	6 8
- Preparatory school	7	6 8
- Secondary school	31	30 1
- Higher education	21	20 4
- Post-graduate degrees	5	4 9
Age:		
21-15	16	15 5
26-30	34	33 0
31-35	31	30 1
36-40	8	7 8
41-45	8	7 8
46-50	4	3 8
51-55	2	1 9

* Mean age ± SD = 31. 2 ±13. 4

Mean age +S. D. was 32. 2 +13. 4. The majority of patients (58. 3%) fall within the range of 26-35 years of age.

As regards the countries of migration, most patients (N = 74 = 71. 8%) had been to Arab countries including Iraq, Saudi Arabia, Yemen and Sudan. The majority had been to Iraq and Saudi Arabia (35 and 26 patients respectively). The rest of the patients (N = 29 = 28. 2%) had been to non - Arab countries including

USA (8 patients) , European countries such as U. K., Germany, France, Holland, ... etc. (9 patients) , and Canada and Australia (one patient each) .

Table (II) shows the frequency of travels (i. e. immigration attempts) and duration of stay abroad among the sample. Most patients (62. 1%) travelled once after which they were admitted for their disturbance, while only 17. 9% travelled more than once. Duration of stay abroad was less than one year in 21. 3% of cases, from 1-2 years in 26. 2% of cases, and three years or more in 34% of cases.

Table (II)

	No.	%
A - Frequency of travels:		
- Once	64	62.1
- Twice	11	10.7
- Three times	4	3.9
- Four times	3	2 9
- Not defined	21	20 4
B - Duration of stay abroad:		
- Less than one year	22	21.3
- 1 - 2 years	27	26.2
- 3 - 5 years	25	24 3
- More than 5 years	10	9 7
- Not defined	19	18 4

Table (III) shows the psychiatric disorders among the sample as diagnosed after admission. Schizophrenia was the most frequent diagnosis (39. 8%) , followed by affective disorders (24.7%) , paranoid disorders (22.3%) and other functional psychoses (6.8%) . A minor percentage of patients were admitted for neurotic depression (3.9%) , drug addiction (1. 9%) and organic mental disorder (1%) . From the presented figures it can be estimated that a high percentage of patients (47.5%) had prominent paranoid symptoms (sum of patients diagnosed as paranoid schizophrenia and paranoid states) . Patients with prominent depressive symptoms, on the other hand, amount to 26. 3% of cases (sum of patients with manic-depressive illness, depressed and mixed types, involutional depression, other and unspecified depressive illness, schizoaffective depression and neurotic depression) .

Table (III)

Diagnosis	No.	%
1- Schizophrenia:		
- Paranoid type	26	25.2
- Schizoaffective type	.6	5.8
- Chronic undifferentiated type	5	4.9
- Hebephrenic type	4	3 9
Total	41	39.8
2 - Manic and depressive illnesses:		
- Manic depressive, depression	7	6.8
- Manic depressive, manic	6	5.8
- Manic depressive, mixed	4	3.9
- Involutional depression	1	1.0
- Depressive illness not elsewhere specified	2	1.9
- Others	5	4.9
	25	24.3
3 - Paranoid states:		
- Acute paranoid episode	15	14.5
- Subacute paranoid episode	4	3.9
- Chronic delusional	4	3 9
Total	23	22 3
4 - Other functional psychoses	7	6 8
5 - Neuroses		
- Neurotic depression		4 3 9
6 - Drug addiction	2	1 9
7 - Organic brain syndrome 1	1.0	
Total sample	103	100

Table (IV) indicates the diagnostic presentation of the sample in comparison with a representative sample of admission to the same hospital. It shows that schizophrenia, paranoid type, paranoid states (and more acute subcategories) are significantly more represented in the immigrant sample. On the other hand-manic, depressive illness, manic type was more significantly represented in the non-immigrant sample. Other diagnostic categories and subcategories show no significant differences.

Table (IV)

Diagnosis	Temporary Immg. Percentage	Hospital Admission Percentage	t	p
Schizophrenia	38.8	32.1	1.41	P>0.10
- Paranoid	25 2	07.2	4 00	P<0. 001*
- Schizoaffective	0.5 8	07 8	0 73	P>0 1
Manic and Depressive Illness	24 3	87 7	0 69	P>0.1
- Depression	6 8	03 8	1 11	P>0 1
- Mania	5 8	15 0	0 02	P<0 01**
Paranoid state	22.3	11.8	2.34	P<0 2***
- Acute	14.5	1.9	3.55	P<0 001*
Paranoid psychosis	47.5	19	5.29	P<0.001*

*p<0. 001 highly significant

**p<0. 01 Significant ***p<0. 02 Significant

Table (V) presents predominant premorbid personality traits as clinically detected among the patients. Schizoid traits show the highest frequency (42. 7%) , while hypomanic or cyclothymic traits and paranoid traits come next, but their frequencies are considerably lower (12. 6% and 9. 7% respectively) .

Table (V)

Premorbid personality traits	N	%
1 - Schizoid traits	44	42.7
2 - Hypomanic or cyclothymic traits	13	12 6
3 - Paranoid traits	10	9 7
4 - Antisocial or sociopathic traits	6	5 8
5 - Obsessive traits	1	1.0
6 - No specific traits defined	29	28 2
Total	103	100

Table (VI) indicates the time of onset of disturbances in relation to migration. In 10. 7% of cases the onset of disturbances was manifested before travelling. However, the majority of cases (81. 5%) , started to manifest their disorder while abroad (54. 3%) or within 6 months after being back in Egypt (27. 2%) .

Table (VI)

Time of onset	N	%
1 - Before travelling	11	10.7
2 - While abroad	56	54.3
3 - After returning to Egypt*	28	27 2
4 - Not defined	8	7 8
Total	103	100

Table (VII) illustrates past and family history data of patients, where 32% gave a past history of psychiatric disturbance before immigration. In 26. 2% of the cases, the disorder was psychotic and the identified diagnosis was mostly of episodic of remittant nature with full or reasonable partial remission before immigration. They included manic-depressive illness (10 patients), schizoaffective schizophrenia (5 patients), paranoid schizophrenia (5 patients) paranoid states (4 patients) and other unidentified disorders (3 patients) .

Table (VII)

Past and family history data	N	%
A - Positive past history of psychiatric disorder:		
- Psychosis	27	26.2
- Neurosis or other non-psychotic disorder	6	5.8
Total	33	32 0
B- Positive family history of psychiatric disorder:		
- Psychosis	18	17.5
- Neurosis or other non-psychotic disorders	5	4.9
Total	23	22 4
C - No relevant past or family history detected:	47	45.6
Total	103	100.0

Positive family history was detected in 22. 4% of patients, mostly of a psychotic nature in psychotic disorders in the rest (4. 9%). In most cases the information provided by patients and their attendants generally allowed a psychotic-non-psychotic distincion but it was not sufficient to allow reliable exact nosologoical specifications. Combined positive family and past history was noticed in 8 cases (7. 8%) .

DISCUSSION

Concerning demographic data, some of the results of this study are rather expected and understandable. This is particularly clear in relation to age and sex, as immigrants are generally known to be male of younger age group (London, 1986) . Other findings, however, may have some special significance. The almost equal number of married and single patients probably indicates that the two groups were equally vulnerable to disturbance. If we are to relate their disorders to the specific stresses of migration, it may be assumed that each group has its own set of stresses but with similar ultimate impact.

As regards the educational level, the percentages of patients belonging to the differentiated four groups (illiterates, lower level, middle level and higher level) probably reflect the relative proportions of such educational levels among immigrants. The group with middle education shows the highest representation (36.9%) , followed by the higher level group (25.3%) , the lower level group (23.3%) and illiterates (14.5%) . It has been assumed that in the face of difficult and unfamiliar stresses, such as those encountered during migration, the less educated individuals are more liable to psychiatric disturbances as a result of their reduced coping abilities (Murphy, 1979) . The above distribution - which is rather than close to a "normal distribution" - does not provide sufficient support to this assumption. Again, each group probably has its own set or level of stresses.

As seen in the results, a majority of the patients had been to Arab or even non-Arab countries that are known to accept immigrants on a temporary basis rather than for permanent resettlement. This is probably a good index of the temporary nature of Egyptian immigration in general. However, this fact does not seem to reduce much of the stresses involved in the process. In fact, temporary immigrants may be liable to additional stresses including the ever renewed conflict of the open choice between immigration and return (Murphy, 1977) , and the stresses of a reverse "culture shock" on their return home (Brink and Saunders, 1976) .

Data from table (II) indicate that most cases (62.1%) were admitted for psychiatric disorder after their first travel or immigration attempt, and that almost half of the cases (47.5%) could not manage to stay abroad for more that 1 - 2 years. This is probably an index of their vulnerability, and reduced coping abilities. However, it can be noticed that a considerable percentage (34%) had managed to stay abroad for three or more years. While a stay before the onset of symptoms indicates a high vulnerability or predisposition and thus gives support to the selection hypothesis, the relatively long stays in other patients suggests that stress plays a significant role (Bagley, 1971). Hitch and Rack (1980) have demonstrated that the liability to disturbance in immigrants under the effect of a stress may not diminish with time.

Data regarding past family histories (Table IV) are probably consistant with the above findings and provide an additional index for the relative weight of predisposition or vulnerability to disturbance among the sample. About one third of the sample had a past history of disorder mostly in the form of psychotic episodes (affective, schizoaffective or paranoid) before immigration. In addition, about one fourth (22. 4%) indicated positive family history of disorder, mostly of a psychotic nature. Taking into consideration the overlap of positive past and family histories in some patients, the above data globally indicate some evidence of predisposition or vulnerability in about half of the sample while such evidence is lacking in the other half.

The diagnostic breakdown clearly shows that schizophrenia is the commonest diagnosis (39.8%) , followed by affective disorders (24.3%) and paranoid states (22.3%) . Although the overall number of schizophrenics does not out number the non immigrant sample, which is not a representative sample, (table IV) for the general population. The prepondrance of schizophrenia in different cultural settings (Gordon, 1965; Copeland, 1968; Begley, 1971; Cochrane, 1977; Rwegellera, 1977; Carpenter and Brockington, 1980) . Such results [2] are usually interpreted in favour of the selection hypothesis (London, 1986). This hypothesis, as introduced by Odegaard (1932) after his thorough epidomiological and clinical

studies of Norwegian immigrants, suggests that during the premorbid or incipient phases of schizophrenia, patients suffer difficulties in adaptation and interpersonal relations in their own societies which make them less rooted and more prone to migrate. According to Murphy (1977) , these inferences still seem valid. In the present study, the percentage of those with premorbid schizoid traits (42. 7%) and past history of schizophenic symptoms (9.8%) probably lend some support to this hypothesis. However, this explanation for the high rates of schizophrenia among immigrants should not be overvalued especially if we consider the non significant difference. Other studies have indicated that preschizophrenics might be less and not more mobile than the average persons (Murphy, 1977) . Also, other studies

However, the subtype paranoid schizophrenia is more represented in the immigrant sample than in the non-immigrants to a statistically significant level. The interpretation of such preponderance is more or less the same as will come for the paranoid symptom content as well as the paranoid states.

Regarding affective disorders, some studies tend to underestimate their prevalence among immigrants, while other studies indicate that they are well recognized and not under represented. The controversy may be related to crosscultural difficulties in identifying and diagnosing such disorders (London, 1986) . In general, the frequency of affective disorders in our sample is relatively high and comes second in order after schizophrenia. This is particularly true in relation to depression which was the main presentation in 26. 3% of cases (including neurotic depression) . These findings may be explainable in terms of both selection and causation models.

2 Due to defects in epidemiological and statistical data concerning Egyptian immigrants such evaluation was not possible in the present study. We are confined to the corresponding sample, although not a representative sample (table IV) for the general population and have demonstrated the important role of stress whic are distinctive for the immigrants in precipitating the disorders.(begley,1971).

Cyclothymic individuals may be more inclined to migrate (London, 1986) . In this respect, a substantial percentage of our sample did show identifiable premorbid cyclothymic or hypomanic traits.

On the hand, it has been suggested that"object loss", which is a major component of migration stresses, plays a significant role in precipitating or causing affective disorder, particularly depression in predisposed or vulnerable individuals (Murphy, 1977; Cox, 1977). However, when we came to compare manic-depressive illness as a whole (and the depressive subtype), we find no significant differences (Table IV) while there is a significant increase in the non immigrants sample as regards the manic type. This result contradicts Rack's (1982) findings who attributed an observed high rate of mania among immigrants to a "reactive mania" which is considered as a type of stress reaction.

Such a difference may be explainable by the fact that in our study, the sample was of those returned back rather than those who stayed there, even using the denial mechanism. Coming back as a relative declaration of failure and frustration is apt to initiate some realistic pain among relatives and acquaintances but does not necessarily ask for inversion and denial mechanisms (acute mania) .

Paranoid states are third in order of frequency, and significantly different from the non-immigrant sample. This holds truth also for subtype disorders. This tendency is also confirmed by the fact that paranoid symptoms are a prominent manifestation in almost half of the cases of the sample (47. 5%) . This finding is in line with several studies indicating that paranoid delusions and symptoms are a prominent or characteristic feature of psychotic breakdown in immigrants (Eitinger 1960; Gorden, 1965; Carpenter and Rockington, 1980; Hitch and Rack, 1980; London, 1986) . In explaining this phenomenon, some authors suggest that predisposed, sensitive or persecuted individuals tend to migrate. Others, however, considered that paranoia in immigrants has a recognized association with the migration experience and is explainable in relation to its specific stresses including social isolation, and feelings of helplessness and insecurity in new surroundings in which the individual may be overwhelmed by

strange and unfamiliar stimuli (Eitinger, 1965; Hitch and Rack, 1980) . The clinical case histories described by Odegaard in the 1930's provide an excellent phenomenological illustration of the genesis of paranoid attitudes in the immigrant as he experiences the typical stresses of such life change (Cox, 1977) . In this study, the percentage of cases diagnosed as acute or subacute paranoid episode (18. 4%) probably provide a manifest index of the effect of such stresses in producing paranoid symptoms. Such acute paranoid disorders are well known to occur in individuals experiencing abrupt environmental changes such as those of immigration (Walker and Brodie, 1985) . The relation of such stresses to the more chronic forms of paranoid may be more complex, but are probably no less relevant.

Some studies have indicated a considerable rate of atypical psychotic conditions among immigrants (Tewfik and Okasha, 1965; Gordon, 1965) . In this study by Tewfik and Okasha (1965) , such atypical psychoses were characterized by a continuum of symptoms with confusion and paranoid symptomatology at either end, were usually temporary with an overall good prognosis, and may be understood as a reaction to the stress. In our sample, this type of disorder is mainly represented by the "other functional psychoses"., a category which - as defined in DMP - I (Egyptian Psychiatric Association, 1975) - includes acute undifferentiated, acute confusional and acute or chronic reactive psychotic conditions. The percentage of patients presenting with such disorders in our study is relatively small (6. 8%) . However, they may represent an additional index of the impact of the stresses of migration in producing psychiatric disorders. From studies and observations of some authors, such atypical psychotic conditions characterized by paranoid and/or confusional symptoms are well recognized in reaction to marked or abrupt change such as that encountered in migration. As Murphy (1979) puts it : "Overwhelmed by the strangeness around him, the person may either make false sense of it (paranoia) , or abandon trying to make sense of it at all (confusional state) "

As reviewed in the introduction, there is a competition between social selection and social causation hypotheses in explaining the psychiatric morbidity among immigrants. As the case with most similar controversies in psychiatry, the answer is usually not an "either-or"one. The observed morbidity most probably results from a complex interplay of variables, some related to predisposition and selection while others are understandably related to the well recognized stresses of migration; both operating with different relative weights in relation to different individuals as well as different types of disorder. The results of study, as discussed before, probably reflect this situation with some criteria suggesting the role of selection and some others pointing to the impact of precipitating or causative stresses. It is to be noticed, however, that this study shares the defect of most similar studies in this area of research which are mostly based on admission rates. Such studies naturally reflect the status mainly as regards major or psychotic disorders while non-psychotic disturbances, which are mostly documented in the context of outpatient services, are not properly represented (London, 1986) . This fact should be taken into consideration since observations supporting the social causation model have mainly originated from studies of non-psychotic patients (Murphy, 1977). A more balanced view will require further research covering this group.

In his discussion of mental health problems of immigrants, Murphy (1977) sees that the immigrants' liability to mental disorder is related to different variables which may arise from the culture origin, circumstances of migration or the society of resettlement.

In the culture of orgin, the attitude of the society towards the act of migration has its significance. A negative selection will take place if migration is viewed as desertion of the home commmunity, or if - on the other extreme - it is idealized or imbued with too much unrealistic glamour. Unfavorable childhood influences in the society of orgin such as those of enhanced dependency and defective internalization of adult attitudes will result in higher vulnerability. Other important factors include the availability of information regarding "real"

conditions in the society of resettlement and the adequacy of preparation for this major act. Lack of such realistic information and adequate preparation play a role in producing higher rates of disturbance. In relation to the circumstances of migration, Murphy stresses the important factor of whether migration is being forced or just free choice. Virtually, however, all migration is perceived to be something of a choice and a stressful conflict is always present. In temporary immigrants, whom seem to have some free choice, serious disturbances may arise when time comes for decisions. This was clearly observed in a good proportion of our patients who started to improve only when a clear decision was reached regarding whether to stay or resume their immigration.

In the society of resettlement, the factor that significantly affects mental health is the relative size of the immigrants own minority group and its cohesiveness. This may act as a vital social support system which provides them with aid in understanding the new society, companionship and economic co-operation, and thus buffers much of the stresses of tensions that may lead to breakdown. For Egyptian immigrants, who still have a relatively short history and limited experience in immigration, this factor is apparently very much lacking.

Mental health problems of Egyptian immigrants is a recently emerging issue that should start to receive sufficient attention in Egypt. The above discussions point to some aspects that may be helpful in understanding the problems and subsequent planning for future preventive measures. Efforts should start in the direction of creating higher awareness of the real size and different dimensions of the problems which may involve high actual or potential hazards both socially and psychologically. Also, plans should be encouraged for the provision of preventive steps including proper selection, adequate realistic information, adequate preparation and aids for establishing effective support structures in the countries of resettlement.

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TROUBLES PSYCHIATRIQUES CHEZ LES IMMIGRANTS EGYPTIENS

ABSTRAIT

Cette étude a été conduite dans le but d'éxplorer quelques characteristiques démographiques et cliniques des troubles psychiatriques chez les immigrants Egyptiens.

Les psychobiogrammes de 103 patients , immigrants , admis à un hopital psychiatrique du Caire durant une période de 6 années ont été évalués , en vue de ressortir des donnés démographiques et cliniques utiles.

Les résultats ont montré une prépondérance de patients du sexe masculin ayant un âge moyen de 31.2 ans . Les patients mariés et célibataires étaient également représentés .La plupart appartenait à un niveau d'éducation moyen. La majorité des patients était des immigrants temporaires dans les pays du pétrol et ont manifesté leurs troubles durant la première tentative d'immigration.

La schizophrenie du type paranoique était le diagnostique le plus fréquent (39,8%) suivit par les troubles affectifs (24,7%) et les états de delire (22,4%). 47.5% ont présenté avec des symptômes paranoiques saillants , tandis que les symptomes dépressifs étaient observés chez le quart des cas (26,3%).

Ces résultats ont été comparés avec un échantillion de patients non-immigrants du même hopital.

Les résultats ont été discutés , en particulier en ce qui concerne les hypothèses de sélection et de causation sociale et les déductions impliquent l'effet complex d'une multitude de facteurs étiologiques plutôt qu'une simple éxplication causale.

الموجز

تمت هذة الدراسة لمعرفة الظروف الإجتماعية والنفسية المحيطة بالمرض النفسى لبعض المصريين فى "الهجرة المؤقتة" . وقد تم تحديد التشخيص الإكلينيكى لعدد ١٠٣ من مرضى "الهجرة المؤقتة" والذين أدخلوا مستشفى دار المقطم للصحة النفسية للعلاج . وقد تم المقارنة تشخيص هؤلاء المرضى بتشخيص المرضى غير المهاجرون وأدخلوا هذا المستشفى أيضاً للعلاج النفسى . وقد وجد أن المرض النفسى أكثر أنتشاراً فى "الهجرة المؤقتة" فى سن الشباب والذين حصلوا على مؤهل متوسط. وكان أغلب المرضى من الذين هاجروا مؤقتاً إلى أحد البلاد العربية سعياً وراء الرزق. وقد ظهرت عليهم الأعراض النفسية خلال الفترة الأولى للهجرة .

وقد وجد أن الفصام خاصاً النوع "الضلالى" هو الأكثر أنتشاراً يلية الأضطراب الوجدانى وذلك بمقارنة المجموعة الضابطة من المرضي الغير مهاجرين ويعانون المرض النفسى وقد وجد أن "الذهان الضلالى" بأنواعة هو الأكثر أنتشاراً فى هذة المجموعة عن المجموعة الضابطة .

وقد نوقشت هذة النتائج وتم مقارنتها على ضوء الأبحاث السابقة فى هذا المجال.