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Summary and Conclusions

E. A. GUINNESS

The findings of this study suggest that the early stages of urbanisation can influence the patterns of mental illness in three ways: selective factors may alter the distribution of morbidity; the process of rapid social change itself may be pathogenic; and certain syndromes may arise or become more frequent during this social transition. These could be called transitional syndromes.

Questionnaire survey of secondary schools indicated higher rates of adolescent psychiatric morbidity in rural than in periurban areas. This could be related to the greater psychosocial adversity identified, and to the effects of rural depopulation as the able-bodied take up urban employment. This contrasts with findings in post-industrialised societies where the focus of disorder is in the inner cities. However, mechanisms may be comparable, such as accumulation of the mentally ill or inadequate in deprived areas, and greater family adversity affecting child welfare.

This study identified significant components of rapid social change by exploring the morbidity associated with education in a society where education is a major agent of change. These components included the greater expectations of social and financial advancement represented by the investment in education, the distortion of cultural defence mechanisms represented by the intense cultural response to education and the breakdown of extended-family support systems because of the social forces of urbanisation and rural depopulation. Predisposing factors were both constitutional and related to early rearing; being reared by both parents in the pre-school years was protective of later mental health.

This study also suggests that these changes have an impact on psychopathology. The syndrome of somaticised anxiety associated with education (brain fag) could be called a transitional syndrome. Yet it is only a variant of neurotic disorder, with phenomena and sequelae which do not differ essentially from neurosis in the general population. Indeed, the profile of neurosis characterised by somatic and 'spiritual' symptoms (paranoid ideas commensurate with cultural beliefs), together with conversion or dissociative features, is that of a pre-industrial society rather than an 'exotic' alien culture. This study indicates how the supernatural concepts of illness and the culturally sanctioned forms of help-seeking behaviour can shape phenomenology. Depression, for instance, did not present with psychological and affective symptoms typical of industrialised societies (although these could be elicited) but with somatic symptoms or salient disturbed behaviour – such as panic attacks, pseudoseizures, hysterical dissociation, and transient psychosis. This suggested possible mechanisms for transient psychosis: intense overarousal with protective dissociation of consciousness, an acute circumscribed disruption of the ego; also intensification of the 'spiritual' symptoms producing psychotic phenomena such as dissociative hallucinations and sub-cultural delusions, and fulfilling Jasper's criteria. The latter required the reactive psychosis to be closely related in content, timing and meaning to the precipitant stress. Transient reactive psychosis appeared to be equivalent, in terms of help-seeking behaviour, to parasuicide in industrialised societies. Active case finding in the community in this study found a lack of parasuicide, eating disorders and self-laceration as syndromes in their own right, although they occurred occasionally as symptoms in the context of acute psychosis. This difference could be related to changes in concepts of illness from supernatural to biomedical or to the aversive rather than supportive response to salient psychosis in industrialised society.

Brief reactive psychosis appears to occupy a position intermediate between the neuroses and the psychoses. The hospital-based comparative prospective study indicated the difficulty in demarcating it as a specific syndrome. Rather, it could coexist with, and distort, other syndromes. Two groups were distinguished in terms of outcome. When brief reactive psychosis acts as a form of illness behaviour for depression, it more closely resembles a dissociative state, relapses in the same form or with uncomplicated depression, and resembles affective psychosis in demographic features. Transient psychosis without preceding depression, however, showed a picture of intense prodromal anxiety in which a major threatening life event precipitated a form of 'reactive mania' or 'malignant anxiety'. These could relapse in stable forms at intervals of years, but they were also the group most at risk for ultimately developing unequivocal schizophrenia. They differed from acute

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remitting schizophrenia in more closely fulfilling Jasper's criteria, and by psychotic features in the dissociative state rather than clear unaltered consciousness. In both, however, education and paid employment were over-represented.

The distorting effect of the admixture of brief reactive psychosis and depression could be seen in the schizophreniform category which was intermediate between the transient and major psychoses. It presented a range of atypical psychoses showing a complex interaction of affective, schizophrenic, dissociative, and reactive features which could best be depicted as a continuum (Fig. 1) with differing

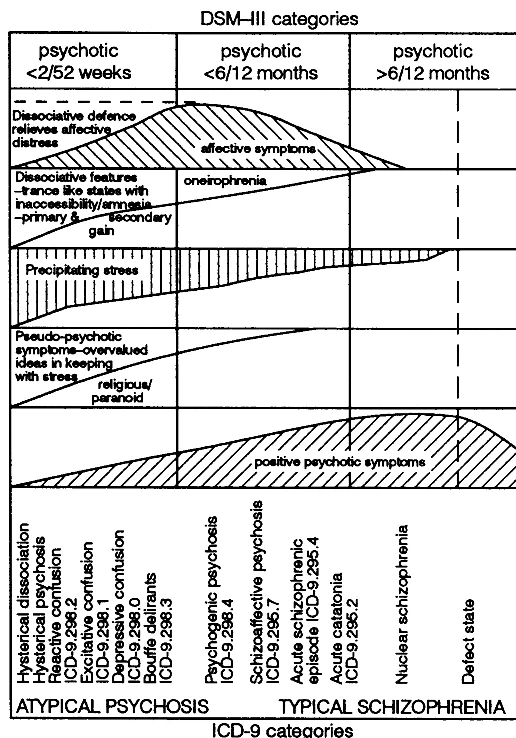

Fig. 1 Continuum model of the range of schizophrenic-type functional psychotic disorders.

degrees of affective distress becoming overt, depending upon the success of the dissociative or projective defence. The genetic vulnerability to major psychosis, and any acquired occult cerebral damage (more likely in an impoverished Third World environment) together with the balance of psychosocial life experience, would determine the individual's place on the continuum. The limited follow-up in this study suggested a tendency for patients to move across the continuum over the course of time, in the direction of increased psychotic decompensation and chronicity.

Review of the literature from 19th century Europe, immigrant psychiatry, and modern developing countries suggests that these societies, all of which are transitional, have a greater proportion of atypical psychosis, i.e. reactive, acute, brief, and of good prognosis, compared with post-industrial societies. It is postulated that the destabilising process of change – increasing adaptational demands, multiplying life events, and decreasing support systems, superimposed upon the pre-industrial forms of affective expression, concepts of illness, and help-seeking behaviour, combine to increase schizophreniform disorders.

These conclusions imply a historical perspective to psychiatry, an evolution of psychopathology in parallel with social forces, particularly related to the complex changes involved in industrialisation. Thus, conditions which were once common in 19th century Europe, such as transient psychosis, have declined but are currently common in Africa and elsewhere in the developing world. Such a shift in disease patterns is taken for granted in general medicine: how much more will psychosocial factors influence psychopathology?

The findings of this study have relevance for psychiatric practice, training, and research in the developing world; for service planning and development; for educational provision; and for the study of transcultural psychiatry.

Psychiatric practice

The conclusions of this study would underline the fundamental similarity of the experience of mental illness throughout mankind. The principles of modern psychiatry are applicable in any culture provided they are used in a flexible and adaptable manner. For there are differences in psychiatric presentation in different cultures but these are variations on a theme rather than fundamental differences, a matter of emphasis on which symptom types predominate and in the relative incidence of syndromes. The use of ICD–9 in this study could have imposed Western constructs and pre-empted the issue, but the syndromes described do occur in the West, if with diminishing frequency. Few of the correlates identified, such as risk and protective factors, or factors influencing symptom formation, are peculiar to African culture. It is their relative combination which may be distinctive.

Western classification systems have been biased towards post-industrial profiles of psychiatric illness –

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inevitably since most psychiatric research has originated thence. The revision of ICD–9 to ICD–10 is taking into account findings in developing countries. Diagnostic difficulties arise with unfamiliar or 'atypical' presentations – for instance, it is clearly important to identify the underlying depression which may be obscured by a transient psychotic presentation rather than simply treating the reactive psychosis as schizophrenia.

Principles of management and treatment in psychiatry developed in the West are also applicable across cultures with certain modifications. Sixty years ago, a Western-trained psychiatrist going to Africa would not have had much to offer over and above the methods of traditional healing. Nowadays, modern drugs and discriminating use of ECT have obvious value, although they also present problems. Under the pressure of excessive clinical workloads and with paramedical staff of limited training, there is a temptation to rely too heavily on biological treatments – polypharmacy and indiscriminate use of ECT. Psychological therapies take more time and training and are likely to be more culture specific. Behaviour-modification methods and the principles of rehabilitation are least so, and psychodynamic psychotherapies perhaps more so.

It is possible that the principles of family therapy may have more in common with traditional healing. Traditional African concepts do not focus so much on the individual as on his place in the social milieu whether this be neighbours, kin, or spirits of departed relatives. Although some traditional remedies may seem crude to a Western psychiatrist and reminiscent of mediaeval methods (vomiting, purging, cutting, etc.) many ceremonies and rituals are geared to readjusting the individual in his social matrix. It is interesting to note that Bateson, one of the founders of systemic family therapy, developed his ideas after anthropological study of a tribe in New Guinea which was facing major social transition (Bateson, 1958).

Nevertheless, liaison with traditional healers presents many problems and is often more strongly advocated by expatriate psychiatrists than nationals. Asuni (1979) points out that incorporating healers into official health systems would require standardisation of practice, and that new, intrusive concepts could fracture the shared cognitive bond between healer and patient. On the other hand, Wessels (1985) of the Durban school, advocates traditional healing methods as more appropriate in the management of culture-bound hysterical psychoses than high doses of neuroleptics. Cheetham (1975) gives an excellent discussion on the dissonance between traditional and Western therapeutic approaches which confront the rural African who migrates to the urban setting.

Research is needed to develop appropriate management regimes for transient psychosis. Optimum use of neuroleptics, psychotherapeutic interventions, and prophylactic strategies need to be developed. For instance, how far would it be possible to engage the patient and his family in adopting less drastic forms of help-seeking behaviour? This could be compared with research into the management of parasuicidal behaviour. Also, to what extent can the risk of schizophrenia be minimised in a case of reactive psychosis? Further research is needed using long-term follow-up designs to map out longitudinal patterns and identify key risk factors. This study was brief and incomplete but it did suggest that competitive academics and promotion at work might be factors. Would a person who had experienced a reactive psychosis be safer to seek a dull, routine life-style with minimal adaptation demands?

Training psychiatrists in the West for work in the developing world must take account of these factors – the clinical and diagnostic differences and the need for training in simple, feasible research methods. Planning of research designs and selection of appropriate instruments could profitably be debated before arrival on site where work loads are likely to overwhelm. The WHO plays an important role in consultation and support. The difficulties in service provision discussed below indicate that the Third-World psychiatrist cannot confine himself to the Western model of practice but must take on the multiple and extended roles required to operate the primary health care model of community psychiatry. Vital to this are the skills of clinical teacher, supervisor and coordinator.

Service development

The findings of this study would suggest a risk of increased incidence of mental illness in transitional societies. The data are insufficient to confirm this, although there are tentative indications in the studies of Orley & Wing (1979), Hollifield *et al* (1990) and the WHO study on incidence and outcome of schizophrenia (Sartorius *et al*, 1986). We do not know whether the apparent massive increase in insanity in 19th century Europe was an artefact of the form of service provision, i.e. custodial asylums, or a real increase. Recent reviews of the evidence suggest the latter and offer social hypotheses (Scull, 1979) or biological mechanisms (Hare, 1983) to account for it. In Africa, the custodial mental hospitals of the colonial era were beginning to fill up at an alarming rate until the trend was reversed by modern drugs and decentralisation policies. The emphasis since has been on developing strategies for improving access

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to services for a dispersed rural population (Bentovim, 1987). However, it is becoming increasingly important to plan for urban services as cities increase in size, particularly with slum shanty development. The combination of poverty, slum conditions, population pressure, and erosion of family networks and protective cultural structures is likely to maximise the effects of rapid social change in Third World conurbations. (One indicator is the prevalence of destitute children so reminiscent of the street urchins of 19th-century London.) Service provision will be most difficult under these conditions – the pre-industrial social supports eroded, and the resources which in post-industrial society have taken their place, not yet developed: minimal social services, no welfare state or unemployment benefit, small health budgets, and little trained manpower. Swaziland is at an early stage in this process, yet it looks inevitable, 'the price of progress'. For it would be the counsel of perfection to suggest that the problems of rapid urbanisation can be forestalled any more than the problems of inner-city decay can be prevented. The social forces are too great. Nevertheless, research designed to identify risk and protective factors can guide planning and target intervention.

Specific interventions in Swaziland

The immediate findings of this study were very relevant to the education services in Swaziland. In order to explore the feasibility of intervention, several workshops were held with head teachers, the school psychology service and the careers officers (teachers in secondary school allocated to this task) together with the community psychiatric nurses (CPNs). The findings were presented concerning the prevalence of anxiety in schools, and the complications of depression, hysteria, and transient psychosis. The identified aetiological factors were outlined – financial pressure, fear of bewitchment, overexpectations, family adversity, and attributes of the school. Many teachers seemed to regard these factors as an inevitable part of life, rather than anything abnormal. Indeed they had been shaped by the same struggle, and to a greater or lesser extent were still experiencing these pressures. How can one comprehend cultural dissonance when one is in the midst of it? This is where those who have acquired some 'cultural distance' and objectivity by study abroad can contribute. It was agreed that when resources permitted, a training module could be introduced into curricula in teacher training colleges on mental health in schools and the complex issues of rapid social change and its impact upon African society.

Treatment was discussed. The brain fag syndrome is difficult to treat, and medication is of little help. This is not surprising in view of the pervasive contributing factors. Many students only lose their symptoms when they leave school. Small group discussion with relaxation exercises has been advocated (Minde, 1974; Howarth, 1986). The possibility was discussed of setting up such groups in schools with the local CPNs and the careers guidance officers. The specific training of these guidance teachers as school counsellors was advocated.

Prevention is also difficult. It could be predicted that anxiety at school would lessen as more students were second and third generation to be educated, or when free, compulsory education could be introduced. Meanwhile a variety of measures could be tried, ranging from financial incentives to teachers in rural schools, to broadening of the curriculum so as to include more trade skills, and a decreased emphasis on academic examinations which are the chief trigger to anxiety. In Zimbabwe, a component called 'education for life' has been introduced to school curricula. This could include discussions on the rapidly changing nature of African society and the pressures this induces.

Transcultural psychiatry

Consideration of the historical time span adds another dimension to transcultural psychiatry. How have other societies fared in the industrialisation process? What has been the effect of different emphasis on the identified components of rapid industrial transition, such as, in China the arbitrary limitation of family size, or in the USSR the command economy which limited opportunities for social and financial advancement? In the USSR there was rapid, indeed forced, industrialisation of a peasant society. Soviet concepts of schizophrenia have been discredited by political misuse, but is it possible that they were based upon a rather different clinical profile in the population compared with contemporary Western societies? The concepts of 'periodic-stepwise' schizophrenia could reflect the pattern of recurrent acute psychosis deteriorating over the course of time while 'sluggish' schizophrenia is equivalent to unequivocal process schizophrenia. In the WHO study (Sartorius *et al*, 1986) Moscow scored as a developing country in terms of morbid risk of schizophrenia. One wonders what will be the effect of another phase of rapid social change with the introduction of the entrepreneurial market economy.

Intensification of cultural belief was identified as a component of rapid social change. Can we interpret

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the rise of militant fundamentalist Islam as a response to sociocultural dislocation in Arab societies? What of Japan? It has achieved a spectacularly successful industrialisation this century. We know relatively little about psychiatry in Japan, yet reports on schizophrenia suggest a very similar profile to Western societies (Sartorius, 1986; Ogawa *et al*, 1987). Is the hypothesis of transitional stress negated or is there a favourable balance of risk and protective factors? Japanese culture, for instance, is described as a child-centred culture (Takahashi, 1986).

Transcultural psychiatry has assumed more than academic interest in the study of the problems of immigrant ethnic minorities. The hypothesis of transitional stress could be useful, particularly in understanding the difficulties of those who come from developing countries to inner-city areas where transitional stresses may be intensified. It has been observed that different ethnic groups have different rates of morbidity and different types of disorder (Murphy, 1977; London, 1986). Study of the interplay of risk and protective factors and also the different points at which operative factors may impinge could be important. Take, for instance, cultural dissonance which presumably would affect all immigrants depending on their cultural origins. Would this have a different impact if it impinged maximally on early childhood or at adolescence or on mature adults? What would be the impact upon the next generation of being reared by parents who were themselves in a state of cultural turmoil? This Swazi study indicated the importance of the caregiver in the pre-school years as a predictor of later mental health – those reared by both biological parents being relatively protected from the hazards of rapid social change. Ethnic minorities who retain close-knit family life, and where the man sees himself as an integral part of the family, provide their young children not only with a good nurturing environment but with greater cultural stability. However, when these children reach adolescence the dissonance with the host culture may become an issue. Could these considerations throw light on the observed differences between ethnic groups in the UK – higher rates of psychosis in Afro-Caribbeans but increasing incidence of suicide among Asians (Harrison *et al*, 1988; Merrill, 1990)?

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