

## *Expatriate Stress and Breakdown*

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A symposium on Expatriate Stress and Breakdown was held on 27 October 1983 in London under the auspices of Guy's Hospital and Charter Medical to bring together psychiatrists, psychologists, sociologists and physicians with an interest in occupational health. Since the 1920s, when one-fifth of the British employees of the Anglo-Persian Oil Company suffered from 'tropical neurasthenia', little has been published on this topic.

A much rarer event than tropical neurasthenia in colonial times was 'Jungle Madness', an acute psychotic reaction which might end in suicide or disappearing into the bush. Roland Littlewood (Institute of Social Anthropology), as anthropologist and psychiatrist, put expatriate breakdown into its historical context, and emphasized that expatriates do not exist in a vacuum but must establish contacts with the local population, which are likely to be sexual, political and moral.

It is virtually impossible to get adequate information on the numbers of those prematurely returned, as most companies do not collect this information centrally and they have no incentive to release this data. Most estimates of early termination of overseas contracts are anecdotal, but an American postal study<sup>1</sup> showed that the figure may be as high as 30 per cent. It has been claimed that one major British company consistently select one-third more employees for overseas service than it requires, while another company allocates an extra 30 per cent of its annual expatriate budget to cover the cost of failures. In contrast to these high failure rates, Mr H. Bridger (Senior Consultant at the Tavistock Institute of Human Relations) had reduced to zero the dropout rate among resettled employees in Ontario by a policy of constructive advice, concern and preparation for families and by dealing with their anxieties.

While frank psychiatric breakdown will account for a significant proportion of these failures, by far the majority will not be seen by psychiatrists and many returnees will have problems with alcohol, substance abuse, marital breakdown, psychosomatic illness or poor work performance. Brigadier P. D. Wickenden (Director of Army Psychiatry) said that although the Army enforces rigorous screening procedures and while the total numbers are small, psychiatric disorder still accounts for the second largest source of medical evacuation and medical discharge. According to Dr P. Constable (Deputy Medical Adviser to the Civil Service), the rate of stress-related illness is higher in the Foreign Office than in the Home Civil Service. Dr C. R. M. Wilson (St Andrew's, Northampton) found that 49.6 per cent of admissions to the Hospital for Tropical Diseases had a

significant psychological component. The expatriate spouse is also often a casualty. Brigadier Wickenden mentioned the vulnerability of service wives who do not enjoy the same group support as their husbands; the youngest wives who need the most protection are the least privileged and may get placed in the least attractive and most remote quarters. Among civilian expatriates, breakdown in an employee's wife is a major reason for early return and it can contribute to his own breakdown. Although Dr J. Brothwood (Chief Medical Officer to Esso) recommended that ideally expatriates should be accompanied by their spouses, it is likely that other companies frequently fail to screen them adequately.

Tirill Harris (Bedford College) pointed out that attention must be paid to the contextual meaning of life events to expatriates. She made the point that those women who succumb to the triggering effect of stressful life events must have been more vulnerable initially. The vulnerability factors identified in the Camberwell study<sup>2</sup> might well be usefully incorporated into a screening procedure. She also mentioned that vulnerability can be reduced if a woman marries a dependable person. The concept of collective coping may be relevant here in that the employee and his spouse often share coping mechanisms and may well survive better as a couple than as single people.

Professor Jack Morgenstern (Mercer University School of Medicine) said that expatriate children resemble refugees rather than voluntary migrants in that their parents move them like chattels in the pursuit of their careers. Geographically mobile adolescents plunge recklessly into relationships from which they know they will be rescued by their next involuntary move. As a result of the built-in transience of their lives they do not need to learn how to make major decisions. Professor Morgenstern pointed out that a polyglot background in children can be an illusory advantage since it can complicate the development of a coherent sense of self.

Four speakers addressed the issue of appropriate medical screening. Dr R. Gill (Medical Officer to the Bank of England) and Dr R. Cox (Phillips Petroleum Co.) stressed the importance of the medical review occurring early in the selection process. There was a disagreement over Dr Gill's advice that psychotic illness should lead to automatic exclusion, and Dr Brothwood was prepared to consider for overseas placement those people who had well controlled affective disorders. Dr Alan Bailey (Director of Research at BUPA) reviewed biochemical predictors of hepatic and cardiac disease. In discussing prophylaxis, the development

of a screening method as an adjunct to the standard interview was outlined by Dr R. Caplan (St George's Hospital Medical School). This technique relies on the identification and use of the potential expatriate's coping mechanisms and those of the spouse, based on the premise that current strategies can predict future adaptive behaviour. Dr S. McKeown (Oxford University Department of Psychiatry) said that breakdown is a predictable and normal response to excessive pressure and that it does not necessarily mean

permanent weakness or disability in the expatriate, who may be capable of dealing effectively with other demands in different circumstances.

#### REFERENCES

- <sup>1</sup>LANIER, A. R. (1979) Selecting and preparing personnel for overseas transfers. *Personnel Journal*, March, 160-3.
- <sup>2</sup>BROWN, G. W. & HARRIS, T. (1978) *Social Origins of Depression: A Study of Psychiatric Disorder in Women*. London: Tavistock Publications.

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## Collaboration between Psychiatric Case-Registers

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There are now six psychiatric case-registers covering areas in England, two in Scotland and one in Wales. All record the contacts made by patients or clients from a defined geographical area with specified medical and social services. This information is stored in a linked and cumulative file so that the care of any individual or group can be followed over time and the patterns of care established. The geographical base allows rates to be calculated and epidemiological research to be conducted.

Registers vary a good deal in the services they cover and in the details of their collection methods, but there is a central core of roughly comparable information. The directors and technical staff of eight registers, encouraged by the Department of Health and Social Security, therefore decided to adopt common definitions and procedures in order to produce a basic set of tables, so that at least some aspects of local services could be compared across areas and with the figures for England, Scotland and Wales.

The first such report has now been produced. It provides socio-demographic information about each area and statistics of in-patients, day care, out-patients and other forms of care for the period 1976 to 1981.

There are substantial socio-demographic differences, varying from inner conurban areas with declining populations (Camberwell, Salford), through medium-sized industrial cities with more or less average population indices (Cardiff, Nottingham, Southampton), to relatively attractive areas with increasing populations (Oxford and Worcester). The eighth register (Aberdeen) is difficult to fit into this scheme because of its mixture of far-flung rural hinterland

and rapid industrial growth. It also shares, with Scotland, an in-patient rate twice that of England and Wales.

In general, the data suggest that three kinds of factor should be taken into account when considering local rates of contact with services. The first is the way that services have developed over the preceding twenty years or so. The second is the extent to which the population is growing or decreasing in size, which may suggest differential in- or out-migration. The third is the pattern of socio-economic characteristics, particularly indices of social isolation, poverty and ethnicity. National rates are not necessarily suitable for local planning.

It is hoped to bring out regular reports in future and to improve both the coverage and the detail of the data provided, particularly of non-hospital services. Individual registers will contribute sections on services of particular local interest. Another promising development is the creation of case-registers in other European countries, notably Denmark, Holland, Italy and West Germany. Most of these have used British registers as a model and it should eventually be possible to provide a much broader comparison of services.

The first report<sup>1</sup> is available from Mr C. Jennings, Southampton Psychiatric Case Register, Knowle Hospital, Fareham, Hants, PO17 5NA; price £2.50. Cheques should be made payable to 'The University of Southampton'.

#### REFERENCE

- <sup>1</sup>GIBBONS, J., JENNINGS, C. & WING, J. K. (1984) *Psychiatric Care in Eight Register Areas*.