that there is a much more abundant supply of nurses, social workers and psychologists (e.g. 390, 19 and 9 respectively for 400 patients) who will enthusiastically support any new enterprise. Agreed, distances are far by English standards, but highways are good and for us here the cities and universities of Edmonton and Calgary are one and two hours away by car. Food is cheap in relation to income; it is only three times city prices if it has to be flown in as in the far north where there is little psychiatric practice.

North American training is for private (i.e. office) practice, hence a low recruitment to the hospital of Canadian graduates. For those who decide on the hospital life work can be truly enjoyable and satisfying and off-duty the Canadian West has so much to offer recreationally. True, registration is now more difficult as so many overseas medical graduates have wished to come here and the former privileged position of those of us from the UK has been lost as discriminatory. Those wishing to apply will be warmly supported by those of us waiting to welcome them.

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Psychiatric problems in Afghan refugees

DEAR SIRS

It may be of interest to readers of the *Bulletin* to learn about the psychiatric implications of the war in Afghanistan. In the past seven years 3.5 million refugees have crossed the border from Afghanistan into Pakistan, with more than two-thirds of them settling in the North-West Frontier Province (NWFP). Because of this influx, considerable pressure has been put on all health services of the Province, including psychiatry. Since there are no formal psychiatric facilities in the refugee camps of towns other than Peshawar, the provincial capital, many Afghans make use of the clinics and hospital services in the capital. We have carried out a psychiatric field survey of 7000 Afghan refugees living in camps near Peshawar, and analysed the diagnostic pattern of 3000 patients who attended the outpatient clinic of the Post-graduate Medical Institute of Leady Reading Hospital over a two year period (1981–1983). We used standardised questionnaires to record age, sex, occupation, education, psychiatric symptoms, past treatment, and religious belief system. Duration and nature of exposure to combat were also recorded. This was accomplished through an initial screening by a social worker and followed by examination of the mental state by a psychiatrist.

The commonest syndrome was reactive depression in which vivid dreams, visual hallucinations and moderate to severe agitated depression were the predominant symptoms. These patients required some kind of treatment, usually antidepressants, rarely ECT. Neither these patients nor their close relatives had been involved in combat in the field. Most had been living in villages close to actual combat areas prior to migration. The main content of their visual hallucinations were 'Helicopter gunships firing at us' 'Aeroplanes', 'Red Russians with guns', and uniformed men attacking. The second most prominent group of the outpatient attendees and of the surveyed psychiatric population showed marked phobic neurosis, in many instances amounting to just short of panic. The main phrase used was 'fear of the unknown'.

Compared with the native Pakistani population of NWFP, as examined by the author in a separate survey of 1500 adults (900 urban, 600 rural), there were both similarities and differences:

Similarities

(1) In both groups a majority of patients sought treatment from traditional healers initially.
(2) The Pathans of both groups (a proud, militant tribal group of Pushtu-speaking people of NWFP and South-east Afghanistan) denied depression and felt ashamed about this word.
(3) Religious faith in Afghans and in the rural host population is very strong.

Differences

(1) There were significantly more psychiatric problems (30%) in refugees compared to the local population (14%).
(2) Reactive depressive psychosis was prominent in Afghan patients (35%) compared to the local population in whom depression was rare.
(3) Phobic anxiety was common (26%) in the refugee population and was mainly a female problem. In the local population this syndrome is rare.
(4) Refugees have a great understanding of the psychological nature of their symptoms while the local population present more somatic complaints in connection with mental illness. Thus, most Afghans relate their illness to psychosocial causes while the majority of the local population with similar problems believe they are physically ill.

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Psychiatric services and the community

DEAR SIRS

We were interested to see Dr M. T. Haslam (*Bulletin*, January 1986, **10**, 10) drawing attention to the accumulation of long-stay patients in psychiatric units, a problem obviously of increasing concern with the move to community care.

We have operated a community oriented psychiatric service in this district of approximately 100,000 population for over seven years, having for most of this time only one mixed admission ward of 30 beds to cope with all problems apart from senile dementia. Currently there are only four patients who have remained continuously on the Ward for over a year and none have remained over six months and