CULTURE, MIGRATION AND MENTAL HEALTH:
A COMPARATIVE STUDY OF BARBADIANS IN BARBADOS AND IN ENGLAND.

A thesis submitted to the University of Surrey
for the degree of Ph.D.

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DEDICATED

to

Mr. Ralph and Evelyn Clarke
(Parents)

and in memory of

Mr. Fitzgerald and Mabel Bailey
(Godparents)

who made it possible.
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which sample was taken. A red * indicates the street.
This research was undertaken, using standardised measures of mental health previously validated in general practice surveys, to survey the level of mental health in two contrasted Barbadian populations, in Reading and Barbados. Hypotheses have been tested about the effects of community integration and mental health level in the contrasted communities including the relationships between the stresses of migration and adaptation and poor mental health. Levels of mental health in the Barbadian population as a whole have been compared with measures of mental health obtained in previous normative samples of the indigenous population in Britain. The roles of social stress, sex, marital status, church attendance, educational level, goal striving/high aspiration in the adjustment of Barbadian migrants have been considered in some detail.

Barbadian cultural norms regarding the nature and causes of "madness" have been explored. Data from the research has shown that Barbadian migrants in Reading have poorer mental health than non-migrant Barbadians, and poorer mental health than the English normative sample. Moreover, the absence of significant sex differences - the scores for the Barbadian males in Reading suggested a particular kind of psychological adjustment following migration.

Patterns of mental health are quite different in the two Barbadian samples. All the factors considered - housing, marital status, pre-migration plans, community support, stress and social mobility - are important for the mental health of some groups. I have examined the interaction between these factors and while some causal connection can be established, the complexity is too great to produce conclusive findings on the various factors.
ould like to thank Professor Chris. Bagley very much for supervising this 
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nally, I would like to say a sincere thank you to Mrs. S. Clarke, who 'braved the
ather' and unstintingly stuck to the task of typing the final draft.
A large number of studies both in Britain and the USA have consistently found that the mental health of immigrants is poorer than that of the native population they join.

In Britain, research into mental health among immigrants had its origin in the early 1960s. Investigations into mental illness among West Indians were carried out by Penton 1963; Kiev 1963; Hemsley 1964; Kiev 1964; Gordon 1965; Tewfik and Okasha 1965. These studies were open to criticism on a number of grounds. The data used for previous research were mainly taken from a sample of first admissions to psychiatric hospitals and from patients visiting their local GPs. Results obtained from this data gave a misleading rate of the extent of psychiatric morbidity among West Indian immigrants in the U.K. Because of the methodology employed in previous studies, no examination of the reasons for immigrants' apparently poor mental health has been possible.

There has not been a single study conducted in Britain which has attempted to look at the mental health of a representative sample of West Indian immigrants. No study had covered more than a small area - usually one hospital's catchment area. No study has seriously examined the poor mental health of West Indian immigrants outside of the mental institutions.

The most extensive study conducted to date was carried out by Bagley, 1971, using the Camberwell Psychiatric Register. Using data collected routinely for this register during 1967 & 1968, compared with the population at risk in the 1966 Ten Percent Sample Census, he was able to calculate rates of contact with psychiatric services from a number of ethnic groups. He found that the number of clinically active cases per 1,000 of the population at risk, for British subjects was 11.68; Indians and Pakistanis 32.83; West Indians 16.00;
Africans 70.00; Irish 23.67; and other Commonwealth immigrants 69.23. Unfortunately the number of patients involved are relatively small - e.g. 22 Indian and Pakistani contacts - so that the prevalence rates for some groups are not very reliable.

The problems Barbadians encounter are by no means peculiar to this ethnic group, but rather common to most black immigrants in Britain. However, the absence of financial resources had limited the researcher to a study of one ethnic group, Barbadians (West Indians).

The arrival of West Indians to Great Britain dates back to the period of the Second World War. During this period West Indians arrived in Britain mainly as personnel in the armed forces and as seamen on merchant ships. When the war ended these men returned home to a disappointing situation. Jobs were scarce and the standard of living at home was lower than that which they enjoyed in Britain. They began to return slowly to Britain with the hope of seeking their fortunes. This initial group wrote home glowing accounts of varied opportunities in Britain.

The influx of immigrants which followed the returning soldiers was not only due to the poor economic conditions which existed in the West Indies but to the demand or pull effects of the British economy. Most of the Barbadians who came to Britain during the 1950s & 1960s did so through officially sponsored schemes. They found employment on London Transport, British Rail or as Nurses.

The Investigation

The research proposed intends to conduct a full scale study into the prevalence of poor mental health among Barbadians (West Indians), living in U.K. and in Barbados. It was the researcher's intention to investigate psychiatric morbidity rates among West Indians - i.e. Barbadians, Trinidadians, Jamaicans,
and Guyanese - but the complexity of the variables, the scale of the work and the absence of any financial support, limited the researcher to a study of Barbadians. It is hoped that by studying one group of West Indians, the result would at least have considerable depth. The study will incorporate several basic differences in conception and design to previous British studies. This, it is hoped, will make it possible to overcome the serious limitations on the usefulness of the information they provided.

Data has been gathered on the basis of "Snowball Sampling," rather than contact with agencies, such as hospitals or General Practitioners. Potential problems associated with differential attendance at referral and treatment practices are therefore avoided. Many studies have shown the existence of large numbers of mentally disturbed individuals who remain completely unknown to treatment agencies.

Snowball or Network Sampling - sometimes known as the grapevine approach - relies heavily on the chain reaction which is built up from the few contacts, who provide a system through which the ethnic minority can be penetrated. This technique is not widely used in the U.K. but has been successfully used by C.S. & J.S. Gunner, 1966, in a study of a new Sikh community in an English town. A particularly successful use of snowball sampling is shown in Solomon Poll's study of the Hasidic community of Williamsburg.

This technique has been only adopted for the present study after much consideration was given to other methods of sampling. There are several reasons why locating a minority population presents special difficulties. Firstly, minority populations are often unevenly distributed, both in size and composition among the general population. Secondly, there is generally inadequate amount of official information on these groups, to enable a conventional sampling frame to be drawn up.
The Barbadian (West Indian) population presents special problems. Most Barbadians have English surnames and therefore any attempt to trace them through the electoral register is practically impossible. Further, the electoral register as a sampling frame may be unreliable, because of under-enumeration.

It is obvious that interviews done by the network technique do not constitute random sampling. The technique of snow-ball sampling seems to have much to commend it for enquiries such as the present one.

Problems of the reliability of diagnosis will be avoided by using standardised psychiatric screening techniques which, because they measure a wide range of states from normal through mild disturbances to more severe impairments, give much more precise and detailed information than a formal diagnostic categorisation. The use of such a device enables more flexible analysis of the data in terms of possible causes of poor mental health.

In studies of this nature it is always necessary to avoid placing too much emphasis on a purely medical/psychiatric model of analysis. To add some degree of balance to the study a sociological questionnaire will be used to measure the various social factors which are likely to contribute to poor mental health. With this type of design, explanations can be sought by cross-group comparisons and within-group comparisons.

Basically, four approaches have been used in previous epidemiological studies of mental illness; clinical interviews, structured non-clinical interviews, information from secondary sources (e.g. conventional diagnosis by psychiatrists) and standardised questionnaires. In addition, the three latter methods have often been augmented by clinical evaluation of the material they uncover. In this study it is proposed to use a number of questionnaires for several reasons.
First, a questionnaire can be administered by interviewers who are not clinically trained. Second, the problems of the unreliability of diagnosis is avoided. Third, questionnaire measurement of poor mental health can be achieved very quickly. Fourth, the questionnaire method is more subtle, in that it taps a large range of potential symptoms. Fifth, it allows for direct comparison between individuals and groups – everyone is asked exactly the same questions. Sixth, more sophisticated analysis is possible with a continuous measure than with a dichotomous one. Seventh, some direct comparison with previous studies which have used the same instrument will be possible.

It may be assumed that the general validity of the Middlesex Hospital Questionnaire and the General Hospital Questionnaire is adequate for the purpose of this study. Much additional evidence on the validity of the MHQ and the GHQ have been recorded. The problem of validity for specifically immigrant is more difficult, because only indirect evidence is available. Evidence from studies done in the area of transcultural psychiatry have shown that Western nosology is often inapplicable to both non-Western (China and Japan) and some underdeveloped Third World countries (St. Lucia, Barbados and Dominica).

The GHQ, despite the laudable claims made about its usefulness, is rather a lengthy instrument. The complete version consists of 140 items, and even the short version contains 60 items. Although this may be a reasonable length for a questionnaire when standing alone it may prove too long when used in conjunction with the other measures (as in the present full scale study). Despite the GHQ's use on black Americans, I remain unconvinced about its suitability with West Indian immigrants in Britain. Furthermore, the MHQ has been used on a Barbadian population (Robertson, E. 1975) with good results.
Using More than one Instrument

Over the years mental health surveys have become decreasingly clinical and increasingly sociological in aim, seeking less to identify the sick than to assess the prevalence of psycho-social stress. With this shift, symptom check lists administered by lay interviewers or completed by the subjects themselves have steadily replaced the physicians search for definite illness. Such check lists are convenient tools that are easy to combine with wider sociological questionnaires.

Attempts to use check lists alone, have often resulted in unsatisfactory findings. Seiler, (1974) reminds that they differentiate only weakly between known patients and presumed normals. In a cross-cultural study they predict less well. What is often overlooked by most researchers is that symptom check lists are best used in determining the sub-clinical levels of mental disturbance and not mental illness per se.

To overcome many of these difficulties we have employed three instruments in our study and have clearly defined what we mean by mental health/illness, and have hopefully been careful to remain within that definition.

The Plan of the Main Investigation

The investigation will involve a questionnaire study of the mental health, social background, family and work situation of Barbadians living in Britain, as well as in a sample living in Barbados.

A network sample of 50 Barbadian men and 50 Barbadian women living in Reading were selected from a community containing a known Barbadian population (1971 Census) of over 2,000.
Subjects completed three schedules: one measuring attitudes to society in general, and descriptions of social relationships with various individuals and social agencies; a questionnaire measuring stress, taken from Cochrane's Birmingham study; and a measure of mental health, the Middlesex Hospital Questionnaire, devised by Drs. Crown and Crisp of the Middlesex Hospital, London. This measures six areas of psychological functioning (including depression, specific and general anxiety, obsessionality, somatic symptoms and hysteria). We used the MHQ in preference to the GHQ (which we had originally intended using but rejected after pilot work), because (a) it was shorter, and as our initial pilots showed, easier to understand and use; (b) it had been previously used, with some indication of validity, in a study of Barbadian women in England (Elaine Robertson, M.Phil thesis, University of Sussex, 1975); (c) Dr. R. Cochrane's study in Birmingham had shown that Goldberg's questionnaire lacked validity when used with immigrant Irish and Pakistani populations (Cochrane's report of research submitted to the SSRC).

The Barbadians living in Reading (according to my exploratory research) represent an interesting social picture. They form a very cohesive community and the extended family appears to be very much alive. A comparison between this group and Barbadians living in Barbados, was therefore undertaken in order to provide comparative data.

A General Outline

It has been established that there is a strong, although not inconsistent, relationship between stress and poor mental health. Bagley, in *Sequels of Alienation*, considers stress factors as contributing to the apparently higher rates of mental illness in West Indians in Britain compared with the native population. He sees the failure to achieve better levels of occupation, housing and income as factors which engender a strong feeling of alienation among West Indians.
One type of stress which possibly affects West Indians most is the frustrations produced by not being able to advance socially, occupationally and in educational terms. This is mainly because of the limited opportunities and racial discrimination.

The process of immigration itself can be stressful experience. Here the immigrant comes into contact with a new culture which he may find difficulty in adjusting. There is much evidence to support the view that cultural dissonance produces adverse reactions. First generation immigrants are usually unmarried or separated from their family and therefore experience stress at this level. Marital status is clearly related to mental illness (Gove, 1972; Geerken, and Gove, 1974). The immigrant may be less integrated into the larger community.

It has been observed that social disorganisation and isolation are associated with mental illness, the exact nature of the relationship is questionable (Dunham, 1976). The immigrant's expectations about his life and adopted country may not have been met or the process of achieving so stressful that his mental health is impaired. The immigrant may have encountered racial prejudice and suffered as a result of this. There is no current evidence which supports a direct causal relationship between racial prejudice and mental illness. It is more likely that the onset of mental illness among immigrants is etiological, with racial prejudice probably one of many factors.

At an ecological level it has been shown that higher population density is associated with evidence of several kinds of psychopathology (Bagley, et al, 1973). Immigrants generally live in more crowded conditions than members of the host country. This variable mediates between immigration and questions concerning the number of persons living in a dwelling and the number of rooms occupied, as well as an inquiry into the ecological aspect of residence (population per acre, etc).
It is the intention of this study to measure family and community contacts. Family contacts will be assessed by simply asking where certain relatives live and how often they have been visited. Community integration will be measured by a systematic enquiry concerning the respondents' formal or informal relationship with other members of their ethnic group. Questions will be included in the sociological questionnaire to measure the respondent's current life situation (family and employment) as well as significant changes in these areas over the length of residence. It will be necessary to get information about some of these factors prior to immigration in order to assess the changes in objective status. Reasons for migration will also be sought. At all stages of the enquiry considerable attention will be given to the difficult problem of separating cause and effect in the study of stress and poor mental health (Brown et al, 1973).

There are three main reasons for mental health questions receiving attention; firstly, the importance of the relationship between the mental health of the immigrant and successful settlement; secondly, the heavy cost of hospitalising someone who has developed a chronic mental disorder; thirdly, the considerable loss of working days, to industry. The amount of mental disorder in an immigrant population could be an indicator of the difficulties and failures which the population experiences in adjusting and achieving in its adoptive country. It is therefore the main concern of this study, to investigate (by an adequate methodology) the possible causal relationship between social stress and mental illness in one group of immigrants.

It is hoped that the results obtained from studies like the one proposed here will provide policy makers, review committees on immigration (seeking further guidance), mental welfare personnel, with an added insight into the
possible cause of poor mental health among immigrants. It may be that immigrants from certain countries, who have consistently shown an excess of mental illness, will necessarily have to undergo pre-migration psychiatric screening. To put such a scheme into operation, further research is needed on immigrants in their own country. What seems of immediate importance, however, is the containment and reduction of mental illness among immigrants. How this will be done does not directly concern this study, but it is hoped that the results obtained will be instructive in alleviating the situation.

Aims of the Study

1. To examine the mental health services within the island of Barbados.
2. To explore the perception and understanding of 'madness' in Barbados.
3. To study the prevalence of poor mental health in a community sample of Barbadians living in Reading, England.
4. To study the prevalence of poor mental health in a community sample of Barbadians living in Barbados.
5. To examine what factors are causally related to poor mental health in the two groups/samples of respondents.
6. To compare the prevalence of poor mental health of U.K. Barbadians and Barbadians living in Barbados.
7. To compare the prevalence of poor mental health between U.K. Barbadians and indigenous white English population.
<table>
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<tr>
<th>Author(s)</th>
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Goldberg, D. and Blackwell, B.


Gordon, E.


Gumrner, G.S. and J.S.


Gumbe, C.S. and J.S.

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Kiev, A.


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CHAPTER 1

CONCEPTS OF MENTAL HEALTH AND MENTAL ILLNESS

- A REVIEW OF POPULAR CRITERIA AND DEFINITIONS OF MENTAL HEALTH/
  MENTAL ILLNESS.

- POOR MENTAL HEALTH - A DEFINITION.

- A SOCIOLOGICAL PERSPECTIVE OF POOR MENTAL HEALTH.
CONCEPTS OF MENTAL HEALTH AND MENTAL ILLNESS

Introduction

Perhaps the greatest handicap of a systematic study of the social conditions conducive to mental health is the very elusiveness of this concept. As far as I could discover there exists no psychologically meaningful and from the point of research, operationally useful description of what is commonly understood to constitute mental health. Yet the establishment of some criteria by which the degree of mental health of an individual can be judged is essential if one wishes to identify social conditions conducive to the attainment of mental health.

Here I review some of the numerous criteria and definitions of what constitutes mental health/mental illness. More importantly I discuss the concepts of 'poor mental health' as opposed to mental illness, which I regard as a more useful and realistic conceptualisation of what the respondents in my study are likely to manifest.

A Review Of Popular Criteria And Definitions Of Mental Health/Mental Illness

So numerous are the suggested criteria by which behaviour or characteristics should be placed in the mental illness (or mental health, if it is defined in a manner other than 'absence of mental illness') category, that several authors have classified these definitions. Jahoda (1958) and Offer and Sabshin (1966) for example, provide classification of approaches to the concept of mental health. Jahoda (1958: 22) based upon her survey of the literature, offers six major categories of concepts.
Mental health is defined in terms of criteria relating to:

(1) A person's attitude to himself.

(2) The subject's growth development.

(3) The individual's degree of independence from social influence.

(4) The individual's integration.

(5) The inadequacy of the subject's perception of reality, or

(6) the attainment of environmental mastery.

In another survey of the mental health literature, Offer and Sabshin (1967: 97-112) describes "four distinctive approaches" which claim to embody the numerous definitions of normality or mental health previously used: normality - (1) 'health' (2) 'utopia' (3) 'average' and (4) 'process.'

The first category includes such definitions as those who equate health with absence of disabling illness. The second group of definitions implies that no person is perfectly healthy or normal, one's degree of health is measured against approximation to the ideal state. The third category of concepts, equates normality with falling into the middle range, and deviancy with variation in either direction. Definition of normality as conforming to central societal values would fall into this category. The fourth class of definitions view normality from the perspective of temporal progression.

Kaplan (1972) outlined four basic issues which he considers underlie much of the variability in the conceptualisation of mental illness and/or mental health, they are:

(1) the relationship between mental health and mental illness,

(2) the universality or criteria of mental illness (health),

(3) the number of defining criteria, and
Mental Health and Mental Illness

The first issue is concerned with the question of the independence of the concepts of mental health and mental illness (Jahoda, 1958; Scott, 1961; Sandford, 1966: 366; Offer and Sabshin, 1966). On the one hand mental illness may be defined by reference to each other, either as mutually exclusive categories, or as poles of a continuum. In the former situation mental health (illness) is treated as an absolute condition, a person is either mentally ill or mentally healthy. In the latter situation, as opposites poles of a continuum, mental health and mental illness are relative phenomena— a person is more or less mentally ill/healthy.

On the other hand, mental illness and mental health may be conceptualised as independent variables, such that if a person is mentally ill it does not determine whether or not, (or the degree to which) a person is mentally healthy.

The decision as to whether mental illness should be conceived of in terms of mental health as mutually exclusive, or as a continuum, or as an independent variable, represents a major source of variation in definitions of mental illness.

Universality V Relativity Of Mental Illness

This concept of the universality of defining criteria has been widely discussed in the behavioural science literature (Maslow and Mittlemann, 1951; Linton, 1956; Devereux, 1956; Jahoda, 1958; Scott, 1961; Offer and Sabshin, 1966; 41-43, 56-82).
In this view one may state universal criteria of mental health (illness), this can occur in two ways. Firstly it is asserted that all societies provide examples of psychic abnormalities, (neurotics and psychoics, etc), which can be recognised by members of other societies. Secondly, in every society there are people who have various constitutional defects, which make them abnormal, irrespective of the socio-cultural system to which they belong, Linton, (1956).

In opposition to the view that the defining criteria for mental illness has universal characteristics, is the assumption that behaviours are abnormal only within the context of particular socio-cultural environments. In this view behaviour which falls outside the accepted range of acting, which fails to maintain the mores of society are judged to be evidence of mental illness. One's interpersonal behaviour is organised by social setting and contextual circumstances (Raush, 1965). Mental illness is defined as one's inability or unwillingness to adapt to the particular requirements of the socio-cultural system.

**The Perception and Control of Mental Illness**

Modern psychiatry has arrived at a stage of theoretical development where the socio-cultural dimensions join with the genetic, biological and psychological interpretation of human behaviour. Valuable contributions to the field of cultural psychiatry, i.e. that branch of psychiatry dealing with the interrelationship of abnormal psychological status and socio-cultural milieu, have been made in the past fifteen years.

Epidemiological studies related to the ecology of city life (Faris and Dunham, 1939; Dunham, 1965 and Brown et al, 1972), to stratification, (Hollingshead and Redlich, 1958; Schwab and Schwab, 1973) and to ethnic groups, (Leighton et al, 1963; Yap, 1965; Carpenter and Brockington, 1980) have been carried out by psychiatrists and social scientists.
Another important development has been the careful study of whole communities such as the Hutterites (Eaton and Weil, 1955) and the Stirling Nova Scotia project (Leighton 1953, 1956), the social structure and culture were brought into direct relation with mental health.

Most of the work concerned with the relationship between culture and mental health have been carried out within the boundaries of a single community. Pioneering efforts have been made by such researchers as Benedict and Jacks (1954), Lin (1953) and Yap (1951) to compare the incidence and prevalence of mental illness in several cultures while some studies have employed samples composed of representatives of different national or cultural groups. These were persons not living in the country of their origin; Hinkle's study of Chinese in New York (Hinkle, 1957 and Hinkle and Wolf, 1957), Roberts and Myers (1954) study of Irish, Italians, Negroes and Jews. Cochrane (1977) study Asians, Irish and West Indians and Carpenter and Brockington's (1980) study of Asians, West Indians and Africans.

Epidemiology

As regards to epidemiology, two methods have commonly been used for the estimation of the prevalence of mental ill-health in the population of a given geographical area. These are:

(1) Investigation of a sample population, taken as representative of the total population, and

(2) Hospital admission statistics. Some researchers have combined both methods. In my study the former method was employed.

Difficulties

Cross-cultural studies present the researcher with problems not normally encountered in 'uni-cultural' studies. While it is difficult enough to make correct estimates regarding the incidence and prevalence of mental disorder in a given geographical unit, the difficulties inherent in the
tasks are multiplied if attempts are made to assess and compare incidence and prevalence of mental illness across cultures.

The construction of a theoretical framework in which to locate the data is even more exacting, especially if the two cultures are markedly different. The question before us then is, how does one account for the prevalence of poor mental health in Barbados and England? Is there a theory which can explain the differences yet similarities in psychopathology in the two cultures? Why in one culture, a certain type of behaviour is labelled deviant and in another the same behaviour is tolerated?

One of the most lucid presentations on etiology has been that of Halliday (1943) who states,

"Illness is regarded not as a fault in the parts, but as a reaction to a mode of behaviour, or a vital expression of a living unit in response to those forces which he encounters as he moves and grows in time. Cause is therefore two-fold and is to be found in the nature of the individual and the nature of his environment at a particular point in time."

What are the implications of this concept/approach to the nature of illness when applied to the field of psychiatry/medical sociology? Stated broadly, this concept implies that all human behaviour is the expression, at a psychophysiological level of a dynamic interrelationship between the individual (personality and constitutional parts) and his environment, a relationship which is in a constant state of motion and change. Mental health, psychopathy and psychosis can then be understood as an expression of varying qualitative aspects of this interrelationship which are at certain crucial levels results in qualitative changes.

Moreover this concept implies that these changes are potentially reversible.
Relative Factors

What is considered psychologically healthy in one culture (Barbados) may not be considered so in another (England). We label homosexuality ("psychopathic personality") as pathological in our Western culture; among the Taralans and Japanese (Benedict 1946; Kardimer 1939) it is accepted as a normal behaviour variant, and meets with no approbation. In our Western culture within the span of the last 500 years, individuals who insist that they see visions, hear voices and communicate with God have at varying times been revered as prophets, burned as witches or hospitalised as psychotics. Moreover even within the same broad cultural group there may be significant variations in standards of accepted behaviour (Kinsey et al 1948).

Mental health I would hypothesise as that state in the interrelationship of the individual and his environment in which the personality structure is relatively stable and the environmental stresses are within the individual's absorptive capacity. Ideally this implies socially adequate behaviour in an individual who is consciously and unconsciously well integrated. If the environmental stresses are increased beyond a certain point however, neurotic symptoms will develop in the most stable individual, and in cases of extreme stress even psychotic symptoms may develop. Thus the first important point which is implicit in this conception is that there is no such thing as absolute immunity to mental illness. Every man has a 'breaking point,' irrespective of culture. Individual adaptation to environmental change and its consequence for mental health/ill health will be discussed later.

Scale Of Disorder

When on the one hand the individual personality structure is unstable owing to unfavourable heredity or early environmental influences, the amount of environmental stress necessary to produce abnormal symptoms is correspondingly less. Thus at one end of the scale there is our theoretically perfectly
integrated individual of whom only realistic threats of the greatest severity and duration can succeed in unsettling. At the other extreme we have individuals whose personality structure is so poorly equilibrated, so fraught with internal intentions and contradictions, that the simplest routine of everyday living is too much for it, and it gradually disintegrates into some form of insidious neurotic or psychotic disorder. Between these two extremes there are infinite gradations and admixture.

Constitutional Factors and Their Role in Mental Ill Health

In my discussion about the scale of disorder, I mentioned that the individual's personality structure can become unstable due to unfavourable heredity and/or early environmental influences. The point being that constitutional factors can and do play an important part in an individual's ability to adapt and cope with environmental situations.

Today it is fairly generally conceded that neurotic disorders arise in connection with various environmental stresses or frustrations in the course of individual development. But psychotic personality, schizophrenia and manic depressive psychosis are still widely regarded as conditions which result primarily from heredity or constitutional factors. In my opinion this point is untenable, both on theoretical and clinical grounds. This is not to deny that constitutional (genetic) factors play a role in schizophrenia, manic depressive psychosis and psychopathic personality. Constitutional factors are operational in all human behaviour whether normal or abnormal. From the moment of birth on, all human behaviour becomes increasingly complex resultant of the interaction of these genetic factors with environmental factors.

Abnormal behaviour must always be evaluated in terms of this two-fold aspect of causality.

Constitutional factors do not operate directly in the production of psychological phenomena, but function as a dynamic substrata, being moulded by and in turn moulding the environmental impact. Heredity is like a sort of psychological threshold, its relative importance depends on the quality, quantity and timing of the environmental stress.
Summary

The theory states that all human behaviour is the expression of a dynamic interrelationship between the individual and his environment, (irrespective of the culture) at particular points in time and space; that mental health and various deviations then formed are but expressions of varying qualitative aspects of this relationship, which at certain crucial levels results in qualitative changes in the individual.

Having outlined the basic theoretical framework into which mental health and mental ill health can be situated in a cultural context, I would like to go a step further and look at some of the assumptions and implications of mental health/ill health across cultures.

Cross Cultural Application Of Mental Health

It is central to the understanding of transcultural mental health/ill health, to discuss how much cultural loading can be transported across cultural frontiers. One approach is to compare the concept of mental health within different cultures. Another approach is to take the most widely held ideas of mental health in Western Europe and North American cultures and identify what aspects are applicable in certain selected cultures. For example, in a modern industrialised and rapidly changing society there is great value set on the ability of each individual to be independent and to adapt freely to changing circumstances. Anyone in such a society who shows marked dependence and rigidity conceivably have the state of his mental health called into question. But in a slow moving community with a relatively unchanging way of life, aggressive independence and the need to experience change might likewise be questioned.
Many people consider that it is artificial to apply the concept of mental health to a society. Instead I would advance for consideration the concept of society being conducive to the mental health of its members to a greater or lesser degree, or conversely to their mental ill health. It might be postulated that a society with institutions conducive to mental health is one which has a capacity to integrate the largest number of its members and the largest number of innate human capabilities, and to allow them optimal development. But variations in the levels at which societies function in these regards must be recognised. Different societies may accept lower or higher levels of integration, or permit different degrees of regression or of autonomy. It is clear that there can never be a simple criterion.

This consideration has determined my selection of the value system for analysis rather than the culture as a whole.

In the past, and still today in some societies, adaptation to society has tended to be highly valued as a sign of mental health, and the failure to adapt has been even more strongly regarded as a sign of mental ill health. This point is illustrated by Shoddy (1961) who cites the case of an individual who wears no clothing in a society where clothes are normally worn. He will almost undoubtedly be thought of by others as mentally disturbed or acting under the influence of drugs, or alcohol. The same individual in a nudist group might not be regarded as disturbed by the others. However different, social attitudes do not alter the essential nature of the individual's condition, and it should be remembered that a person's motivation for being nude in a nudist colony might be pathological; because behaviour receives social approval does not mean that it is not psychopathological. There are occasions and situations in which from the point of view of mental health, rebellion or non-conformity may be far more important that social adaptation. The point here is that no single act should be taken out of
context and no single criterion of behaviour used in judgement of mental health. It is the whole meaning of behaviour in the social situation over a period of time that should be considered.

Summary

This discussion dealt with a number of questions, for example, does the concept of mental health and its derivative behaviour mean different things to different people? What is the relationship between such matters as social approval, adaptability, conformity, social harmony and the concept of mental health? Societies differ in the degree to which they permit variations in the adaptation of the individual. Is the relationship between adaptability important for mental health, is it possible that adaptability can also lead in the direction of mental illness? To what extent does lack of adaptability contribute to social stresses that may impair mental health?

Is the deviant behaviour a sign of poor mental health? Since social attitudes tend to change, the criterion of social acceptance of behaviour is unreliable. For what degree of deviant behaviour is the individual held responsible by society? Practically all cultures recognise a certain degree of disturbance of behaviour as irresponsible, but in all societies we know, people insist upon individual responsibility for some aspect of deviant behaviour and term it wrong. To what extent do societies differ in their toleration of deviance and make provisions for eccentric and deviant individuals in the structure of society?

Behind all these questions it is important to consider the individual's aspirations and how near he can get to attaining his aspirations in his own society; what desires the society stimulates in the individual; whether or not it promotes the satisfaction of the desires it stimulates. Are the expectations of the society such that an individual can adapt at a low level without being subjected to undue stress?
Anthropological studies have shown that in Samoa the people learned to make limited demands, which the society met. The majority of people appeared satisfied, but it seems that the more intense people and the more demanding people in that society contributed little. Such persons suffered from acute frustrations in their aspirations.

Finally, my discussion is neatly summarised by Cummings, who noted:

"Society must at all times remain in some kinds of equilibrium or it loses its integrity and ceases to be a system. As we have said earlier, the fundamental basis of this equilibrium in a stable society, is the members' desire to act most of the time in the way that is expected of them. This complementarity of expectations is disrupted by mental illness, the affected person appears no longer to be governed by the norms which apply to his fellows. He seems insensitive to the expectations of those around him. He has therefore in a very real and crucial way, broken his ties with society. He appears no longer to be bound to the expectations which govern the rest of us; he has skipped out of the web of obligations, and therefore he poses a problem of control. The need for control raises the question, can a member of society break the rule and not be punished? All societies punish deviants in one way or another, because the implications of not punishing them threatens the stability of the society. As the (great) sociologist, Emile Durkheim perceived, it is not entirely to punish the criminal that punitive action is taken, but rather to allow the remaining members to reassure one another that they are members of a society which is safe from deviant tendencies."

(Cummings and Cummings, 1957, p. 99.)

Numbering Of Defining Criteria

A third issue underlying the diversity of concepts of mental illness related to whether mental illness is regarded as uni-dimensional or multi-dimensional. This issue had been discussed by Scott (1961), Blum (1963; 276-277), Davis (1965; 28-29), Offer and Sahshin (1966), who cite several examples which
might be taken to be representative of each view. Kubie (1954) and Money-
Kyrle (1957) define mental illness in terms of a single criteria.

For Kubie it is 'flexibility' - easy adaptation to new experiences and
changes; for Money-Kyrle it is 'self knowledge' - adequate feelings of security
and adequate self evaluation.

Maslow and Mittlemann (1951), Klein (1960) and Rogers (1963) define mental
illness in terms of multiple criteria. Klein describes five components of
the integral personality.

(1) emotional maturity, (2) capacity to deal with conflicting emotions,
(3) a balance between emotional life and adaptation to reality,
(4) integration of different parts of the personality, and
(5) strength of character.

Maslow and Mittlemann cite eleven manifestations of psychological/mental
health, including adequate bodily desires and the ability to gratify them,
and the ability to have satisfactory relationships with the members of the
group or culture. Rogers, in addition suggests that 'the fully functioning
person' will have at least ten specified characteristics including openness
to experience.

Manifest Behaviour V Process-Condition Or Cause?

In defining mental health and mental illness, a distinction is often made
between manifest behaviour and underlying personality characteristics
(possible causes of these behaviours). This view has been put forward by
a number of behavioural scientists. Dohrenwend (1969; 147) makes a dist­
inction between symptomatic expressions af distress and the underlying
personality defect. Langner and Michael (1963; 393-394) accounting for
differences in mental illness between high and low socio-economic status
subjects, noted the following basic characteristics:
(1) the ability of the subject to recover from strain/stress, and
(2) the ability to resist, not yielding to stress.

The basic question this issue raises is whether mental illness should be
defined in terms of manifestations, that is, by symptoms or in terms of more
underlying causes or conditions, which produces the symptoms, including both
stresses and personality systems.

Having described the basic issues which appear to underly much of the variability
in the conceptualisation of mental illness and/or mental health, Kaplan
concludes that even if behavioural scientists and mental health practitioners
were able to resolve the four issues in the definition of mental illness,
they would probably still disagree on the definition of mental health. When
one considers that the borderline between mental health and mental illness
has shifted constantly over the years, it is not surprising that definitional
problems arise.

Other criteria of mental health are:
(1) clinical definition of health and pathology.
(2) individual's adaptation to environmental change.
(3) normality of behaviour.
(4) integration.
(5) the absence of mental disease/illness.

Integration - A qualitative criterion of mental health.
One of the most basic attitudes of the living organism is integration, the
hierarchial ordering and functional interdependence of its structural elements.

Most psychologists conceive of the structure of the personality as an
organised whole composed of sub-systems. These sub-systems are controlled
by the integrated action of the 'I' - ego or self. Under stress, this
hierarchial structure tends to break-down; the sub-systems free themselves
from the central authority. We are then in the process of a divided or
dissociated personality.

Among the theorists of personality, Kurt Goldstein (1939) in particular has
formulated mental pathology, in the terms of a failure of integration.
The concept of integration while useful in guiding our thinking about mental
health, has the drawback of overgenerality.

Clinical Criterion of Health and Pathology
A seemingly more straightforward criterion of abnormality is proposed by
the so-called clinical approach, which defines health and disease in terms of
symptoms. Symptoms are manifestations of dysfunctions which lead to
complaints on the part of the affected person (pain, fever, loss of appetite).
As long as the patient is free from symptoms he considers himself healthy and so
does his doctor. (However there are diseases, such as early stages of stomach
cancer, which are asymptomatic). This clinical approach, defines health in terms
of a minimal rather than a maximal performance. The clinical criterion of the
presence or absence of symptoms work quite well in the field of somatic
medicine, but it is more complex than it looks at first glance when applied
to abnormal psychology.

Social Conformity And Mental Health
In striving after social conformity, the discrepancy between the society or
group ideal and the individual's ability to attain it may be so great as to
produce strain that is incompatible with mental health.
Another cause of strain affects people who live in societies which stimulate
certain desires but do not permit their satisfaction, or possibly worse,
promote certain long-term aspirations and do not allow their attainment to
such a society might be maintained only at some cost of his contentment or
satisfaction, because of the strain, conflict or tension engendered by his
efforts to maintain his adjustment.
The Absence Of Mental Disease/Illness

There is widespread agreement that the absence of mental disease is a necessary, though by no means sufficient condition of mental health. Anthropologists tell us about cultures where behavior Western civilization would regard as symptoms of mental illness is generally accepted. According to Ruth Benedict (1934) the Indians of British Columbia engage in behavior which would be called paranoid and megalomaniacal in our culture.

Identical observable symptoms are regarded in one culture as achievement, while in another they are regarded as a severe disability. There are several examples of behavior evaluated as sick, or normal, or extraordinary in a positive sense depends largely on accepted social conventions.

Mental disease is not to be defined in terms of isolated symptoms but rather in conjunction with the social norms and values of the community in which the symptoms are observed. Even with this qualification, the absence of mental disease is not a satisfactory indication of mental health. For the borderline between what is regarded as normal and as abnormal is dim and ill-defined in all but the most extreme cases.

The Shifting Borderline Between Mental Health and Disease

Those who want conclusive evidence of the uncertainty of the borderline between mental health and pathology need only glance through a history of medical psychology or a book on social psychiatry. They will find that the borderline has shifted time and time again, from historical era to historical era; as well as differing between cultures.

The Middle Ages interpreted as demonic possession what we now call a mental illness and until fairly recently, this concept of illness was applied in the psychic realm only to the most extreme forms of disorder; what was called idiocy, lunacy and deep melancholy. In the same historical era, this border
line was drawn differently in different societies, or in the different social strata of the same society. A case of dishonesty or extreme excitability would be indulgently classed as "neurotic" by a middle class psychiatrist if perpetuated by a member of his own class. However this same case may be labelled "psychopathic" or "criminal" if it happened to a slum dweller. A certain type of beatnik or other eccentric may appear more or less sick depending on whether one judges him from the vantage point of upper or middle class values. The clinical criteria of mental health and disease are rarely clear cut enough to be independent of social values. They are influenced by the group's or the individual's moral ideology, by the state of scientific knowledge, and by the considerable improvement of therapeutic methods. They are subject to sudden shifts brought about by the ideology or scientific revolutions.

Thus one observes that in America and other Western societies in the few decades since the advent of psychoanalysis the sphere of emotional illness - or what is interpreted as such - has expended, and the domain of health correspondingly diminished. According to the Western way of thinking, a condition diagnosed as "illness" limits the afflicted person's moral liability the proliferation of disease entails a contraction of the domain of personal freedom and responsibility. However it is quite conceivable that twenty years from now, moral muscle building and spiritual exercises will become once more the fashion for dealing with certain types of neurotics.

By now it ought to be clear that to find criteria which differentiates between mental health and pathology is both a perplexing and important task. Still less can we hope to establish normality in statistical terms. Even if such an endeavour were theoretically feasible, we would be handicapped by the fact that:

"We know nothing of the distribution in the total population of those behaviour variables in which psychiatrists are particularly interested, such
as anxiety, depressions and hallucinations." Redlick (1957: 41).

We just do not know how anxious or dejected the average person, and to the extent that we think we know we are likely to be mistaken. Psychiatrists who deal with unselected control subjects are struck time and time again by how much "pathological" material they discover in their supposedly normal populations. The statistical approach to the identification of mental pathology being so patently impractical, the psychological clinician has to rely on qualitative criteria.

In spite of the diversity of definitions there exists a large area of overlap in the concepts of mental illness. Although it is very difficult to find several practitioners and behavioural scientists agreeing on a simple definition, it is likely that they might agree on certain "extreme" forms of behaviour being indicative of mental illness.

There is no simple definition of mental health/illness, definitional ambiguity abounds, there it seems absolutely necessary for researchers and other practitioners in the field to clearly define or outline what they are examining when researching psychological disturbance. Such an approach would assist considerably the level of ambiguity and confusion that exists in the literature on mental health/illness.

Poor mental health, best describes the multiplicity of sub-categories of 'mental illness' which to the majority of the general population experience in some form and some degree at some time in their lives.

Poor Mental Health - A Definition

Here, we are concerned with poor mental health (as opposed to mental illness) of a Barbadian population, in Barbados and in Reading, England. The term "poor mental health" has been employed here deliberately. Firstly the psychological instrument used - the Middlesex Hospital Questionnaire, MHQ - does not identify mental illness per se, but rather varying degrees or levels of neurosis-based conditions, for example, various types and levels of
anxiety. Secondly "poor mental health" is a more accurate description of what members of the community sample are likely to manifest. Below we discuss the working definitional concept of "poor mental health."

Some social scientists (Szasz, 1960; Mowrer, 1961) would like to dispense with such terms as "illness" and "pathology". One of their objections is that these words are burdened with all sorts of theoretical pre-suppositions and connotations originating in somatic medicine, pre-suppositions which may be misleading or irrelevant if applied to the field of emotional disorders. Thus the word "illness" is apt to conjure up in the mind of medical men the notion of a "diseased entity" and of an "underlying disease process," preferably of a somatic nature.

If we view mental health and mental illness as opposite poles on a continuum, then at one end of the pole is the "fully integrated" person whose state of health is more ideal than real. At the other end of the pole is the completely unintegrated person, totally unable to make meaningful decisions without assistance.

Between these two extremes there are numerous gradations. Most of us fluctuate over time between being mentally unwell to being pathologically unwell and in need of medical attention. Our state of relative poor mental health may vary daily, weekly or monthly. For example, today we may awake feeling apathetic, suffering from psycho-motor retardation or even depressed. As the day proceeds the depressive feelings may lift and there is a resurgence of energy. These feelings may never recur until the next week, month or even year; or they may return in various degrees of disability. Now, are we to assume from this description of one's emotional state, that we are suffering from some type of neurosis, i.e. mental illness? If this is the case then we are likely to be mentally ill weekly, monthly or even yearly.
Since illness connotes disease and pathology, it is misleading if not definitionally inaccurate to discuss the findings of this study in terms of mental illness.

It was therefore necessary for me to classify the varying levels of emotional conditions by using an unwell or mentally unhealthy categories. To cover the majority of people who are likely to be found near the mean of this continuum, I unified the categories mentioned above into one general category, called 'poor mental health.' 'Poor mental health' may be defined as a general feeling or state of being unwell, but not necessarily ill to the extent that medical (psychiatric) assistance is needed. Here then, we are looking at what may be regarded as sub-categories of "mental illness."

It is important to note that this is not simply a nominal change but a conceptual one which is fundamental to a proper and relevant interpretation of the research findings. Given the confused and varying definitions of the phenomena mental health/mental illness, I consider it necessary for all researchers to clearly define or outline what they are analysing when they are studying mental illness.

Conclusion

Much of the present data on mental health/illness is useful. However, I find it somewhat inadequate in assisting me to understand/interpret the life situations or experiences of Barbadians/West Indian immigrants in English society.

Work in the field of medical sociology has focused attention on an outstanding aspect of social reality for black people, in this context Barbadian immigrants. This social reality is largely to do with the nature of the historical and contemporary relationship between the black man and the white man. Historically a relationship based on slaves and master; contemporary, one of inferiority and superiority in varied and subtle forms. This
relationship has important consequences both for the successful integration of the black man in a white society, but more importantly for his (the black man's) mental health.

To understand the contemporary life situation of the black man in English society we have to look closely at his historical and cultural background. This background had important consequences for the psychological development of the black man. This will be further discussed in a sociological perspective of poor mental health.

A Sociological Perspective of Poor Mental Health

To construct a trans-cultural theory of psychiatry accounting for mental ill health/illness in two societies - England and Barbados - is by no means an easy task. To date no one has adequately accomplished this task, primarily because such an analysis is fraught with complexities.

Central to the construct of this theory is the process of colonialism - the 'master' and 'slave' relationship. Here we will see how 'the encounter of man with his fellow man,' was disturbed, other directed, several affected by forces alien to 'fellow man.' What becomes of culture?

Before we can begin to understand the prevalence of mental ill health/illness among Barbadians, it is absolutely essential to discuss the dynamic and traumatic experience of colonisation. How the physical and psychological subjugation of a race, has affected the psyche of the colonised people, as well as their socio-economic lives. The colonised people were stripped off their original culture, were told that what their ancestors had been doing for generations were different to the European way of life and by definition bad and undesirable.
There are a series of postulates and propositions that slowly but subtly with the help of the media work their way into the mind of the black man, further reinforcing his inferiority. Such feelings are disabling for the black man. "Phobia, a neurosis characterised by the anxious fear of an object (in the broadest sense of anything outside the individual) or, by extension of a situation." (Fanaon, 1967: 154).

Further we shall discuss how colonisation has shaped the identity of Barbadians, how it created within their minds, false, misleading images, distorted their values, creating a body of ideas, expectations and concepts about themselves and their white masters. These constructs and concepts proved to be instrumental in creating confusion, distortion and disappointment, in brief, the psychological environment, in which stresses and psychological disturbance developed. We shall discuss how the formation of an incomplete identity pattern put Barbadians at psychological risk.

The Coloniser and the Colonised

Barbados has been since 1610 a British colony, the only island of any significant size that has never changed hands. It has been ruled for over 300 years by the British. Before the British came there were a few Caribs, but they were soon eliminated.

The British plantation owner, unlike those in other islands, spent most of the year on the island supervising and administering their estates, and weren't absentee landlords. Barbadian slaves were unable, like their 'brothers' in the other islands to openly rebel against the oppressive rule of their masters and run away. There were no hills, forest or jungle to conceal them. They therefore had no alternative but to remain on the plantations. This
accounts for one of the main reasons why slavery lasted in Barbados longer than it did in other islands. It also meant that the Barbadians are more colonised than other West Indians, and aspire to all things British.

The British settlers and plantation owners brought with them their folk ways - culture - habits, mannerisms, language and rule of law. They ruled the island completely - there were no difficulty in imposing their culture on an enslaved people. The slaves eventually came to see the white man and his culture as desirable and their own culture as undesirable or indeed non-existent. For the slave, to be white meant to be free, wealthy, independent - whiteness became the symbol of success. This distorted perception arose from the dominance of one group over another in the social structure.

The Colonised In Present Times

Updating this analysis, to the present times, one finds that the social structure, the realities of the 19th century, the self confidence of the Victorian age combined inevitably to drive home the lesson already implicit in language and metaphor, that white meant all that was desirable and black meant everything that was to despised and avoided. This was the universal conviction. The black man accepted the social order as inevitable, like his slave ancestors accepted their servitude with calm reserve.

They were socialised unequivocally to despise all that they stood for. Mothers would tell their children 'stop acting like a nigger,' but who was the child suppose to act like? Like a white man? He was forced to adopt the white belief that blacks were dirty, idle and stupid. He came in a confused way to see himself as white, despite his black skin. But this was not how the white man saw him, so his illusion was liable to frequent and bitter betrayal.
Everything in Barbadian society, conspired to heighten the contempt for all that was West Indian. Education for those who achieved it was European, primary education was designed for children in Europe, while the source of the contempt in the first place was the social system. The masses realised that if they wanted to better themselves, they must first aspire to 'whiteness' - values, moves, standard of English life style - things that the white man used. Only through this process could success be achieved. The Barbadian more than any other West Indian aspired to 'things' British.

Emigrating to Britain afforded the Barbadian the fulfillment of a dream, the realisation of ambitions and expectations, harnessed for many years. It was the non-realisation of this fulfillment which more than any other factor created confusion, disappointment and disbelief in the minds of most Barbadian immigrants. This reaction to the experience depended largely on other mediating, and supportive factors within their social and constitutional framework.

Nowhere is this type of situation best distilled than in Fanon's social psychology.

Fanon observed that the black man's encounter with his European fellow man entailed a profound depersonalisation under the weight of a repressive colonial culture. The health or pathological condition of man had to be cast within a definite socio-cultural historical context. This social psychological perspective is best illustrated in his analysis of alienation among people of colour, this alienation being collective and sociogenic. In *Black Skin, White Mask*, Fanon stressed the dialectical and materialistic underpinning of his work:

"The analysis that I am undertaking is psychological. In spite of this, it is apparent to me that the effective disalienation of the black man entails an immediate recognition of social and economic realities. If there is an inferiority complex, it is in the outcome of a double process;
In his analysis of Fanon's concepts of 'internalisation' and 'objectification,' Bulham (1980) notes that 'internalisation' refers to the process by which external socio-historical reality is assimilated into internal psychological reality. 'Objectification' is the reverse process, in which man through praxis (and particularly through labour), objectifies and actualises himself or his personality in the world around him.

According to Fanon, man attains self worth and a conscious reality through recognition by another self-consciousness. But where the desire for recognition is frustrated, there is a struggle, a conflict. It is out of this struggle for recognition that subjective certainty becomes transformed into 'objective truth.' Further, he who obtains recognition without reciprocating becomes the master. The other who submits to non-recognition becomes the slave. The slave lack recognition and independent self-consciousness internalises inferiority and seeks to find his 'self' (identity) in the person of the Master. The Master in contrast usurps all recognition and consciousness, all thewhile retaining unlimited license to use the slave's body and labour to his self-objectification.

Here, through Fanon's analysis of the social psychology of oppressed people, we get a clear picture of the insidious, psychologically destructive nature of colonialism. The socio-historic context - as outlined above - is one in which the British ruled Barbados unchallenged for over 350 years. During this time the Barbadian slaves endured a long and intense period of enslavement - the longest in Caribbean history. There was no way to escape the oppressive system of slavery. The white masters were always present in sufficient numbers to make their presence felt. The slave was denied self-worth and
time came to see himself as inferior to his master. Freedom for him could only be attained through the 'vestiges of whiteness'. For the Barbadian slave, whiteness meant wealth, happiness, a life of ease, respect and recognition. Although being aware of his blackness, he realised that betterment for him could only be attained through white values, practices, language, education and laws.

Fanon studied the oppressor - oppressed psyche historically. He observed that reciprocal recognition was totally negated in the encounter of the black man with the white man. For the white man, recognition of the black man was tantamount to self destruction. The white man's unrelenting desire for self-objectification gave use to the internalisation of inferiority and depersonalisation in the black man. Born into and socialised into a situation of oppression these two protagonists behave according to the dictates of long established patterns. In colonies Fanon notes that,

"there is no occupation of territory, on the one hand, and the independence of persons on the other. It is the country as a whole, its history, its daily pulsation that are contested, disfigured, in the hope of a final destruction. Under this condition the individual's breathing is observed, an occupied breathing."

(Fanon, 1967).

According to Fanon,

"psychopathology generally and the neurosis in particular are socio-cultural, historical conflicts finding symptom crystallisation in those having a lower threshold for such conflicts." (Fanon, 1967).

He concluded that the neurotic, and the alienated, is first the victim of others and later of himself. The intensity of these conditions were only mediated through the supportive role of the family and lived conflicts of individuals.
We have shown in the preceding discussion how colonialisation effects the psyche of the oppressed: how it destroyed his culture, engendered inferiority depersonalisation and self hate in the black man. Lacking recognition and independence the black man seeks to find his identity in the person of the white man.

How is the identity of the colonised black man formed? It "involves the individual in taking the role of the other (the white man) towards himself and the role of the generalised other (society) towards himself in a particular self-conscious period." (Kimmel, 1974) - only the other (white man) can give him worth that is, on the ethical level - self-esteem.

Identity is formed and developed through the process of socialisation - through words, gestures, significant symbols, and as Fanan (1967) observes, through "a constellation of postulates, a series of propositions that slowly and subtly - with the help of books, newspapers, schools and their texts - work their way into one's mind and shape one's view of the world of the group to which one aspires or belongs."

Identity is also formed and developed through conscious and unconscious realisation. Erikson (1965) puts forward the view that a sense of identity has conscious and unconscious aspects, and further, that the core of the identity is at best pre-conscious. For the most part it is repressed and is therefore related to all those unconscious conflicts accessible only to the individual through dreams or in flashes of insights.

Barbadians have a dual identity made up partly of British norms and partly African folkways and heritage - which are different from those of the white man. However, the nature of the social structure is such that British cultural influence predominates, thus shaping the Barbadians identity to be more British than African or West Indian. His 'white' identity is incomplete, and alien. It is the embodiment of certain aspects of 'whiteness' at best
the worse - because it lacks wholeness/unity between past, present and future.

The acquisition of a white identity created high expectations and aspirations among Barbadians. For most of them such expectations and aspirations could only be realised on immigrating to England, the mother country. This was to prove to be a traumatic and disturbing experience.

**Immigration: Its Effects on Tropical Man**

The Barbadian/West Indian coming from a tropical country to a temperate climate first encounters a different bio-climatic and physiological environment - the cold, relative lack of sunshine, a disruption in network ties and a disturbance in diet - all at first convey in purely physical terms the difference of milieu.

On arriving in England, the informants soon became aware that the England they had been brought up to respect and praise, the values they had cherished were in no way relevant to their own experiences with England and the English. They were made to feel unwelcome, when they thought they were going to feel welcome. They were treated as third class citizens, when they expected mutual respect. They became confused and began to ask themselves, "is this really the same England that I have heard so much about?" "Are these the same Englishmen like the ones I met at home (in Barbados)?"

"These people are not like the English people I met and worked for." "They treat me differently, Why is there a difference?"

The new immigrant also faced 'colour shock', an awareness of colour existing between himself and the milieu, in which he suddenly finds himself. He recognises the unreality of many of the beliefs that he adopted. Fanon commenting on the ignorance of the black man in a white society, points out that,

"there is a myth to be faced - a solidly established myth. The negro is unaware of it as long as his existence is limited to his own environment, but
the first encounter with the white man oppresses him with the whole weight of his blackness - the later the discovery the more violent the shock. Suddenly they perceive that others know something about them that they do not know, that people apply to them an upsetting term that is not used in their own families (or country)." (Fanon, 1967).

It took many Barbadians, a considerable time to recognize that contact with the white English man forced them to face a number of problems, that they had not previously encountered. And yet these problems were by no means invisible, because they have always occupied a lower status position than the white man, they were always subservient. Here in England, the harsh realities of their position, unpleasantly reminded, was psychologically crushing. Those whose psyche structure was weak experience a collapse of the ego. Extending this point, Fanon reminds us that,

"the neurotic structure of an individual is simply the elaboration, the formation, the eruption within the ego, of conflictual clusters arising in part out of the environment and in part out of the purely personal way in which that individual reacts to these influences." (Fanon, 1967).

Thomas J. Cottle (1979) in an enlightening article, discusses the psychological dilemma that most West Indian immigrants encountered. He aptly distills my thoughts on the socio-psychological problems which Barbadian immigrants encountered in England.

Cottle accounts for some of the possible psychopathology among West Indian immigrants by considering some of the socio-psychological feature of identity formation. He notes that,

"whereas much of the past store of experiences turn out to be useful and productive during the adjustment period to the new culture, some of the experience turns out to be irrelevant if not counterproductive." (Cottle, 1979).

Having some idea about England and being able to speak the language - if not in
a grammatically correct form - did assist the Barbadian immigrants to settle initially, but when he began to interact with the society and become socially mobile he soon realised that his previous knowledge and the social constructs he had developed were inadequate, misleading and incongruous with the new complex meanings in the interaction process. The immigrant was unable to predict and control what kind of events were likely to occur and how to interpret them, for example, prejudice, the racist nature of the society, the status position he held and the lack of respect he received. He was therefore forced to forget all that he had been socialised to believe about England.

Here the immigrant is almost obliged to forfeit his identity, formed during childhood and adolescence, since the social patterns of these earlier experiences - through socialisation are lost in the immigration process, along with the time of the experience. Elaborating this point, Cottle (1980) states that,

"when a person is forced to accept the breaking of the linkage between past and present, or even feel the linkage splitting, then resistance emerges." This resistance is "to confront both past and present in all their detail irrespective of the degree of distortion that one might create in one's assessment of the past and present."

What can the immigrant do, faced with the alienating and painfully confusing situation?
There are four avenues of action open to the immigrant. Firstly, he can regard, "the status quo, the tradition and norms of the new culture with inviolate respect," thus reinforcing his respect for British culture and society. Secondly, he can totally disregard the new culture as being useless. Thirdly, he can rationalise his situation, making a limited compromise, adopting some features of English culture, while remaining deeply committed to a Barbadian/West Indian cultural mode. Fourthly, he can act non-responsibly to the new culture, acting as though nothing mattered yet wishing that things were different - that England was different or that he had never migrated,
or that he wasn't experiencing any hardship.

Many of the Barbadian immigrants in our own study have been faced with these four avenues of action. Those who have embraced British culture and life style have by and large unified/or completed their identity. Those who have totally disregarded English culture, or found it difficult to compromise, have sought refuge in a West Indian/African culture. Finally those who act non-responsibly, experience some psychological anguish. These are the immigrants whose disillusionment with English society have left them seemingly incapable of taking positive action. Such individuals feel unhappy being in England, and yet remain.

Many respondents commented on their belief that their own lack of success in England contributed to their sense of insecurity in their roles as adults. Immigration has proven to be a painful experience- and sometimes failure. They saw themselves as failures, unsuccessful in achieving their life ambitions. The feelings of powerlessness, dependency and beholdenness destroy their spirit. As one respondent poignantly reminded me: "Immigration was the only step of freedom, many of us could take, no matter how good or bad it came out."

For many immigrants this experience is doubly painful, because they cannot return home (Barbados) as failures. Therefore they remain in England for many years, hoping that one day they'll achieve their goals, which is the passport to respectability and high status in Barbados.

Cottle symbolises the immigrants relationship with England - in terms of a mother and child relationship. The immigrants- 'little Englishers' as Barbadians are often called- are like children returning to mother- England, eagerly looking forward to be accepted with open arms, loved and made to feel secure. Instead they are rejected and treated like orphans, begrudgingly provided with food and shelter. Always with a reminder that they were unwanted and unplanned for. They are the babies who should have been aborted. Their parents in this symbolic framework, became the traditional and host citizens, thereby producing the native born, the brothers and sisters who openly.
resent the arrival of the new child." (Cottle 1979).

Fanon (1967) commenting on Antillean immigration to France, in similar symbolic style, noted that, "the Antillean who goes to France pictures his journey as the final state of his personality." - the completion of his identity.

The immigrants are seen as strangers belonging to someone and somewhere else, having no rightful claims to the English family. Ironically it seems that the more immigrants adopt the life styles of the British the more the host despises their presence.

This limited symbolism raises a serious point. The negative white attitudes and beliefs about blacks, held for centuries, are incorporated in the self image of the immigrants, through the psychological process of internalisation.

Once again brought into contact with the man of colour, the white man - if unconsciously attempts to recreate the slave-master dialectic. Fanon reminds us that "the concept of the empire is still alive, however shattered it may seem. It rest on the platform of colonialisist ideals and practices."

In summary, colonialism is a particularly insidious virus and, when and where it strikes it creates a profound imbalance in the human personality. You have a history, yet you do not, you have a culture of your own, yet you do not, you have a language of your own, yet you do not, you have a homeland of your own, yet you do not. When one's soul has to struggle with these contradictions over decades and generations, it is no wonder one wants to be someone else, a small wonder more black immigrants don't go 'mad'.

**Conclusion**

Here we have looked at the functions and consequences of colonisation and the effect it has had on the 'black' colonised. It has had severe repercussions on his social, economic and psychological development. The psychological
consequences are mirrored through deviant behaviour – psychiatric disturbances of illness of varying kinds.

Two of the most common forms of psychiatric disturbance are depression and schizophrenia, which will be examined cross-culturally.
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CHAPTER 2

THE CULTURAL ANALYSIS OF MENTAL ILLNESS: A BARBADIAN VIEW

- IDENTIFYING DEPRESSION IN BARBADOS.

- TOLERATING, IDENTIFYING AND LABELLING DEVIANT BEHAVIOUR.
CHAPTER 1

THE CULTURAL ANALYSIS OF MENTAL ILLNESS: A BARBADIAN VIEW

Introduction:

One of the most important sociological questions in the study of social psychiatry is not what causes human beings to develop such symptoms as hallucinations, delusions, etc., but what it is about their behaviour which leads the community to reject the mentally ill, and generally treat them as outcasts. A second important question is related to the function of societal rejection in the dynamics of mental deviation.

Mental deviation is defined by Szasz as a breakdown in social communication. The individual's concept of the self does not reflect or resemble the societal definition of the person. This differentiation of the symbolic process of the person is usually accompanied by a rejection of the self by society.

How does this theoretical construct fit into a Barbadian context? Why is it that certain types of deviation go unnoticed and hence uncontrolled or unpunished, while others are identified, labelled and stigmatised? Of what significance is the symptom pattern of the illness in the process of identification?

In answer to these questions I will consider the two main classifications of mental disorder - neurosis and psychosis, exemplified by depressive neurosis and schizophrenia. First a review of the literature on the transcultural aspects of depression will be undertaken to evaluate the work so far carried out, and to indicate some of the problems in research of this nature. In the literature reviewed, the term depressive disorders has been used to include psychotic and endogenous depressions, neurotic and reactive depression, and involutional melancholia.

A REVIEW OF THE LITERATURE

Reports of the rarity of depressive disorders in underdeveloped countries may have to do with social attitudes about depressive reactions rather than an actually lower incidence of such conditions.
Much of the symptomatic behaviour that is associated with depressive disorder is secondary to the response made by the patient and others to his basic symptoms. How the individual describes and reacts to his depressive state may be influenced by the beliefs and customs of his society. This may lead to a reduction of anxiety about the condition, or it may contribute to the non-recognition of illness in the patient.

General reviews of the transcultural aspects of depressive disorders have been made by Stainbrook (1954); Benedict and Jacks (1954); Wittkower and Hugel (1968); and Pfeiffer (1970).

**ETHNIC AND CULTURAL GROUPS**

**AFRICA**

Considerable interest has focused on this region. Early reports based mainly on hospital samples indicated that depression was rare in Africa (0.38% of total hospital population) and when it occurred it was light and fleeting. Ideas of sin and guilt were rare, and mania was commoner than depressive illness. Kraeplin (1921) on return from his world tour noted that depression in Java was dominated by excitement and confusion.

Gordon (1936) in a series of 120 conservative admissions to Matharri Hospital in Kenya, found only two cases of affective psychosis.

Reports about depression in Africans have come from Greenless (1895); Gordon (1934); Shelly and Watson (1936); Carothers (1945, 1947, 1953); Tooth (1950); Lamot and Bignault (1953); Moffson (1955); Smart (1956); Lambo (1956, 1960); Field (1960); Assicot (1961); Collomb and Zwinglestein (1962); Leighton et. al. (1963); Wintrob (1967); El Islam (1969) and German (1969).

Writers on depression in African cultures have expressed difference of opinion about the rarity of depression and whether depression manifests typical ideas about sin, guilt and suicide. Shelly and Watson (1963) found that the prevalence of hospitalised depressives in Zambia was similar to that in Europe, while Tooth (1950) in a field study (excluding hospitalised depressives) found a prevalence of 19.7% of affective disorder, a figure comparable to the western one.
More recent and more reliable studies have thrown doubt on the early beliefs that depression is rare in Africa. It has been found to be common, in Nigeria—Lambo (1960) and Asuni (1969); in Senegal—Collomb (1965, 1967); in Ghana—Field (1960) and Weinberg (1965); in Ethiopia—Torrey (1966) and Marinke (1966); in Sudan—Elsarrag (1968) and Caderbad (1968) and in South Africa—Gilles et. al. (1968); Binite (1975) in a factor analytical study across two cultures, African and European, found certain similarities and important differences.

Depression in African cultures was presented principally as depressed mood, somatic symptoms and motor retardation. In European cultures, depression was presented with depressed mood, guilt, suicidal ideas and motor retardation or anxiety. Both groups lost interest in work and their environment. Guilt and suicidal ideas and acts are uncommon in African samples and appear to be culturally determined.

Figures for hospitalised depressives ranged up to 23.5% of the population. Differences in manifestations were noted by the above-mentioned authors; in Nigeria a predominance of somatic symptomatology, in Senegal a predominance of paranoid symptomatology and of mania, in Ghana a high frequency of self accusations of witchcraft, in Sudan more shame than guilt feelings, in Ethiopia and South Africa the picture of depression resembles the western pattern.

AFRO-AMERICANS

It has been suggested that depression is relatively uncommon among southern Afro-Americans—Vitols (1961) reviewed patterns of psychiatric illness and concluded that depression and suicide are rare in the southern black community compared with both southern whites and northern blacks.

Vitols suggested that the reported low incidence of depression among southern blacks might arise from the fact that they have less to lose (in terms of "object loss") and are less likely to lose it. He postulates the reason for the low incidence; limited expectation and aspiration on the part of the southern black; protection afforded by a fundamentalist's religious practice, which provides opportunity for adequate grieving; and the support of the extended family, which is more widespread—the southern black community than in other groups. However he offers very little objective evidence to support these contentions.
A study of the effects of racial integration on some Southern psychiatric hospitals found that there was a much higher incidence of psychotic depression among new black patients admitted to the hospital than previous statistics had revealed (McGough et al 1966). It is therefore possible that the low incidence reported for southern blacks is a spurious finding that will disappear with better clinical and epidemiological work, which is less biased by white, ethnocentric assumptions.

THE ARAB COUNTRIES
Katchadourian (1969) reported a low prevalence of hospitalised depressives. Reports on depressive symptomatology have contradictory, some affirming that the picture is similar to the western pattern, others to the "primitive" pattern. Racy (1970) and Bezzoui (1970) have reported a "primitive" pattern for the Arab East and Iraq respectively. Okasha (1968) noted the predominance of a western pattern for our-patients in Cairo.

THE INDIAN SUB-CONTINENT
In India regional differences have been reported. Dube (1964) and Sethi (1970) reported a prevalence of depression in field surveys in North India ranging from 9-16.7/1000, population.

Elnager et al (1970) noted a prevalence rate of 2.9/1000 among a rural community, while Rao (1966) observed that only 1.3% of patients in a psychiatric hospital were depressives. No data is available on the prevalence in the general population.

With regard to manifestations in North India, Teja et. al. (1971) noted that guilt feelings were prominent in a sample of clinic patients, but Roch (1963) found these were rare while somatisation was prominent. Similar findings were reported by Rao (1966, 1970) for hospitalised patients in Southern India. Bagadia (1970) reported similar findings in Western India.
Chu and Lin (1960), published data on hospitalised patients in Peking, admitted during the years 1933 - 1943. Diagnosed manic-depressive psychosis comprised 22.1% of total first admissions.

Taipale and Taipale (1973) and Sainsbury (1974) have recently noted that the prevalence rate for manic-depressive psychosis is low, ranging from 2.5%.

Among the Chinese in Indonesia a high prevalence of depression was observed by Van-Wufften-Pathe (1936) and Osterreicher (1950). This was later reaffirmed by Pteiffer (1966), who also observed that high frequency of hypochondriasis in Chinese depressives. No data are available on the prevalence of depression in the general population.

In Hong Kong, Yap (1965) studied depressive symptomatology retrospectively in Chinese in-patients. He concluded that the clinical features described paralleled those described in the West, but that ideas of guilt and unworthiness were infrequent and mild, and delusions of sin were absent.

Singer (1972) found that depressive disorders were infrequent (7% of admissions) and mania rare in the hospitalised population on Hong Kong.

In Thailand, Tongkonk (1972) noted that somatic symptoms were commoner among Asian depressive patients seen in private practice than Occidentals. Asian patients complained more of headaches, dizziness and labile blood pressure, and Occidentals with complaints affecting the extremities and skin.

Kato (1969) in an epidemiological study in Japan, reported a prevalence rate for affective psychosis of 2/1000. Kimura (1965) observed that guilt feelings occurred with equal frequency both in Japanese and German depressives; his findings were contrary to those of Saligman (1929) who found that guilt feelings were absent in Japanese. However, Kato (1969) found in the direction of guilt feelings that Japanese felt guilty towards their parents, ancestors and fellow workers, while the Germans felt guilty towards children and God.

In Korea, a field study in the rural areas, conducted by Yoo (1969) revealed a prevalence rate of manic-depressive psychosis of 0.3/1000.
Kidson (1967) and Kidson and Jones (1968) reporting on a field survey carried out in Central and Western Australia, noted that depressive illnesses they diagnosed did not resemble what they understood as endogenous depression, and that guilt and self-recrimination were absent. A similar pattern of symptomatology was reported by Burton-Bradley (1965) in New Guinea.

Foster (1962) found that the rates for manic-depressive psychosis in mental hospital admissions in New Zealand were higher among Europeans than Maoris.

THE WESTERN HEMISPHERE - NORTH AMERICA

Silverman (1968) cited a number of studies generally indicating a lower frequency of depression among Negroes in the United States as compared with Whites. These conclusions were based on hospital statistics. McGough et al. (1966) has reported that the pattern of psychiatric illness among Negroes in the Southern States has changed. The proportion of Negro patients suffering with psychotic depression has increased, in some cases to over-exceed that of white patients. McGough believes that this increase among blacks in the Southern States is probably due to the availability of better treatment facilities and the introduction of racial integration in the psychiatric hospitals.

Tonks et al. (1970) noted that Negroes in the lower classes attending in and out-patients departments in New Haven showed less guilt than whites.

Among North American Indian tribes, a high frequency of depressive illness was found in the Mohave by Devereaux (1961), and in Dakota the Sioux, by Johnson and Johnson (1965). The reports were based on field impressions.

In South America, Stainbrook (1954) found that depressive illness and guilt feelings were rare in hospitalized Bahians in Brazil. He further observed that depressive illness was much more frequent in private hospital patients.
In the Caribbean, mania was observed by Royes (1961) to be almost twice as frequent as depression in hospitalised patients. Periodicity and guilt feelings were reported to be rare, while hypochondriasis was common in depressive states, Despinoy and Camelio (1967). Similar findings were reported for Haiti by Bordeleau (1963).

We have shown that depression can and does present in varying ways; as a result there has been an under-representation of depressive illness in many countries. Researches on depression in Africa and the Far East have expressed differences of opinion about the rarity of depression, and whether depression manifests typical ideas about sin, guilt and suicide. Further, Silverman (1968) reviews many studies which indicate a lower rate of depression among negroes than white. A similar assumption is made about Barbadians/West Indians. This raises several questions. Is there a low rate of depression in Barbados? If so, why? What factors are implicated in any hypothetical absence of depression among Barbadians in Barbados and Reading, England? In the next chapter we attempt to answer some of these questions.
The word depression is rarely used in Barbados, despite its wide use in developed countries, to describe pathological mood changes.

Depression is one of the commonest experiences known to mankind. However the word - depression is used for different conditions and a good deal of difficulty in its description is the need to be clear about which of its features is being described. Within western societies depression carries different connotations for doctors and patients, (Benoist et. al. 1965). These problems are multiplied in non-Western and underdeveloped societies.

Jack Dominion (1976) views depression from these levels:

"Depression refers first to mood. This may vary from feelings of slight sadness to utter misery and dejection. Secondly it is used to bring together a variety of physical and psychological symptoms, which together constitute a syndrome. Finally depression is used to indicate an illness which prevents the suffered from functioning and requires active treatment to restore the body and mind to a state of health."

When a Barbadian or West Indian feels "mentally low" he uses such phrases as "feeling down", "browned off", and "fed-up". He never says "I feel depressed" unless he has lived abroad for some time or has been taught to recognise his feelings and so describe them.

Having informed his friends or relatives that he is "feeling down", he is likely to be told:

"Man/Woman, go to the sea and have a good soak and wash away your problems."

and/or

"You need some tonic man."

"Pull yourself together man."

Whereupon several herbal remedies would be suggested as possible cures for one's ill-feelings. In addition to receiving such advice, the sufferer is likely to encounter friends who identify with him and who have experienced similar problems. These problems will be discussed at one of several meeting places or "limes", where persons experiencing
social hardships and other day-to-day problems meet informally. Here, time is spent chatting and indulging in various forms of casual entertainment, which help to pass the time away. This kind of interaction performs a psychotherapeutic role. Within a few days or weeks the gloom, sadness and despondency which once hung over the sufferer lifts. Admittedly his problem might not have been solved, but his attitude towards the problem has been redefined and he can now cope with the situation. This experience is very dissimilar to that of a large proportion of depressives in western societies, where depression is more likely to lead to hospitalisation. The prescription of tablets and possible hospitalisation in themselves probably do not cure the sufferer, but provides temporary relief removing him/her from the stressful situation. However it is often the case that the sufferer returns to the same situation which led to the onset of the depression.

MEDIATING FACTOR IN DEPRESSION

EXTENDED FAMILY SYSTEM

According to Amara, patterns of reliance on peer groups and on the community mitigate self-reproach, guilt and suicidal feelings in depressed patients in most third world countries. This community support is markedly absent in developed western societies.

Stainbrook (1954) suggested that non-western societies with an extended family structure may have a lower incidence of depressive disorders than western societies with the more restricted conjugal family. He hypothesized that in the extended family with its multithering group, the child would have greater opportunities to seek rewards and avoid punishments and frustrations. Whiting (1959) suggested that guilt is less prominent in cultures characterised by extended families. Fernando (1969) found that Jewish depressives were less guilt ridden than Protestant depressives and attributed this difference mainly to closer kinship ties in Jewish families.

Very few cases of depression reach the local doctor and fewer still to the mental hospital. However, I am not stating that depression in its "clinical sense" does not occur in Barbados. What I am saying is, firstly, that depression as diagnosed in developed societies does not manifest itself easily. (It occurs only when folk/traditional supportive systems have been unsuccessful in assisting the "depressed" person to cope with his feelings of misery.) Secondly, the society
does not view persons suffering from depression as mentally ill. This is clearly demonstrated in two ways:

Firstly, expressions of apathy, "fed-up", "feeling down", "browned off", are viewed in the first instance as signs of laziness, and in the second instance as signs of "being run down". This means that the person through overwork, poor eating etc., has neglected his health and is therefore in need of a tonic. Hence the sufferer is admonished to drink lots of sago, tapioca and various herbal beverages. Should these folk remedies fail, the sufferer is admonished to visit a doctor. This raises an important question. How do individuals seek help? How do they become patients.

HOW, WHY AND WHEN - ON BECOMING A PATIENT

The whole process of seeking help involves a network of potential "consultants" from the intimate confines of the nuclear family through successively more select, distant and authoritative laymen until the professional is reached. This network of 'consultants' which is part of the structure of the local community, Freidson, Yarrow et al (1955) and others call the "lay referral system or structure".

Freidson (1961) has outlined four types of lay referral systems, of which only two need to be discussed here. First, a system in which the prospective client(s) participate primarily in an indigenous lay culture, in which there is a highly developed lay referral structure - due primarily to extended kin relations. The second, the opposite extreme of the indigenous extended system, is found when the lay culture and the professional culture are very much alike and when the lay referral system is truncated, or there is none at all. Here the prospective client is very much on his own, guided by his understanding and experience. Since his knowledge and understanding is fairly similar to the physician's he may take some time in trying to treat himself, but nonetheless will go directly from self-treatment to a physician.

Of these two types of lay referral system, the former is exemplified by the behaviour of the peoples living in Barbados and other relatively underdeveloped countries, where there is still a strong traditional belief system about illness and its treatment. Another crucial determinant which reinforces the extended lay referral system, found in
most underdeveloped countries is the high cost of medical care. In these countries private medicine is practised. Most people (the majority) cannot afford to pay for medical attention, therefore considerable efforts are made to use all the folk remedies available before visiting a doctor.

The latter, (the truncated lay referral system) is exemplified by the behaviour of peoples living in developed western countries where scientific development and the exposure to medical information through the mass media both contribute to the widening of knowledge and the reinforcement of the doctor as the repository of knowledge.

DEVELOPED INDIGENOUS LAY REFERRAL CULTURE

The need for 'outside' help for a physical or 'mild' mental disorder seems to be initiated by purely personal tentative self-diagnosis, that stress the temporary character of the symptoms and end by delay to see what happens. If the symptoms persist simple home remedies such as rest, aspirin, local herbal drinks or mixtures or ointment and tonics will be used. The use of such remedies attracts the attention of the household, if he has not asked for attention already. Diagnosis then is shared, and new remedies may be suggested or a visit to the physician. If a practitioner is not seen, and the symptoms continue, the diagnostic resources of friends, neighbours, relatives and fellow workers may be explored. This is rarely very deliberate. Advice from friends and others is usually given casually, during daily intercourse, initiated first by enquiries about one's health or by complaints about discomfort from the prospective patient.

The casual exploring of diagnoses, when drawn out and not stopped early by the cessation of symptoms or by resort to a physician, typically takes the form of referrals through a hierarchy of authority. Such as, discussion of symptoms and referral to some other layman who himself had and cured the same symptoms, to someone who was once a nurse and therefore knows about such things, to a local druggist who once fixed up a wonderful tonic, to a 'good' physician who treated the very same complaint successful.

Jones (1978) in a review of the literature on when people are most likely to seek help, found that such action is taken under conditions of high psychological distress.
The concept of the lay referral system illuminates the ways in which the client's choice is qualified and channelled, and how the physician can or cannot operate successfully in his medical practice.

"LAY REFERRAL SYSTEM" IN A BARBADIAN CONTEXT

I have shown that when visiting a doctor doesn't complain of feeling depressed, but of feeling "run-down". The doctor does not seek a psychiatric explanation for the patient's ill health unless his symptoms and demeanor belies severe disturbance, but rather a physical one. Instead of receiving an anti-depressant, the patient is prescribed a tonic or vitamin pills.

The relationship between doctor is doubly reinforced. On one hand the patient has been socialised to interpret feelings of malaise and mental fatigue as a sign of being physically "run-down". This is reinforced by his friends and relatives. His visit to a doctor only occurs because folk remedies have failed and because he is seeking a stronger 'tonic'. He therefore expects the doctor to support his self-diagnosis and prescribe a tonic.

On the other hand the doctor is aware of what the patient expects from him. This relationship develops out of traditional medical practices. The doctor is also aware that the success of his practice depends on "satisfying" the "client", and to a lesser extent on reducing the number of admissions to the already overcrowded mental hospital. Whether the physician's prescription will be followed or not, and whether the patient will visit the same doctor again seems to rest partly on his retrospective opinion by himself or he may compare notes with others. Physicians soon become aware of lay evaluations, whether through repeated request for vitamins, tonics, or certain mixtures, or through repeated disappearances or protest following the prescription of scientifically acceptable drugs. Whether their motive be to heal the patient or to survive professionally, physicians will feel pressure to accept or manipulate lay expectations whether by administering harmless placebos or by giving up unpopular drugs.
This analysis however, raises the question how can sufferers know that they are reaching a level of depression which is beyond an appropriate norm of the situation? In other words, how are some depressed people identified and admitted to the hospital?

The brief answer is that often they do not know, nor do they use the term "depression" to describe this state. Unless they are familiar with the term through their circle of friends/family, the usual path to discovery is through a lonely journey of personal exploration or recurring symptoms.

Some people know that they are subject to recurrent mood changes but are afraid to acknowledge the fact or do anything about it. Fear is one of the reasons for avoidance; the fear that confirmation of their state will somehow stamp them with a seal of inadequacy or failure. Whatever the reason(s) a few of the informed and uninformed will eventually reach breaking point and will be compelled to submit to psychiatric treatment.

CONCLUSION

CULTURAL SICK ROLE

It has been suggested that within Barbadian society the "depressed person rarely enters the sick role; his behaviour is not seen as deviant. He presents no threat to society and its members. His violent actions are usually self-inflicted, he withdraws into himself and away from society.

Ari Kiev has further noted that depressive symptoms may not lead to the adoption of the sick role in cultures that institutionalise certain experiences or symptom states, with the result that they are not "ego-alien" to the members of that culture.

Brody (1964) has noted that in some societies the sick role varies, such differences may be reflected in the presenting of complaints. Without such consideration one cannot meaningfully assess the absolute frequency of sickness across cultures.

Culture may define the sick role predominantly in somatic terms on the basis of the prevalent ideas of disease, as appears to be the case in lower social classes.
Greenley and Mechanic, (1976a, 1976b); Girvin (1960); Scheff (1963); Rosenstock (1966); Kasl and Cobb (1966a, 1977b) and Becker (1974), claim that two classes of variable determine the nature and direction of an individual's help seeking behaviour. These are the perceived threat of a particular disease condition and the extent to which a particular action is believed to be beneficial. They claim that help-seeking behaviour occurs when it is triggered by internal and/or external cues. Zola (1969) identified five triggers which affect the point at which an individual seeks medical care. These triggers are:

1) Interpersonal crises; the situation calls attention to the symptoms and causes the individual to dwell on them.
2) Social interference; the symptoms threaten a valued social valued activity.
3) Sanctioning; others tell the patient to seek care.
4) Patient's perception of the symptoms as a threat.
5) Patient's knowledge of the nature and quality of symptoms.

SUMMARY:

Here we have seen that when an individual feels ill he usually thinks that he is competent to judge whether or not he is actually ill and what general class of illness it is. On this basis he treats himself. Failure of his initial prescriptions leads him into the lay referral structure and the failure of the lay referral structure leads him to the physician.

However in most third world countries for the physician to be successful he has to operate within the constraints of the lay referral system. Patient's estimation of a 'good' physician is largely determined by his willingness to prescribe locally accepted remedies and treatments, which over time have proved to be beneficial even though he may feel professionally compromised.
The sick role for depressives may be totally denied, as in the case of some African societies in their language.

**THE CULTURAL COMPONENT OF DEPRESSION**

In Barbados both psychiatrists and laymen have expressed the belief that there is little depression. Thus, there seems to be an "agreement" not to diagnose depression. When it does appear it is likely to be rationalised in some other way, or attributed to physical causes.

This general atmosphere of tolerance of depressive symptoms contributes to the non-recognition of them and consequently to the reduced reporting of cases.

The rarity of depressive illness in Barbados and in the Caribbean could be attributed to the failure to recognise cases because of the application of western standards.

Murphy et al, have noted that depressive mood, insomnia and loss of interest are reported for depression in Asia; preoccupation with body and mind, religion and family, as well as loss of libido are common among Indians. In Barbados (West Indies) depressive illnesses are frequently associated with confusional symptoms and are of shorter duration than the depressive pictures diagnosed in European countries.

Murphy et al further stated that diurnal mood changes, insomnia, early morning waking, a falling off of interest in the social environment, fatigue, loss of sexual interest, self accusatory ideas, anorexia and weight loss were common symptoms among Europeans, but not in persons from developing (Third World) countries.

In contrast to depression which we have shown to be relatively unrecognised/diagnosed in Barbados, schizophrenia is widely diagnosed. Dr. Mahy, the medical superintendent of the Psychiatric Hospital in Barbados has informed me that:

The high prevalence of schizophrenia vis-a-vis depression is a common feature throughout the English-speaking Caribbean. It has been noted by Benedict and Jacks (1954) and Leurkay and Crocetti (1958) that schizophrenia and schizophrenia-like reactions are fairly common
in all known societies. In spite of widespread prevalence of schizophrenia, diagnostic comparability is absent when findings from many different societies are assembled. This is true not only because of different types of rates, different case finding procedures but also because of cross cultural applicability of designations of normal and abnormal behaviour patterns.

Reviews by Benedict and Jacks (1954), and Leurkau and Crocetti (1958) of non-western groups, highlight both the lack of substantive findings and many of the methodological problems involved.

Benedict's (1958) exhaustive review includes studies of Africans Negroes in Latin and South America, American Indians, Micronesians, Australians, Formosans, Japanese, Fijians, East Indians and assorted immigrant groups to the United States and Canada. These demonstrated the con-comparability of incidence and prevalence with the exception of Lin's (1953) study of Formosa. Further, Benedict as well as authors he reviews, asserts that not only are the forms and symptoms of the disease derived from the culture, but also there are obvious "cultural" differences in diagnosis, treatment, hospitalisation, admission rates and tolerance of behaviour in the community.

Leurkau and Crocetti while reviewing much of the literature covered by Benedict have focused completely on schizophrenia. They noticed that there are many descriptions in the literature of psychopathological pictures, in other than Western European cultures, but most of these are anecdotal descriptions of a single case of a group of cases with no relation of a standard population. Many are reports of cases which are clearly comparable to schizophrenia, as it is known to western psychiatrists trained in Europe and the United States who seem to find cases which fit these diagnostic categories in whatever cultures they work in. As a symptom picture the disease appears to occur in every population that has been thoroughly studied, whatever its cultural background. The rate of occurrence is quite another matter. There are a great many unsupported statements in the literature that this or that culture has more or less schizophrenia than others. Most of this data are purely impressionistic and are frequently based on one or two equally undependable indicators. They concluded:

"that there is extremely little valid data on the incidence and prevalence of the disease in other than Western European type
cultures." This is partly due to the fact that in different societies psychotic behaviour is not necessarily labelled deviant, and schizophrenia. From the above it is evident that the literature dealing with schizophrenia, from a comparative cross-cultural approach has until now been of limited value with regard to an understanding of the etiology of schizophrenia.

Instead of looking at the prevalence of mental disorder (schizophrenia) in Barbados, I have focused my attention on the process of identifying and labelling through which societies and Barbados identify, tolerate and label deviant behaviour as psychotic. This process of identification is exemplified in Barbados - from my discussion of Cosmo, a mentally disturbed person who lives in my locale/village and whom I knew from childhood.
Tolerating, Identifying And Labelling Deviant Behaviour

In the sense used here the term 'deviant behaviour' is used non-specifically to indicate any kind of behaviour, whether pathological or otherwise, that is not usually within the limits of recognised normality in the society concerned.

Mechanic, (1962) makes the point that "although seemingly obvious, it is important to state that what may be viewed as deviant in one social group may be tolerated in another, and rewarded in still other groups."

In every society extremes of insanity are recognised, i.e. in every society at some point in the range of possible human behaviour from normal to abnormal, the society comes to regard the individual as insane, this differs from society to society. For example, certain individuals may be recognised as eccentrics, and others may be regarded as vulnerable, in the sense that if things go wrong with them they may show disturbed behaviour. Again similar items of behaviour are recognised by society as harmless in some instances and dangerous in others. It seems that the attitude to deviant behaviour in a society depends to some extent upon the degree of determinism in the beliefs of the people. Further, social response may influence the frequency with which deviant behaviour recurs. A number of researchers have hypothesised that holy men, shamans and witchdoctors have been rewarded for their psychotic behaviour by being made incumbents of highly regarded and useful roles. (Devereux, 1956; Kroeber, 1952; Linton, 1956 and Silverman, 1967).

It is therefore appropriate to ask whether shamans in Eskimo cultures, healers in Yoruba culture and voodoo or obeah men in West Indian culture are thought by the people to be mentally ill.
other set of questions have been posed by Jane Murphy (1976). If Eskimos and Yorubas have a stereotype of insanity, are they less harsh than we, with those defined as insane? Do Eskimos and Yorubas have labels for psychological and behavioural differences that bear resemblance to what we call mental illness?

To answer the questions relating to the Eskimos and Yorubas, I will draw on research findings of Jane Murphy (1976). On questions referring to voodoo obeah-men I will refer to research done by Ari Kiev (1964) and my personal observations of obeah-men.

Jane Murphy (1976) noted that both Eskimos and Yorubas recognise differences among themselves but described them in terms of what people do and what they say, el and believe. Some differences lead people to seek the aid of healers, me differences arouse sympathy and protection, while others disapprove. me are called sickness, others health, some misconduct, others good nduct.

spite these numerous differences, the Eskimos have the word nuthkavihak, ich means "being crazy." It refers to a complete pattern of behavioural ocesses, the basic hallmark is, that something is wrong with the person's ul; the spirit and the mind is out of order.

e manifestations of nuthkavihak are: "talking to oneself, screaming at meone who does not exist, believing that a child or husband was murdered witchcraft when nobody else believes it, believing oneself to be an
imal, refusing to eat for fear eating will kill one, refusing to talk, running away, getting lost, hiding in strange places, making strange grimaces, rinking wine, becoming strong and violent, killing dogs and threatening people."

Murphy, 1976: 1022)

or the Yoruba, there is a word Were, which means insanity. Were like ntkavihak refers to a complex pattern of behavioural manifestations. Murphy again observes that the phenomena includes, "hearing voices and trying to get older people to see their source though none can be seen, laughing when there is nothing to laugh at, talking all the time or not talking at all, asking oneself questions and answering them, picking up sticks and eaves for no purpose, throwing away food because it is thought to contain ujin, tearing off one's clothes, setting fires, defecating in public and then mashing around in the faeces, taking up a weapon and suddenly hitting someone with it, breaking things in a state of being stronger than normal, believing that an odour is continuously being emitted from one's body."

(Murphy, 1976: 1022).

It is important to note that both Were and Nuthkavihak were never used for a single phenomena such as talking to oneself, but rather a pattern of four or more phenomena. Therefore one could manifest some of the phenomena described above and still not be labelled insane.

In Eskimo culture the ability to see things other people do not see, and to prophecy is recognised as a highly valued trait. It is called "thinness" by Eskimos. When Shaman are healing they become "thin."

This leads one to ask the question: How can Eskimos differentiate between
"thinness" manifested by Shaman and by others? In other words, why was the same behaviour viewed differently?

Here Murphy refers to the case, reported by Morton Teicher, of a Baffin Island Eskimo who believed that a fox had entered her body; (Teicher, 1954). Although her possession by the spirit of the animal was similar to when a shaman is undertaking a curing rite, her behaviour was labelled differently. Her possession by the spirit was continuous, she barked herself hoarse and tried to claw her husband. The woman was thought to be crazy but the shamans do not. One Eskimo described the distinction thus; "When the Shaman is healing he is out of his mind, but he is not crazy."

The distinction seems to be the degree to which one is in control of one's behaviour and the ability to utilise the behaviour for a specific social function. Further, behaviour which is threatening and potentially dangerous to other members of the society usually invokes social control of one sort or another.

A number of researchers in the field of cross-cultural psychiatry take the position that the underlying processes of insanity are the same everywhere, but that their specific content varies between cultural groups. (Dereuck and Porter, 1965; A Kiev, 1972).

The answer to the question, whether Eskimos and Yorubas have labels for psychological and behavioural differences resembling what we call mental illness is 'yes.' The ethnographic literature on this topic indicates that most other non-western groups also have labels. (Berger et al, 1972; Micklin et al, 1974).
As mentioned in the above section the phenomena described as mental illness developed in Western societies is found in every society. The extent to which it is recognised varies from one society to another. This therefore implies that in one society 'abnormal' behaviour will be tolerated and not labelled mental illness, while in another society the same type of behaviour will be labelled mental illness.

Murphy, (1976) in studies among the Eskimos and Yorubas, noted that she was unable to find a word in Eskimo and Yoruba vocabularies which referred to neurosis, or words similar to our meaning of anxiety and depression. However, the Yoruba lexicon included words for 'unrest of the mind which prevents sleep, being terrified at night, fear of people among people, tenseness and eagerness.' Similarly the Eskimo had terms for 'worrying too much until it takes the person sick,' (which is similar to the main reason Barbadians reported the cause of 'madness'), "crying with sadness, head down and rocking back and forth, shaking and trembling all over, afraid to stay indoors and so on."

The point Murphy makes, is that neither group had a single word or explicit label that lumped these phenomena together as constituting a class of illness. However people did recognise their disabilities and tried to do something about them; these were illnesses for which the Shaman and the Witchdoctors had effective cures.

Murphy has therefore shown that there is a behavioural phenomena which is labelled neurosis (mental illness) by us, but which, although recognised to be an illness, remains unlabelled elsewhere.
This brings us to another important aspect of labelling theory. How are the persons who manifest abnormal psychological behaviour treated? How are they controlled?

Here again from a cross-cultural analysis one finds that such persons are treated differently. This depends initially on what is regarded as mental illness by the society (institutional values), the severity of the disability and the extent to which the behaviour endangers the lives of members of the society or threatens social stability.

Regarding Eskimos and Yorubas, Murphy observes that the Eskimos physically restrain insane people on violent phases. For example, one insane Eskimo was killed after he had killed dogs and threatened the lives of his family. Here, the insane man had broken two of the cardinal rules of Eskimo societies. Firstly, dogs are treasured in the society and are as important as one's livelihood. Anyone killing dogs threatens the very fabric of Eskimo life. Secondly, attempting to kill one's family is unacceptable in any society. Both these acts were considered potentially disruptive to the stability of the society.

In describing the Chukchee, a Siberian group of Eskimos, Bogoies, (1904-1908) reported the case of an insane woman who was tied to a pole during a period of wildness. Teicher, (1954) describes the use of an igloo with bars across the opening, which allowed food to be passed. Selby (1974) observed that the Zapotes barred the door of a bamboo hut as a way of restraining psychotic men.

These are only a few examples of the many ways and means employed by different societies to control the insane.
Labelling theory proposes that the concept of mental illness is a cultural stereotype referring to a residue of deviance which each society arbitrarily defines in a distinct way. Murphy, in her study among Eskimos and Yorubas has produced data which calls the assumptions of the theory into question.

In both Eskimo and Yoruba society explicit labels exist for insanity, the afflicted person seeks the aid of the local healers. However, what is of major significance is the fact that the labels of insanity refer not to a single attribute or specific behaviour, but to a pattern of several interlinked phenomena.

The absence of a single label among Eskimos and Yorubas for the phenomena we call neurosis, or the notable absence of patients diagnosed as suffering neurosis admitted to the Barbados Mental Hospital, does not mean that manifestations of such phenomena are absent in the society, in the case of the Eskimos and Yorubas, this phenomena (neurosis) forms a major part of what the Shamans and witchdoctors are called upon to treat.

Murphy points out finally, that schizophrenia, were and nuthkavihak, "rather than being simply variations of the social norms of particular groups, as labelling theory suggests, symptoms of mental illness are manifestations of a type of affliction shared by virtually all mankind."

Asuni (1968) in describing a group of vagrant psychotics in Nigeria, noted that they usually stayed in one locale; people often fed them and allowed them to sleep in the market stalls. They were treated mildly and laughed at for minor deviations, but the same people took severe action to control them when they became violent. This description by Asuni is remarkably similar to the way in which vagrant psychotics are treated in Barbados.
There is apparently a common range of possible responses to the mentally ill person. This is determined more by the nature of his behaviour than by a pre-existing culturally uniform way of responding to whatever is labelled mental illness. If the behaviour indicates helplessness, sympathy is invoked and help tends to be given. If the behaviour appears foolish or incongruous, laughter, teasing or mockery is the response. If the behaviour is noisy, violent physically threatening, the response is to restrain and possibly confine.

The answer to the questions posed at the beginning of the section seems to be that persons who manifest abnormal psychological behaviour are treated differently according to the related institutional values of the society, the nature of the behaviour and attitudes towards the behaviour.

It has been shown that every society has evolved ways of dealing with the eccentrics, the vulnerable and the disturbed among its people. It may be that society shelters or perhaps persecutes those who are regarded as insane, or alternatively they may be left alone, so long as their behaviour is not judged to be innocuous and does not threaten the status quo.

Innocuous eccentrics who withdraw from active responsibility and participation in community life receive varying treatment. They may be ignored, tolerated, subjected to attempts at rehabilitation, excluded from society by removal into an institution or neglected, and in extreme circumstances allowed to die from lack of care and attention.

Examples of social institutions that shelter eccentrics, vulnerable and disturbed members of the community have been found in many societies and at many different times in history. In the Christendom of the Middle Ages
Religious communities played a large part in this regard, both giving shelter to such people by design and also inadvertently, by providing a way of life for many eccentric individuals.

In many rural societies, it is characteristic of village life to find that small number of eccentrics are sheltered by the community and may be found useful employment. Every parish in Barbados has its 'idiot' and 'madman'. These eccentrics usually do odd jobs such as weeding, bringing sand and pebbles from the beach, picking fruits and other chores. They are given food and some money for their services.

In the industrialised countries of the west it is often found that large organisations and the state find employment for a few individuals who are regarded as not being socially responsible.

Islam religious mendicants are tolerated by society and allowed to live freely. In India, religious mendicancy may be a shelter. A particularly interesting example is that of the Senjussi people who have taken to the jungle for a variety of reasons, and live there in an unorganised existence outside the wider society, but supported by the religious feelings of the neighbouring communities.

There are numerous ways of controlling the mentally ill. This varies from allowing people to confine or exclude themselves, to the society deciding to confine individuals.

It has recently been indicated by two studies in the United States, that stigma is not automatically and universally applied to mental illness, but rather complex responses are typical. (Bentz and Edgerton, 1973).
identifying Psychotic Behaviour In Barbados

It is from the visible aspects of mental deviation that signs arise which initiate the segregative actions of members of the community and cause the deviation to be labelled "insane." The visibility of the mental symptoms will vary with these intrinsic features as well as the cultural and immediate social context in which they appear.

Psychotic deviation is not in itself the reason for collective action to bring the mentally disturbed person(s) under restraint. Rather it is the highly visible nature of the deviation of the psychotic from the norms of his group. This places strain upon other persons, which excites his family or the community and causes them to take formal action against him.

Any instances can be provided in which the psychotic symptoms of a deviant were socially benign, and he is tolerated or indifferently treated in the community; he/she is viewed as a harmless eccentric providing some amusement and a source of gossip for others. (Murphy, J. 1976).

There are certain forms of psychotic behaviour, such as the person going through manic episodes, which will be penalised to some extent in particular any cultural milieu. A more significant fact is, that definition, recognition and treatment of psychotic symptoms as abnormal or insane vary in contradictory ways from culture to culture. Many of the behaviours regarded as psychotic are seen as normal in some societies, or even viewed as the pre-requisites to roles of prestige or power. For example, extreme suspiciousness, ideas of reference and delusions of grandeur and/or persecution are regarded as normal among the North western Pacific Coast Indians.

It is necessary to know the consequences of psychotic symptoms in a given social setting in order to understand the reactions of others to the deviant.
What are the reactions of Barbadians to psychotics?

The low visibility of early psychotic reactions and the variability of the overt behaviour associated with them make it difficult to isolate phases in the process by which primary symptoms are converted into symbolic psychosis or insanity.

Early psychotic reactions are looked upon by the community as "strangeness" or "oddness" which is usually passed off as a joke. This means that an individual can develop into a florid state of psychosis without being identified during this development. It is only when the deviant becomes aggressive and threatening the family and/or community members that his behaviour is defined as "mad." Commitment to the mental hospital occurs only after a long and exhausting provocation by the psychotic individual.

An examination of Cosmo, a psychotic living in my locale, aptly demonstrates my analysis of the community's attitude to psychotics. Cosmo is the name of a diagnosed psychotic who lives in my home district in Barbados.

When an inquiry is made about the onset of Cosmo's illness, villagers reply, "he jus' stan' so and went off one day." His breakdown, everyone believes was caused by the departure of his woman. How factual is this statement? To what extent was his woman's departure instrumental in his breakdown?

Reflecting on my early life in the locale, Cosmo was always regarded as a strange character, his moods were highly unpredictable many years before his first admission to the mental hospital.

I shall recount a few of the numerous incidents in which Cosmo's behaviour was unusual and strange. Everyone in the community felt that his actions were abnormal.
one occasion he beat all his children and chased them from the house, because he claimed, they were looking at him and laughing. No one paid any attention to this and several of his other irrational outbursts. The villagers attitude was, "they are his children so he can do whatever he feels like."

On other occasions he would walk the streets talking to himself while looking upwards to the sky or cursing anyone whom he felt disliked him.

This kind of strange behaviour continued for many years. At times it appeared more bizarre than others. No one thought of Cosmo as mad or "sick in the head." He was regarded as "that man who is very touchy, who thinks nobody likes him or his children." In spite of his strange behaviour Cosmo had some kind of relationship with everyone in the village. No one hated him or made fun of him. During his residency in the village no-one escaped his abuse. Sometimes he would stop speaking to a villager for days or weeks, for no apparent reason. Afterwards he would shout greetings to everyone.

His behaviour in no way disrupted the villagers relationship with him; they understood him.

There were occasions when his behaviour provoked much laughter. No-one really cared about how he acted or what he said because he never physically attacked anyone. No villager reported him to the police, no member of the welfare services ever visited him.

e day he attacked his wife and children with a knife, stabbing his wife and one of the children, he said that they were planning to kill him and sell his soul to the devil. This was highly unlikely as his children were between the ages 3 and 7 years, and his wife was a devout Christian. This attack resulted in his arrest, trial and subsequent admission to the mental hospital, where his delusions and hallucinations became more pronounced.
No one in the village or in the wider community had previously regarded Cosmo's bizarre behaviour as signs of mental ill health. His irrational outbursts of anger towards his children, his suspiciousness and often abuse of villagers were “understood” and tolerated. It was only when he viciously attacked his family that people regarded him as dangerous and a threat. The police were promptly summoned to protect other villagers; who would he attack next?

Cosmo's act had threatened the fabric of the village, he could no longer be tolerated as a "funny man." The community had to be protected from further attacks, as one villager remarked, "only madmen behave like that."

Summary

Here I have described the Barbadian attitude towards mental disorder - depression and schizophrenia. Both disorders typify the commonest forms of neurosis and psychosis respectively.

The highly visible and often threatening nature of psychotic behaviour acts as a determinant of the subsequent identification, apprehension, treatment and labelling of the psychotic person.

Unlike psychotic illness, presents no real danger to society and its members. A mad person is seen as someone who is violent, dangerous, unpredictable, funny and untrustworthy. The depressed person presents none of these characteristics. He does not see himself as mentally unwell, and is therefore unlikely to seek medical help.

Initially Cosmo's behaviour was tolerated and absorbed in the village life, and viewed as odd and possibly comical. However the identification and labelling process was activated when his behaviour could no longer be accommodated in the structure of the community.
Embodied in labelling deviant behaviour is a set of attitudes which come into lay when the behaviour is no longer tolerable. The behaviour once, 'odd', 'strange' and 'funny' is now considered 'mad', 'crazy' and unpredictable. The village idiot or eccentric is now a 'madman' and the community reacts to a stereotype of a 'madman.'

In the following chapter we will examine the development of these attitudes and their effects on the mentally ill.
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Introduction

In the previous chapter Barbadian attitudes towards mental disorder were examined; it was discovered that stereotypes of the 'madman' exist, and people react to these stereotypes.

Here we review empirical research into attitudes towards mental patients in an attempt to discover whether similar stereotypes of the mentally ill are universal and uniform.

An early and simple survey was carried out in 1947 by Ramsey and Seipp (1948a, 1948b). Selected adults in Trenton, New Jersey were asked six questions meant to elicit their notions about the etiology and treatment of mental illness. The investigators noted that respondents with higher educational and occupational levels were less likely to regard mental illness as punishment for sins or poor living conditions. They were less inclined to believe injurious effects of associating with the mentally ill and were more optimistic about the possibility of recovery.

Cumming and Cumming in 1957, conducted a study designed to 'understand and change attitudes towards mental health and mental illness' (p 5). Their sample consisted of an entire Canadian prairie community. The investigators tested the residents before and after a six month educational programme designed to promote more accepting attitudes towards mental illness. Three propositions were stressed in the films and group discussions. These were first, that the range of normal behaviour is wider than often believed, second, that deviant behaviour is not random but has a cause and can be understood and modified, and third, that normal and abnormal behaviour fall within a continuum and are not qualitatively distinct.
Gumming's study showed the initially negative attitudes towards mental illness of a middle class community, and the strong attachment to the existing value system. Despite these negative findings the study is valuable in providing insights into attitudes and their sources.

Hollingshead and Redlich (1958) found distinct differences in attitudes and knowledge about mental illness and mental patients as a function of social class and education. In their studies, attitudes were formed from observed behaviour in psychiatric treatment situations, they noted that upper class members had more favourable attitudes towards psychiatrists, are better informed about mental illness and are more accepting of mental illness than those in the lower classes.

After an extensive 6 year survey conducted during the 1950's Nunally (1961) reported that:

"as is commonly suspected, the mentally ill are regarded with fear, distrust and dislike by the general public," (Nunally 1961, p 46). The stigma associated with mental illness was found to be very general, both across social groups and across attitude indicators, with very little relation to democratic variables such as age and education.

Old people and young people, highly educated people and people with little training all tend to regard the mentally ill as relatively dangerous, dirty, unpredictable and worthless," (Nunally, 1961, p 51).

Much of the negative halo effect seems to be derived from the public's feeling that the mentally ill are unpredictable and are "considered unselectively as being all things bad." (Nunally, 1961, p 233).

Like Nunally, Freeman and Kassbaum (1960) found no evidence that the attitudes about mental illness are related to educational level in their study of over 400 adults representing the general public in the state of Washington. These findings are consistent with the observation that individuals who have more education are more likely to classify certain behaviour as mental illness,
In contrast to Nunnally (1961) and Freeman and Kassbaum (1960), Hollingshead and Redlich (1959) noted that attitudes and knowledge about mental illness and mental patients varied with social class and education. The general public tends to reject disturbed behaviour that is socially visible and disruptive. Thus a paranoid schizophrenic is more often identified as mentally ill than a depressive.

Nunnally’s respondents were able to make a distinction between psychotics and neurotics. Neurotics were seen in a more favourable light, being more predictable and intelligent. Although sharing the negative evaluation of the mentally ill, the neurotic is not stigmatised to the same degree as the psychotic person.

Turkan and Crocetti (1962) using only three of the Star (1955) vignettes, found that 91% of the urban sample identified the paranoid as mentally ill, 8% identified the sample schizophrenic as mentally ill, and 62% identified the alcoholic as mentally ill. Morris, Hunt, Brawerm and Kercher (1965) found at contrary to their predictions, psychiatrists as well as the general public were more influenced by the social visibility than the severity of symptoms deciding who to label mentally ill, based on a set of 20 descriptive paragraphs.

Philips (1963, 1964) studying a sample of white housewives, presented them with one of the Star (1955) vignettes and one vignette of his own devising that described a normal person. Philips found that people who sought psychiatric help especially when they sought help from a mental hospital, were more strongly affected by the normal sample than those who consulted the clergy or medical personnel as measured by a scale of social distance. Philips further noted that the overt behaviour of the fictitious person in these cases exerted a much more powerful influence on social rejection than the source of help.
Yamamoto and Dizney (1967) replicated Philip's study using a sample of student teachers in a mid-western university and obtained comparable results.

Schroeder and Erlich (1965) also replicated Philip's study, using psychiatric nurses as subjects. They found that the behaviour variable was even more important in influencing responses of social rejection than among Philip's housewife's subjects and that source of help was of far less influence.

Wicker (1969) in a careful review of studies of this nature, found that attitudes are typically unrelated or only slightly related to actions. He also noted from the studies he reviewed that a substantial proportion of the subjects show striking discrepancies between their words and actions.

Bord (1971) using a sample of college students also found that the behaviour of the mentally ill person was the main predictor of social rejection and that the source of help was seemingly unrelated to the level of social rejection. These findings question Nunnally's (1961) observation that lower class population groups are generally more tolerant of disturbed behaviour than are middle and upper class groups.

Dahrenwend and Chin-Shon (1967) directly rebutted this assumption in their study of public attitudes towards deviant behaviour in a New York City sample. Lower class respondents were more likely to disregard the pathology of withdrawn behaviour, and regarded anti-social behaviour as being serious but not mentally ill. Once they decided that an individual was mentally ill, they were more rejecting than were respondents in higher socio-economic status. The authors noted:

"lower status groups are predisposed to greater intolerance of the kinds of deviance that both they and higher status groups define as serious mental illness. Their definition of serious mental illness is narrower than that of higher status groups, giving the appearance of greater tolerance of deviance from the vantage point of the higher status groups, including the mental health profession." (Dahrenwend and Chin-Shon, 1967, p 423).
A broad range of behaviour seemed to be viewed by the public today as "mental illness" than was fifteen years ago.

To test this general hypothesis, Bents, Edgerton and Kherlopian (1969) conducted a study using four of the Star (1955) vignettes. In this study 50% of the subjects labelled each category as describing someone who was mentally ill. Assuming that a majority of this group would have been labelled the paranoid schizophrenic - who have been excluded from this study - the investigator postulated that there is an increasing tendency to identify a broad spectrum of behaviour as mental illness. However, this conclusion must be tempered by the observation that the apparent historical shift may be "more of a superficial labelling than of conviction, for there are still some important differences in the way psychiatrists and the public view the cases."

(Dohrenwend and Chin-Shon, 1967, p 511).

Celia Haddon, writing in the Sunday Times of October 28th, 1973, reporting on an opinion poll noted that;

"much of the fear and shame that once surrounded mental illness have been replaced with public sympathy and understanding."

However, one major problem remains, generally people are unwilling to work voluntarily with the mentally ill patients. In Ireland the hostile and negative attitudes towards the mentally ill are shaped by the generally greater contact with psychiatric patients. Overwhelmingly, the 1,032 adults interviewed by Opinion Research Centre said that they did not mind living next door to someone who had been mentally ill.

The poll further revealed evidence of public ignorance of the seriousness of mental illness, (See Table 1). For many it ranks as a greater calamity than multiple sclerosis, even though mental illness is curable and multiple sclerosis is not.
Table 1

Question: If a relative were to get one of these illnesses, which one would you be most concerned about?

<table>
<thead>
<tr>
<th>Mental Illness</th>
<th>All 32</th>
<th>Men 34</th>
<th>Women 30</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple Sclerosis</td>
<td>29</td>
<td>26</td>
<td>32</td>
</tr>
<tr>
<td>Blindness</td>
<td>22</td>
<td>23</td>
<td>20</td>
</tr>
<tr>
<td>Arthritis</td>
<td>5</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Diabetes</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Loss of a limb</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Don't know</td>
<td>3</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>

The young fear mental illness most, the old and middle aged who are most likely to become mentally ill seemed less frightened.

There seems to be strong public support for encouraging mentally ill people to lead as normal a life as possible in the community. About half of the respondents replied that they would be prepared to give help either in hospital, an after-care centre or in the patient's home.

Carl D'Arcy and Jean Brockman (1976 & 1978) failed to find any difference in public recognition of mental illness between their 1974 replication study conducted in Saskatchewan, Canada and the original study done by Cumming and Cumming (1951). D'Arcy and Brockman (1978) noted that 1974 re-survey of the Cumming (1951) Closed Ranks baseline study area showed a slight overall shift towards more acceptance of the mentally ill and appears to support the relationship between age, education and attitudinal distance. They also noted that education had no appreciable impact on attitude and that age had negative influence only for those in the over 40 age group. However, they suggested that the social distance items may be reactive to change cultural patterns and largely responsible for the indications that attitudes have become more favourable.
egal (1978) noted that Schwartz, Myers and Astachan (1974) is the only study which seriously questions the relationship of negative attitudes towards the mentally ill and the public's conception of them as violent and unpredictable.

chwartz et al (1974) pointed out in their study of 124 relatives of former patients that the type of rejection they found was due to primarily to neurotic impairment and to a lesser extent to the psychotic type of behaviour described by Star (1955). However, this population of relatives of former patients expressed less rejection of the mentally ill than is evident by other samples of the general population.

A consideration of five studies, Aviram and Segal (1973) found that on a six point scale of acceptance - rejection, the average amount of acceptance taken across studies was 326 indicating a willingness on the part of the public to live next to a former mental patient but not to a room with one. These findings appear to indicate that the type of rejection reported by chwartz et al (1974) occurs with a family as opposed to the response of the general public to a mentally ill group.

Attitudes of Specific Groups

Attitudes of professionals who work with the mentally ill have been exhaustively studied. Most studies of the attitudes held by mental health workers have considered employee sub-groups separately.

Investigators have reported that personnel with lower status are more authoritarian and restrictive in their attitudes towards mental patients while those with advanced professional training - e.g. psychiatrists, social workers and psychologists - are more tolerant, understanding and optimistic about their prospects for recovery.

General medical practitioners possess generally accurate information about the etiology, symptomatology and prognosis in mental illness. Nunnally (1961) found that the attitudes towards mental patients were similar to those of the general
They viewed neurotics as weak, foolish, twisted, complicated and ineffective; psychotics were described as dirty, unpredictable and dangerous.

There are marked differences in attitudes toward the mentally ill even on the part of those involved in their care; Wilson, M. and Myer, E. (1965). Exposure to mental patients in an institutional setting does not in itself influence an employee to greater acceptance of the mentally ill. Freed (1964) found that employees of a large veteran administration psychiatric hospital were less accepting mental illness than of physical illness or alcoholism.

Cohen and Struening (1962, 1964 & 1965) have conducted the most extensive series of studies concerning attitudes of mental health workers towards mental illness. Working within the veterans Administration Psychiatric Hospital System, they studied members of 19 occupational categories and grouped them empirically in ur clusters, in terms of their attitudes, as elicited by the opinions about ntal Illness Scale (O.M.I.).

Cohen and Struening (1965) noted that the overall atmosphere of a given hospital s largely determined by the attitudes of the nurses and aides and that thoritarian and restrictive atmospheres were negatively correlated with ischarge rates (Cohen and Struening, 1964).

Findings consonant with those of Cohen and Struening have reported by Appleby, Lis, Rogers and Zimmerman (1961), Rezinkoff (1963), Rezinkoff et al (1964), right and Klien (1966), Williams and Williams (1961) and Vernallis and St ierrie (1964).

Appleby et al (1961) found that professional staff members differed from aides d administrative personnel in being less authoritarian and more humanistic. Rezinkoff investigated attitudes towards psychiatrists, psychiatric hospitals d psychiatric treatment held by nurses and aides using a 12 item Multiple
Voice Questionnaire. He found nurses generally more favourable towards psychiatrists and psychotherapy than aides and supervisory personnel more favourable than others within each group.

Light and Klein (1966) found professional staff nurses more accepting than aides and other employees with less education and formal training, while hospital personnel as a group were more accepting than members of a small Southern town.

Williams and Williams (1961) found that student nurses were less authoritarian and score lower on anomies than aides, as measured by scales they constructed. Attitudes of volunteer workers at Veterans Administration Hospital in Topeka were compared with those of other hospital employees by Vernallis and Pierre (1964). Volunteer workers were more receptive to Mental Hygiene and were more socially restrictive than white collar and professional workers.

Brief, the available evidence shows distinct attitudinal patterns for different categories of mental health workers. As several studies have suggested, these attitudes seem largely shaped by age, education and social class.

Dudleyton (1953), using a 47 item Prejudice Test with a dichotomous agree-disagree format, found that better educated, younger and more intelligent hospital employees were less prejudiced than others.

Middleton, Lawton (1964b & 1965) using the OMI found that Authoritarianism and Social Restrictiveness were positively related to age and years of service. He also found a negative relationship between Social Restrictiveness and education. Similarly Clark and Binks (1966) reported that greater education and younger age were associated with more liberal attitudes about mental illness.
contrast Reznikoff found low but significant relationships between positiveness of overall attitudes and years of experience for both nurses and aides. Weakness in the statistical design cast some doubts about the validity of his results.ohen and Struening (1962) did not find age highly correlated with any of their actors of the O.M.I., but education was negative and correlated with authoritarian and Social Restrictiveness and positively correlated with Mental hygiene Ideology and Interpersonal Etiology factors.

Isworth (1965) related the attitudes of 65 aides and nurses in a Veterans Administration hospital, as reported on the O.M.I. Scale, to average rating ade by patients on their wards. He found that aides and nurses who scored high on the O.M.I. social restrictiveness sub-scale were more likely to have their behaviour characterised as rigid, inconsiderate, domineering and lacking understanding, trust and responsiveness by patients.

though most studies have focused on separate occupational groups in studies of attitudes about mental illness, some investigators have examined general staffs beliefs about mental patients. In one of the earliest studies of its kind, Myers and Schaffer (1954) reported more positive staff attitudes towards upper class patients, an observation similarly reported by Belknap 1956) Mendel and Rapport (1964) studying determinants of the decision to hospitalise patients appearing at the psychiatric admitting offices, found that he professional staff members, responsible for such decision all believed that symptom severity was the major consideration in determining which patient to hospitalise and that a history of prior hospitalisation was irrelevant, contrary to the beliefs of the staff members. Mendel and Rapport found that patients who were hospitalised were indistinguishable from those who were not in the basic of symptom severity, but far more had a prior history of hospitalisation.
n summary, attitudes about mental illness vary markedly between different categories of mental health workers and are related to the demographic variables of age and education which was not found consistently true for the general public. Differences in orientation have been studied by Bielianskas (1960); he noted that these differences are so deep seated that they cannot be reversed by the usual mechanism - for example, ward staff conference.

Attitudes of Patients and their Relatives

In addition to attitudinal studies of the general public and on mental health workers attention has been devoted to the attitudes of mental patients and their families toward mental illness. (As used here the term mental patient refers only to the hospitalised). Overall findings indicate that mental patients' attitudes are similar to those of non-patients of comparable age, education and social class and that the condition of patient does not significantly alter their beliefs and judgements.

iovannoni and Ullman (1963) studying Veterans Administration psychiatric patients, reported that they were no better informed about mental illness than the general public, and their attitudes towards mentally ill were as highly negative as those of normal. Crumpton, Weinstien, Acker and Amis (1967) noted that on semantic differential scales, both patients and normals viewed the mental patient in unfavourable terms.

niss, Honts and Blake (1963) compared hospitalised psychiatric patients' attitudes toward mental illness, measure on a scale like Nunnally's with those of medical patients and mental health professionals. They found no significant attitudinal differences between medical and psychiatric patients. Those with more education believed that mental patients were like normals in appearance, and that mental illness is curable.
ntinck (1967) compared the O.M.I. responses of 50 hospitalised Veterans Administration schizophrenics and their relatives, 50 medical patients and their relatives, and the Veterans Administration hospital personnel. She found that the schizophrenics were less benevolent and Socially Restrictive in their attitudes than either their relatives or hospitalised personnel. The attitudes of the schizophrenics' relatives resembled those of blue collar hospital personnel, rather than those of mental health professionals, and they also tend to come from the same social background as the blue collar hospital workers.

Attitudes of relatives to mental patients were also studied by Freeman (1961) who made a standardised interview scheduled with mothers and spouses. He found that better educated relatives tended to hold more enlightened attitudes about mental illness, as did younger relatives, but that social class was not a significant factor. He also found that relatives' attitudes were not influenced by duration of hospitalisation, number of hospitalisations, or diagnosis of the patient except on the question of recovery. The patients' behaviour after release from the hospital did influence the families' attitudes about the chances of a complete recovery.

llingshead and Redlich (1958), in contrast to Freeman, found distinct social class differences in relatives' attitudes about mental illness and their mentally ill relatives. They observed that the lower the class, the greater the feelings of fear and resentment, the higher the class, more pronounced the feelings of shame and guilt.

In summary, mental patients are as negative in their opinions about mental illness as the general public. Attitudes of relatives to their sick members tend to vary according to age, education and social class.
Effects of Society's Attitudes on the Mentally Ill.

Following release from an institution, the patients' principal adjustments involve work and family. The attitudes of relatives and employers are of considerable assistance in maintaining a satisfactory adjustment.

Employers share society's negative appraisal of the mental patient, based not on personal contact in a work situation, but on the sources of attitudes common to society in general (Hartlage, 1966). However, (Bieliauskas and Wolfe, 1960; Bieliauskas and Griffiths, 1958; and Olshansky, Grob, and Malamud, 1958), have noted that employers are willing to hire discharged mental patients, especially when the labour market is "tight." Even though often regarded as poor risk, discharged mental patients prefer to find their own jobs rather than rely on the services of the hospital and the labour exchange, presumably because of the concern over revealing their background. (Olshansky, Grob, and Ekaabal, 1960; and Hartlage, 1964).

Lovers

Olshansky, Grob, and Malamud (1958) in an extensive, carefully controlled study of the Boston area, found that employers' attitudes towards the mentally ill were negative and more similar to attitudes expressed by the general public. For a large number of employers, mental illness connoted character weakness. Enneman and Margolin (1954) noted that in many instances personnel officers expressed fears about the patients' ability to handle the job. These fears are expressed in terms of concern over the ex-patients' productive capacities, their ability to accept supervision, their ability to adjust to their fellow-workers, the impression that insurance carriers would increase rates or refuse coverage for former mental patients. There is noticeably less stigma attached to having had psychiatric treatment than having been in a state hospital, e.g., Springfield.
an experimental study, Farina, Felner and Bondreau (1973) attempted to
cument the reaction of male and female workers to job applicants of the same
x, half of whom were described to the interviewers as former mental patients.
e investigators found that the male workers were more rejecting of former
ntal patients than the normals. In several previous studies males have been
and to receive higher rejection scores (Philips 1963) and to be viewed as
re dangerous (Levinson and Zan York, 1974).

nd, the National Association for Mental Health says that in the report
obody wants you," that people with a record of mental illness are probably most
ected by discrimination in applying for a new job. The report detailed 40
se histories of people who have encountered discrimination because of their
ntal illness. Mind, in a letter to Mr. Albert Booth, Secretary of State for
ployment, advocated the introduction of legislation similar to that passed by
e United State Congress to protect former psychiatric patients. (The Times

reporting the results of a 20 year follow-up study of hospitalised schizo-
renics, Clausen and Huffine (1975) indicated that over time,
"if a former patient manages to function well on the job and in the family
any do - such feelings of stigma as were originally engendered will
inish and neither patient, family or friends will be disposed to think in
ms of former patienthood or mental disorder (p 415)."

Family

ny clinicians are familiar with the fact that relatives often do not except
cure to be effected by a mental hospital, they desire merely the isolation
the patient. They are reluctant to take part in the treatment and are alarmed
the prospect of the patient’s return to society. This is particularly true
families of chronically ill male patients who often admit to fear of
gressive acts. (Evans and Bullard, 1960).
ever, negative attitudes on the part of the family, once established are
fractory to change, even by frequent visits from trained hospital personnel. Freeman and Simmons, 1963).

The effects of familial attitudes have been studied in considerable detail. Erling and Mendelshon, (1965), have shown that supportive family reaction day, hospitalisation and participation in family therapy sessions are related to success in avoiding re-hospitalisation. If the family assumes that the discharged mental patient will carry out the functions of a "well person," he has a better chance of successful adjustment, than if he is kept dependent and treated permissively by the family. Where there is pressure to assume an active role prognosis is generally more favourable (Freeman and Simmons, 1963, 24-77).

Angina: Attitudes Towards Mental Patients

Investigators have taken two distinct approaches to the problem of altering attitudes. The first has been to encourage contacts between the public and the mental patient under the assumption that the mentally ill will be perceived as normal," not aggressive, unpredictable crazy beings. The other has involved the usual information - dissemination approach, such as lectures, discussions and use of the mass media.

Personal Contact

Personal contact approach has yielded equivocal results and clearly indicates at the factors that determine effectiveness are largely unknown. Kimball and Skey, (1964) have found that institutional tours were effective in changing attitudes toward mental retardates in a positive direction.
seems well established that positive attitude change occurs among those who work in a distinct helping relationship with mental patients. This has been the case among hospital personnel, (Hicks and Spanes, 1962), college students enrolled in a "companionship program" of 30 weeks duration (Holzberg and Gerwirtz, 1964), and student nurses completing a psychiatric training period, (Altocchi, Eisdorfer, 1961).

It may be that the key to the effectiveness of the personal contact, is the introduction of the mental patient into a role that can be perceived as presenting "normal" behaviour. Current treatment philosophy, which emphasizes t-patient care and hospitalization within general hospital settings is a step in the right direction.

However, it should be emphasized that simple contact with the mental patient is not sufficient to change attitudes, in most cases it is necessary to provide additional education.

**Dialectic Methods**

Attempts to change attitudes towards mental patients through public information usually followed the techniques of lecture, group discussions, distribution of literature and motion pictures. Not much is known about the relative effectiveness of these techniques. One study reports movies to be effective in changing the attitudes of well-educated, middle class group, although a series of fewer than a single film, was required to bring about change, (Mc Ginnies, a and Smith, 1958). Nunnally and Bobren (1959) reported considerable success in both lectures and written communication.

One of the few studies to report effective attitude change, due largely to the traction received, was conducted by Coston and Karl (1962). The authors found that all women, regardless of social class rank, and men in the upper class score less Authoritarian and less Socially Restrictive in their attitudes.
raham (1968) gave the O.M.I. to students in introductory and abnormal psychology. At the start and end of a 10 week term, scores on the Interpersonal Etiology scale rose in both classes.

A similarly designed study, Gulo and Fraser (1967) found the Social strictiveness scores declined. Iguchi and Johnson (1966), contrasted the attitudes of students taking an abnormal psychology course with those of students taking the same course in conjunction with a volunteer "companion programme," at a local hospital. The investigators reported that students acting the companion programme were more humanistic - as measured by the O.M.I. The addition of patient contact added nothing beyond that gained by students in class alone.

Con (1967) used the O.M.I. to compare attitude changes after completion of psychology courses. He found some favourable changes. Subsequent interviews with the instructors led the author to conclude that the instructors' attitude had a greater effect on students' attitudes than did the content of the text used.

In summary, several attitudes have succeeded in demonstrating the effectiveness of academic instruction in changing questionnaire-measured attitudes about mental illness. These findings do not mesh with those of Cumming and Cumming (1957), Freeman and Seaburn (1960), and Casper (1964) who have reported that imparting information about mental illness does not by itself alter attitudes of the general public.

Summary and Conclusions

A variety of studies have been conducted to delineate attitudes toward mental illness, their amenability to change and relationship to behaviour. Investigators have succeeded in describing attitudes held by workers in the mental health field well as those of the general public.
A general public lacks information about mental illness. It is not mis-
formed, but uninformed. The general public holds negative attitudes about
a mental patient—usually defined as someone who has had contact with a mental
hospital—who is treated with fear, distrust and dislike. Only a little
stereotyping is made between the neurotic and the psychotic. However, when the
mental patient" label is not imposed, society is likely to be tolerant of a great
deal more aberrant behavior.

Among specific groups within the populations attitudes and information do not
incide. Even among professional working with the mentally ill, there are
differences of opinion on what constitutes mental illness, and employees in
mental hospitals differ in their degree of acceptance of mental patients. Mere
contact with the mentally ill is not sufficient to change attitudes.

Employers seem reluctant to employ mental patients. Patients understandably are
luky to reveal past hospitalisations.

Families regard discharged mental patients with suspicion and fear. These
attitudes are refractory to change, once they are established. Society's
attitudes affect the patients own views of themselves and they bend to see them-
elves negatively.

Little is known about what factors determine society's attitudes. Social class
se is not applicable, although educated and younger people have less
rogatory attitudes and are more willing to have contact with the mentally ill
than older and less educated persons.

O'neill (1979) studying the factor of class in Ireland, noted that class member-
ship was not a major influence on the content of stereotypes, except in the case
of the lowest socio-economic group; a substantial minority of which seem to
fuse the mentally ill with the mentally retarded.

Studies have shown that the attitudes of a patient's family affect the patient's
agnosis and ability to avoid relapsing; where there is pressure for a patient
o assume an active role in the family and community, the chances of his
rehabilitation are greater.

The subsequent chapter we will examine Barbadian attitudes towards the
electronically ill in Barbadian society; individuals who have been discharged from
the mental hospital but whose families refuse to rehabilitate them. They are,
therefore forced to live rough/walk the streets and thus perpetuate the image
of themselves as insane.
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CHAPTER 4

BARBADIAN ATTITUDES TO, AND CONCEPTS OF MENTAL ILLNESS

- FIRST STUDY - THE IMAGERY OF MADNESS IN BARBADOS.

- SECOND STUDY - THE IMAGERY OF MADNESS - BARBADIANS IN READING.
CHAPTER 4

BARBADIANS ATTITUDES TO AND CONCEPTS OF MENTAL ILLNESS

Introduction

To discover the community's attitude, I divided my investigation into 2 sections. Section I looks at the community's attitude towards "characters about town" - persons who have been discharged from the mental hospital and who now roam the streets. Section II deals with what I term "imagery of madness." Ideas, concepts and beliefs about madman and mental illness were elicited from a randomly elected group of community members in Barbados and England. The 'English sample' consisted of Barbadians living in Reading and the London Borough of Brent.

Section I

Barbadian Attitudes to the mentally ill.

Differences in attitudes towards the mentally ill and mental illness are identified according to class and status positions of community members. The first of such differences is related to the terms used to describe individuals who suffered or are suffering from mental illness. In the event that the individual is of low social and economic class, his mental illness leads to the term "madman" or "madwoman." In the case of the "well-to-do" and "better-off," as they are called in Barbados, no one dares refer to the mentally ill members of this class as mad; the more respectable terms of "nervous breakdown" or "she's got the nerves" are used. This difference also extends to the attitudes towards employment of the mentally ill. Those persons described as having a "nervous breakdown" have little or no difficulty in returning to their old jobs or even finding new ones. Those unfortunates, from the lower classes, who have been described as "madmen/women" have little or no chances of being re-employed. They are usually seen as unreliable, shady characters who might "go mad" at any time and frighten fellow employees. It was this general attitude of fear and mistrust
f the mentally ill directed mainly towards the mentally ill of the lower lass - that prompted the new Medical Superintendent of the Mental Hospital, Dr. Patrick Smith - during his first year of office in the early 1970's - to set himself the task "to completely remove the old stigma attached to the hospital and to the mentally ill." He cites public relations as the biggest problem in achieving his goals. Part of his campaign to remove the stigma attached to the mental hospital, would entail changing the name of the hospital and improving the general appearance of the building. Sadly, six years have passed, Dr. Smith's term of office has expired, the name of the mental hospital is unchanged and very little work has been done to improve the "general appearance of the place" and erase the stigma attached to mental illness.

He further admitted that there were still some classes in the community who kept their mentally sick at home, instead of committing them to the mental hospital, where they would receive the professional treatment and care they needed. Such actions and attitudes are based on fears distilled from the many stories told about the maltreatment and suffering in the mental hospital. Sadly, many of these stories have been true.

Attitudes towards discharged patients

How does the Barbadian society react to the discharged patient?

Most people entertain a stereotype of the mentally disordered as hyper-active persons, unkempt, noisy, wild-eyed, homicidally impelled, always on the alert to escape from their keepers and to damage life and property in the surrounding community.

Having punished the deviant for his anti-social acts, society further punishes him when he attempts to return to conventional roles. Although he is encouraged to rehabilitate himself in the community, he usually finds himself
discriminated against in seeking to return to his old position in the occupational, social, marital and other spheres.

Recent studies have shown that former mental patients encounter considerable difficulties in finding employment, even when their behaviour and qualifications are acceptable. In an experimental study, Philips has shown that the rejection of the mentally ill is largely a matter of stigmatisation, rather than of objective evaluation of their behaviour.

When a person is described as having been in a mental hospital, he is more likely to be rejected than a psychotic individual who is not seeking help, or is seeing, say a clergyman. Even when the normal person is described as (only) seeing a psychiatrist, he is more likely to be rejected than a schizophrenic who is seeking no professional help.

The rejection of the discharged patient by the community is inhospitable. This kind of reception usually sets in motion a symbolising process which can quickly convert what may be a normal amount of conflict into the signs of recurring insanity. For a person who has acquired an image of himself as lacking the ability to control his actions, the process of self-control is likely to breakdown under stress. Such a person might feel that he has reached his "breaking point" under circumstances which would be endured by a person with a "normal" self-concept.

Finally, to the extent that the deviant role becomes a part of the deviant's self-conception, his ability to control his own behaviour may be impaired under stress, resulting in episodes of compulsive behaviour.

The local community/village of which the patient was a member, and in which he had made his home, in which he had relatives and friends, make no provision for his return. It has no responsibility for his condition or care; it receives no notice of his impending return and for the most part is indifferent to his return and subsequent welfare. Relatives and friends
spurn his company, reluctant to be identified with him, for fear of being
tigmatised as a member of "that mad family" self interest takes precedence.
There is an unbridged gap and lack of continuity between the mental hospital
experience and life in the community outside. This gap occurred because the
community has ignored the welfare of the mentally ill. Services provided by
the social service workers of the mental hospital are inadequate and dis-
organised.

Attitudes of doubt and suspicion constitute the substance of the stigma
attached to the mentally ill, and complicates the deviant's post-hospital
adjustment. Such facts as these are doubly meaningful when it is recalled
that a large percentage of discharged mental patients are readmitted; most
of whom were not "cured" or discharged, but merely "improved."

From what has been outlined above, the situation of the discharged mental
patient makes role integration and self-acceptance hard to achieve.
Even though his symptoms have probably been eliminated and he is restored
to full economic and social competence, his welcome back into the community
as qualified and watchful. Some persons are strong and flexible enough to
dismiss or overcome the difficulties encountered in role-adjustment and
social acceptance. For others, the veiled or open suspicion of others
in the community is more than enough to heighten the discharged patient's
anxiety, and magnify normal mistakes and inadequacies, thus leading to a
possible relapse.

It is not often realised by relatives and others, that no person who
as experienced psychotic behaviour and hospitalisation will ever be the
same as he was before the experience; his conception of himself has changed
and he needs special understanding and acceptance from his family and
friends - an understanding he seldom gets.

or some discharged patients understanding and acceptance by family members
s denied. Such individuals are left to fend for themselves, to depend on mall hand-outs from benevolent passers-by and tourists. They eventually join the growing number of characters who roam Bridgetown.

**Characters About Town**

'I have asked this question before but have never had an answer. Can anything be done to help those poor people suffering mental illness who roam the streets day and night? We all see these people day after day. These unfortunate folks frequent a certain area. Whenever you pass they are there, either like a statue dreaming into space, or ranting and raving up and down the road.

There are certain ones, especially in the St. Michael and Bridgetown area who could do with some help. These poor people living a life of torment and our society should not allow this sort of thing to happen. The callous way which we treat them reflects badly on our society." (Advocate News - 3.9.77)

This is Mr. Carlton’s view of the Barbadian attitude to mental illness, one of callousness and indifference. His observations seem to be well supported if he view of other concerned citizens writing to the Advocate Newspaper are to be taken seriously.

The general attitude of indifference, "it’s not my problem," has resulted in Bridgetown being the host to a mixed group of social outcasts, some of whom are mentally sub-normal, some "simple-minded" and others acutely mentally-ill. They live cheek by jowl and are viewed with disgust, disdain, or as objects of amusement.

Tony Padmore, a concerned citizen, writing in the Sunday Advocate News of July 27, 1977, makes some very interesting observations; he says,

"It's time that much more be done to help some of those unfortunate mentally sick people whom we see so often on the streets in Bridgetown. Recently there has been an increase of these unfortunate "characters" on
he streets, behaving in an odd manner, and there seems to be a new face almost every month."

Those with the capacity to help these people have limited powers. Few people admit themselves to the mental hospital for treatment (although more do now than have done in the last ten years) therefore most mental patients are usually "recommended."

The problem comes when people must be admitted for treatment. Before someone is admitted, provided that this individual does not sign for himself, he must be admitted by two medical practitioners or a magistrate as a remand case.

Some people don't have others to advise or act on their behalf, and what might be an early suspected case in need of early treatment might very well be ignored and end up as a more serious case.

So often we see people in the streets behaving in the most extraordinary manner. Passers-by sometimes look on, they might find it amusing or simply just ignore it and continue on their way.

Another alarming fact is that there are many patients in the mental hospital who have responded to treatment and who can be discharged, if only a relative or someone responsible would sign for their discharge. Many of these 'healed' females will spend the rest of their days within the walls of the Black Rock institution because Barbadians - like too many others - have the ignorant belief that "once mad always mad." Many of the patients whose relatives have given them up as hopeless cases end up on the streets, increasing an already large population of social outcasts.

Here are some of the "odd characters" Mr. Padmore has seen around Bridgetown.

"There is a cricketing fanatic called "Salaam," this dauntless W.G. Grace goes around playing imaginary games of cricket. He bowls both fast and slow
without a ball. After making one of these deliveries, "Salaam" then bats and
put to execute the finest strokes without a bat. Where the fear comes in is
then "Salaam" takes his run to bowl. To the utter astonishment of shoppers
and passers-by, he runs up to the imaginary popping crease and makes his
delivery. Or worse yet, many a passer-by really gets the daylight scared out
him or her, when they happen to walk into the hip-pocket position when

old or "Capesclers" (as he is often called) is another of these city
arters, who roam around town "spitting spanish" among other crazy practices.
er was a time when he would give a chase to anyone who dared utter his name,
cially agile school-boys.

"Now he has retired to less fleet-footed practices like sleeping under
iconies or under the sidewalks, walking around in filthy rags, sometimes
osing his person, and very seldom sober.
art from "spitting spanish," "Capesclers" also spits abusive language and
iva all over the place."

Padmore continues,

"Usually hanging out in the Fountain Gardens is another type, he is seen
rowing boxing, gesticulating and sometimes fighting phantoms, he even barks,
cuts and snaps." Females are also to be found in this predominantly male
ld "about town."

Padmore cites a familiar female, "who walks around tidying herself as she
es. As she tidies her clothes she throws her dress in the air to show off her
dies, when she is wearing and when she isn't, it's most embarrassing.
metimes she is perched on a low wall in the Collymore Rosk area, ironically,
t opposite the Enmore Health Centre, knees apart, embarrasement if you
pplen to look up."

me cases of persons roaming the streets during the day and until very late
at night are not only restricted to the St. Michael Parish. In every parish there are "street roamers," mentally ill persons who need care and attention.

Mr. M. Carlton noted one sad case of a young woman in the St. Mathais/Hastings area. He writes,

"This woman is supposed to be very intelligent and could be contributing something worthwhile to the society but instead her days and nights were spent roaming aimlessly up and down the streets existing under bad conditions." (Advocate News, 5th September 1977, Barbados).

Mr. Ridley Green adding his views to those of the few concerned citizens who feel aggrieved by society's indifference towards the mentally ill, says that,

"The people of Bridgetown - and for that matter Barbados - would be as non-concerned as the people of Bridgetown could be. Just a few would cast a glance or would not stop at all. The man they would so hurriedly look at, would be as indifferent to the situation as his passers-by."

Mr. Green recalls an odd "man about town" who frequents Trafalgar Square, in Barbados. Sometimes he seems to think that he is a lawyer addressing a judge on behalf of the defendant, other times he believes he is an army sergeant giving orders to his platoon. To some he is a most interesting character, (something to talk about, a conversation piece) poor chap, I have seen tourists take pictures of him.

Why must a man be so degraded? Why do most of us think so little of him? Is it fair to say that because it is himself he punishes and no one else, that he should be left alone (to further destroy himself)?" (Sunday Advocate News, July 24th, 1972).
r. M. Carlton thinks that the police should be given the right to investigate these cases and be given the power to take them to the mental hospital. However, it seems that the society has already meted out its own form of punishment - indifference and disdain. This is clearly demonstrated by the community's unconcern about these "poor creatures," who are seemingly everywhere in the same places yet everyone turns a blind eye as if they weren't here.

The detrimental factor to the successful recovery re-acceptance and mental health of the mentally ill lies in the general attitude of the public and more specifically of relatives of patients.

A brief survey which incorporated an informal discussion with nurses and patients, conducted on one of the male wards of the mental hospital, indicated that several of the mentally ill patients remained at the hospital, sometimes permanently, and without a visit from friends and relatives. Often patient's relatives prefer not to have the responsibility of caring for their relatives, or feel unable to cope with a mentally ill person, even though he or she may be considered recovered. Here, the relative is afraid of taking the risk of having him/her home again because of the fear of a relapse. Others find it difficult to maintain the mentally ill person.

So there is the plight of the recovered (mentally ill) person who returns to a community which rejects rather than accepts him.
Summary

Dr. Richard Browne, psychologist, noted in a paper presented on "Unemployment and Mental Health," that the 1961 Census on mental hospitals indicated "a poor prognosis for recovery for mental patients."

My brief look at Barbadian attitudes to mental health suggests that the mentally ill person encounters considerable difficulty in being re-accepted into society, and more so in his immediate community. Fear and indifference characterise Barbadian attitudes to the mentally ill. As in many societies in the West, tolerance is notably lacking. Tolerance implies a disposition to be patient and understanding with the opinions and practices of others. On the whole, Barbadians show no patience or understanding for the mentally ill. They are treated with indifference, disdain and at best in a pharisaical manner - passers-by pausing only to glance at the afflicted.

There is no formal means of monitoring and controlling mental illness apart from the possible hospitalisation of those members of the community whose deviant behaviour presents a threat to the community and its members.

Government authorities are unconcerned about the "characters" who roam the town and frequent the tourists areas. No action has been taken to remove them. Instead, as Mr. R. Green observed, tourists find such persons objects of curiosity and amusement, and are eager to take their pictures.

This attitude of those "characters" so amusing and strange is not unique to the tourist but is widely held in Barbadian society. The development of the image of the 'madman' is an essential element in understanding the cultural definition of madness in Barbados.
Section II

The Imagery of Madness

This section deals with the way in which madness/mental illness in Barbados, and among a sample of Barbadians living in London and Reading, is seen by the layman, and the causes to which he attributes it. It is concerned with identifying the way in which beliefs and practices help to constitute the social view of madness and how they feature in the development of mental disorder.

Methodology

A survey was conducted among some members of the community in Barbados and England. The survey was divided into two studies. The first study took the form of an informal interview with 40 respondents, 20 male and 20 female - from a larger study which was conducted to determine the levels of psychological impairment. (See Tables Ia & Ib). All respondents were asked one key question:

"What in your opinion is the cause of madness?"

Answering this question the respondents spoke freely about other related aspects of mental illness.

Refrained from asking more than one question because the respondents had previously been interviewed for about 45 minutes, and I wished to avoid 'question saturation.'

The second study took the form of an informal interview with 40 respondents - 20 female and 20 male - (See Tables IIa & IIb). Twenty respondents 10 male and 10 female - were taken from a larger study conducted in Reading to compare levels of psychological impairment between the Barbadian population living in Reading and in Barbados.
## Table 1a

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Occupation</th>
<th>Marital Status</th>
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<tr>
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<td>30</td>
<td>Labourer</td>
<td>M</td>
</tr>
<tr>
<td>t. Andrew</td>
<td>26</td>
<td>Bank Clerk</td>
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<tr>
<td>t. Thomas</td>
<td>40</td>
<td>Agricultural Worker (own land)</td>
<td>M</td>
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<tr>
<td>Christ Church</td>
<td>34</td>
<td>Mason</td>
<td>M</td>
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<tr>
<td>t. John</td>
<td>23</td>
<td>Civil Servant</td>
<td>S</td>
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<tr>
<td>t. Philip</td>
<td>32</td>
<td>Labourer</td>
<td>M</td>
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<tr>
<td>t. Michael</td>
<td>48</td>
<td>Carpenter</td>
<td>M</td>
</tr>
<tr>
<td>t. Peter</td>
<td>29</td>
<td>Waiter</td>
<td>S</td>
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<tr>
<td>t. Thomas</td>
<td>37</td>
<td>Bus Driver</td>
<td>M</td>
</tr>
<tr>
<td>t. Andrew</td>
<td>22</td>
<td>Student</td>
<td>S</td>
</tr>
<tr>
<td>t. George</td>
<td>25</td>
<td>Civil Servant</td>
<td>S</td>
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<tr>
<td>t. Lucy</td>
<td>50</td>
<td>Watchman</td>
<td>M</td>
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<tr>
<td>t. Lucy</td>
<td>35</td>
<td>Nurse</td>
<td>S</td>
</tr>
<tr>
<td>Christ Church</td>
<td>44</td>
<td>Unemployed</td>
<td>M</td>
</tr>
<tr>
<td>t. Joseph</td>
<td>28</td>
<td>Unemployed</td>
<td>S</td>
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<tr>
<td>t. James</td>
<td>39</td>
<td>Customs Officer</td>
<td>M</td>
</tr>
<tr>
<td>t. George</td>
<td>29</td>
<td>Teacher</td>
<td>S</td>
</tr>
<tr>
<td>t. Philip</td>
<td>30</td>
<td>Motor Mechanic</td>
<td>M</td>
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<tr>
<td>t. James</td>
<td>26</td>
<td>Student</td>
<td>S</td>
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<tr>
<td>t. Michael</td>
<td>36</td>
<td>Unemployed</td>
<td>S</td>
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<tr>
<td>t. George</td>
<td>30</td>
<td>Clerk/Typist</td>
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<tr>
<td>Christ Church</td>
<td>35</td>
<td>Housewife</td>
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<tr>
<td>t. Michael</td>
<td>28</td>
<td>Teacher</td>
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<td>t. James</td>
<td>21</td>
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<td>t. Lucy</td>
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<tr>
<td>Christ Church</td>
<td>24</td>
<td>Bank Clerk</td>
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<td>t. Thomas</td>
<td>29</td>
<td>Cleaner</td>
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<tr>
<td>t. Andrew</td>
<td>32</td>
<td>Factory Hand</td>
<td></td>
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<tr>
<td>t. Michael</td>
<td>40</td>
<td>School Meal Attendant</td>
<td></td>
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<tr>
<td>t. Thomas</td>
<td>39</td>
<td>Dressmaker</td>
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<tr>
<td>t. Philip</td>
<td>25</td>
<td>Teacher</td>
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<tr>
<td>t. Lucy</td>
<td>45</td>
<td>Housewife</td>
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<tr>
<td>t. Andrew</td>
<td>43</td>
<td>Housewife</td>
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<td>t. Michael</td>
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<td>Unemployed</td>
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<td>t. James</td>
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<td>t. Philip</td>
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<td>Factory Hand</td>
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<tr>
<td>t. Joseph</td>
<td>23</td>
<td>Unemployed</td>
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</tbody>
</table>
The other 20 respondents, all resident in London, were selected on the basis of acquaintances and on recommendations/referrals by friends. This method of selection was used firstly because of the difficulty the researcher encountered in locating a Barbadian population living in London. Secondly, the researcher felt that he would be able to obtain a representative Barbadian sample from his many Barbadian friends and acquaintances, plus referrals he would receive from friends and acquaintances.

Twenty Barbadians were selected from the London area because the researcher wanted to compare attitudes and beliefs between a Barbadian population living in a suburban town - Reading - and a large metropolitan area - London.

Similar to the study conducted in Barbados, all respondents were asked one key question.

"What in your opinion is the cause of madness?"

In answering the question the respondents in both studies spoke freely about other related aspects of mental illness.

Both samples were matched as closely as possible for sex, occupation and locality. For example, Reading vis-a-vis London and parishes in Barbados. Although the samples in both studies are small, in my opinion the findings reflect to a large degree, public beliefs about the causes of mental illness. I will discuss first the Barbados study.

First Study: The Imagery of Madness in Barbados

Findings

"What in your opinion is the cause of madness?"

The most frequently occurring cause was "studiation."

Things That Set People Mad

1 Study/Studiation

A. Collymore, 1970, pg. 103 defines study in his book Barbadian Dialect a:
"To give thought to, to pay attention to, as I didn’t study I would ave to do this, or I have to go and study feeding the fowls.

He relates the noun "studiation" to madness.

Too much study can set a man mad. Studying is usually associated with worry.

What yuh studying about?

However study is not always associated with worry; as in the case of 'book study' or 'thinking about.'

1) I gotta go and study muh books
2) I was studying about you all nite

It also means 'to worry about,' to play on one's mind.'

1) I was studying how I gine make ends meet, girl, so I din get a wink a sleep.
2) Doan study to hard son, tek yuh time, doan let dem books sen yuh mad.

dness and Studiation

Response to the question, "What in your opinion is the cause of madness/ sends people mad?" one of my respondents replied;

"Studiation set yuh mad. When yuh study too much it humbug yuh brain. Yuh go to sleep studying one thing, it does hurt yuh brain. It's best tuh think about several things, so dat yuh wont tire out yuh brain and humbug yerself. Dats why lots of people in Jenkins, dere study too much an' keep udyng one ting all de time. After a time yuh brain work so hard it turn h head. Once yuh head gone yuh have fuh go to Jenkins." Jenkins is the local mental hospital.)
The Ill Effects of Study in Courtship.

is believed that when conducting a love affair one must be careful to safeguard against certain hazards. As illustrated later, it is believed that when a jealous lover is crossed and finds out what has happened, he or she subsequently injures the ex-partner. The effects of unrequited love can be very damaging. In this next example, the term 'study' is used to mean thinking deeply about.

Boy why yuh studyin' she so fuh, yuh dunno she gine sen' yuh mad. Dwell too much on the loss of a lover is believed to be another frequent use of madness.

The Educated Boy and Madness

Yuh keep studyin' all dem big books, dem gine sen' yuh mad jus' like how m do lawyer Clarke.

Other frequently reported area of madness was madness induced by others; in other words 'people set yuh mad.' Here, evil spirits and the obeah man were powerful forces affecting the lives of others.

People set you mad

I'll recount some of the many stories told to me by the respondents about people harming others. This power to harm and control people, especially lovers, is attributed to the practices of obeah.

People can 'do yuh tings,' 'work tings on yuh' or 'give yuh something to eat or drink.' This power to harm and control people, especially lovers and enemies is attributed to the practice of obeah.
Pansy was living wid Dougie, and wen he wife get to find out she put something in Pansy food and hamper she.

Thw word 'hamper' means to 'turn stupid or send one mad.'

One respondent said to another,

'Do yuh know how Mrs. Griffiths daughter went off?'

'No!' the other replied.

'Well lemme tell yuh, she husband heard she was going around wid another man, so he give her someting to stop her seeing de other man, but he miss and put too much in she drink, and she went off.'

Another respondent said,

'The same sort of ting happened to Herbie up de road. He went to the church excursion and being a fast eater he tek some food from one of he old girlfriends, when he get back home he started crawling all over the floor like a child, sense den he turn foolish foolish. Yuh should never eat fast, fast eating ain good, cause what go down in yuh can't wash out.'

A fast eater or fast eating, means, being very greedy, eating without due consideration to the circumstances.

Another respondent replied,

'Look what happened to Ada-Breed. His brother girlfriend bake a cake an sen' it down to the house. When the cake come the brother was out, so dem mother put it in the larder till the brother come home. Ada-Breed being fast and greedy, din ask any questions, but went and eat de brother cake, and from den till now, he walking 'bout de road shouting, I wanna get married.'

People can harm others not only through food and drinks but by using something they own.
Here again, several examples were given by the respondents.

**People can tek piece of yuh clothing and put it wid de dead and it would set yuh mad.**

**If people get hold of yuh hair they could set yuh mad, mad. That’s why my mother always tell me to burn any hair dat fall from meh head.**

**ther items of clothing that can be used to send one mad are:**
- hoes and socks
- persons hat (here the sweat band is the object of attention)
- underpants/undies and/or
- ankerchief
- brief, any palt of the person’s property which absorbs perspiration.
- othes that have been washed and not currently being used are not preferred.

**other widely held cause of madness was ‘taking things on.’**

**Taking Things On’ Can Send One Mad**

A person believes others are doing wrong things to him, he may go mad as a result of his belief, and not because of witchcraft/obeah. The manifestation of evil and wrong doings credited to obeah has made it into a very powerful force/system which is widely feared and believed. This belief is further strengthened when one encounters some bizarre occurrence for which there is no logical explanation.

**e respondent explained her belief in obeah this way:**

* I find some of it hard to believe, but yuh got to believe tings can happen, and they do happen. On this earth there are good and evil spirits. d the evil spirits have a lot of power and can cause tings to happen.
- ere are wicked people who use these evil spirits aganist others, but yuh could not believe in dem, it could get on yuh brain and so yuh start lieving that somebody is doing yuh something, this could sen yuh to a mad-use. I try not to believe in dem tings. I just leave everything to God.

**is more powerful than de devil.**
While another respondent gave an example of 'wickedness and devil possession.'

Miss Watkins jus' stan' so and went off. Everybody believes that somebody put a duppy on she. Everytime yuh pass by she house yuh could hear she groaning, while dis ting in the house licking down de chairs and throwing down de pots. Somebody said dat she din pay de Indian man so he ut a baccon on she. Those Indian people can be very wicked yuh hear.

Some other causes of madness reported by the respondents were:
lining (lying in) colds (post partum psychosis)
high blood pressure
inheritance
your lover leave you
shock or excitement
studying about what you can't get
weak nreves
'a grudge-ful minded person' (someone who envies one for what one has)
working (physically) too hard
studying evil
poor food
getting your head wet after having your teeth extracted

Lining colds (Post-partum Psychosis)

Mr. Walker granddaughter had a baby only a few days old, instead of stayin' in she went to de shop, although she know she shunt go, she got wet, and from den she went to Jenkins.
Another example cited was,

*My sister Doris went mad from a lining cold. De roof of de house galvanised so de heat of de day and de cold at night gave her a lining cold and fever, den she went mad.*

**High Blood Pressure**

High blood pressure is also believed to be a cause of mental illness. It's believed that anyone who has high blood pressure - hypertension - andalk about when the sun is high - at its hottest - runs the risk of aggravating their condition. This causes the person to experience izziness, black-outs and possibly periods of memory loss. On most occasions the memory loss causes a disturbance in behaviour patterns which is usually judged to be madness of a sort.

*s an elderly lady pointed out:

*De pressure goes up wid de sun, when yuh got de pressure de sun doan agree wid yuh atall. If I stan' or walk in de sun too long, meh head start to swing and tro me offside.*

**Heritage**

is is self explanatory, it is believed that madness can be passed on from parents to children, or at least that mental illness runs in some families. In our society this view is substantiated by such writers as R.D. Laing).

*s some respondents commented:

*Some have it (mental illness) by nature. Yuh know it run in families.*

*Other observed:

*Miss Goddard mother went to Jenkins and so did she brother, and now she in dere too, it like it run in de family. Someting must be wrong wid dem blood. Yuh know some people have bad blood.*
Other Related Aspects of Madness

There are two groups of characteristics which are consistently associated with madness. These are:

1. Wild, unpredictable, violent and frightening behaviour, and
2. Foolish amusing pointless behaviour.

(1) A mad man is unpredictable.

The actions of a mad person are regarded as highly unpredictable. He is capable of fits of extreme aggression without a warning. (This idea of the unpredictability of a mad person survives across cultures).

(2) Foolish, amusing behaviour.

Foolishness and amusements are usually associated with madness.

"A mad person does funny things like talking to themselves and sweeping the floor with no broom."

Never sometimes amusing and foolish behaviour, when accompanied by violent acts is not associated with madness.

In Bridgetown there is a character called 'Sharky' who haunts the 'bus stations' acts foolishly and is quite amusing. I have never over-heard anyone referring to 'Sharky' as a madman. Everyone regards him as an 'idiot' someone who has less intelligence than they have, although it is often said that 'Sharky has his good sense.'

Though Sharky sometimes becomes aggressive and violent - usually when excessively taunted by passers-by - he has never been labelled mad. This may be due to the observers realisation that his out-bursts results from
their taunting, and are not self-induced.

The Flexibility of the Mad Label

For most Barbadians the 'mad' label is flexible. The extent of this flexibility can be observed at the village or local level. Members of a village seldom label people from their community as mad. The behaviour of the mad person/s is usually viewed as foolish and amusing. The underlying reason being that by labelling members of their own community as mad, they are exposing the same member to verbal attacks and inuendos from outsiders.

"You live in de Bay land? Man you must be mad, all de people who live down dere mad."

Fisher (1973) in his study of village Barbados, recounts a discussion he had with a village woman about the local madman.

"Moon ain mad, he just study too much high books. He wants to be a magistrate or lawyer. He read a lot auh books and it turn he so, but he ain mad. He half foolish, I wouldn't say he mad. He wouldn't hurt nobody. He was at Jenkins, but dey say he ain mad, he just read a lota books."

Here the woman outlines the reasons why she and others consider 'Moon' not mad, because 'he half foolish' and therefore 'wouldn't hurt anybody.'

Fisher (1973) further recounts a statement from a 12 year old girl who explains her understanding of the distinction between 'mad' and 'foolish.' The term 'foolish' is equated with being 'bewitched.' She goes on to point that 'Moon' in Fish Village is mad. The only madman in the village is "the one who walks through the village."

"Madmen are violent, if you are bewitched you might be violent, but not dangerous. It is more like you foolish. Gert and O'One Sally more foolish and bewitched than anything else. O'One Sally pelts stones but she never hit
nobody. Nobody in Fish Village really mad. Dere is one madman who walks through the village with a sword. One of the young boys pelt a stone at he and he actually hit the sword. He run them with the sword. The same man cut a man (in the next village) for no reason at all. He is a real madman."

One respondent said,

"A madman is violent and strong. If someone is bewitched or foolish there is no extra strength an he will return to normal. Dey know what dey are doing."

Discussion

Underlying the villagers subtle distinctions and qualifications of madness, is an aspect of social reality which should not be overlooked.

Villagers living in the same community as a madman, often knew him before he became 'mad.' They not only know the madman, but also his extended kin. The villagers therefore know how to interact with the madman, and he with them. There is an unwritten code of conduct between the village madman and the villagers. This code of conduct is not applicable to people from outside the village. This means that the level and type of 'mad behaviour' which the villagers tolerate and accept may be viewed as intolerable and unacceptable by outsiders.

However violent and homicidal acts by the mad person would be severely censured - irrespective of the village community - and labelled as a sign of a 'real madman.'

Types of Madmen

In Barbadian folklore there are two types of madman. These are:

(1) A sensible madman.

(2) A peaceful madman.
Besides being foolish and amusing to most people, the mad person in Barbadian society is seen as having 'mad sense,' which he uses to manipulate and confuse others. Sometimes pretending to be mad, at other times really being mad.

A classic example of a sensible madman is described in Peter Wilson's book "Oscar" - a sensible mad-man of the same name.

"Every madman got he good sense," is a remark often heard during any conversation about madmen. This statement was further supported by an incident I observed, and from stories told by my mother.

While I was in England, one of the inhabitants of my village had to be hospitalised because of mental illness. On returning, I inquired about him, whereupon my mother promptly replied:

"Who Darcy? Boy he ain mad. He walk about fooling everybody that he mad, but he can't fool me, he got he good sense. He know who to trouble and who to frighten. I betcha he wouldn't trouble any of you all."

"Why?" I asked.

"The other day he came knocking on my window, when I look out he start up one set a cursing. I told him that if he don't move from my window I would put two dead spirits on him. Boy you should see how quickly he ran off to his house.

Yesterday, just before you came home, he was cursing everybody in the gap. When he saw me looking out through the window he said, 'You Mrs. Clarke, I ain talking about you, wunno so believe in too much obeah, yuh wants to sen me mad, but yuh won't.' Since then he didn't trouble or interfere with any of my children."

The experience of Darcy's violence and 'madsense' occurred one night when I was on my way home.

Situated quite near to my parents' home is a post-office. The Post Office is adjacent to Darcy's house. On the night in question I witnessed Darcy
attacking the post-office and the watchman with a crow-bar. Having done considerable damage to the post-office, he ran into his house and locked all windows and doors.

When the police arrived several minutes later, Darcy refused to answer when they called. For the rest of the week, and a long time afterwards Darcy kept a low profile, scarcely seen. His behaviour after the incident was construed as example of 'mad sense' by the other members of the community. Here Darcy displayed awareness of his actions. It is this awareness of actions that determine the community's reaction to the mad person.

Madmen Are Unaware Of What They Do

If an individual behaves in a manner that he could not know what he is doing, because if he knew what he was doing he would not do it, he is acting like a madman. 'Lack of awareness' is a necessary, though not sufficient condition to complete the image.

Violence and foolishness are observable in a person's behaviour, but the fact that someone is aware of his actions, must be indirectly inferred from the quality of his actions, or the content of his speech. Conversely, any evidence that a person is performing organised, purposeful behaviour will mitigate against the mad label.

A Peaceful Madman

Wild, unpredictable, violent behaviour is the primary indication for the application of the ('mad label'). However, the mad label can be less strictly applied if the mad person exhibits all the characteristics of madness except violence. He is labelled 'a peaceful madman.'

Summary

Awareness of one's actions or purposefulness of behaviour indicates a 'sensible madman.' Evidence that one is unaware of one's actions, but
does not manifest violent features, qualifies a peaceful madman. Conversely, if the individual is manifesting unpredictable and foolish acts against himself, or community members, he completes the mad image and is labelled a 'real madman'. A 'real madman' or lunatic, is the strongest label used by the community to describe mad behaviour. It is the unpredictable nature of the madman's actions that invokes the community's censure of mad behaviour.

As a respondent reminded Fisher:

"We call Martindale mad, but that doan necessarily mean he bound for Jenkins. The term (mad) is more general than that. If someone is annoying me all the time, I'll say 'look man, doan get me mad, yuh'. They feel that most mad people are raucous, frightening and everything. Any person could get to that point. But yuh won't know when a mad person might pass and start beating you. It isn't predictable madmen like Martindale who won't lay a hand on you, but the others would chop you up".

The mad label is awarded, primarily on observed behaviour, which people associate with madness. Hence a depressed person is not usually called mad. Secondly, the label is affixed on interference drawn from the quality of one's actions.

"It is the actions which show us if a man is mad or not. First thing people say 'look at dah madman.' Everything is action, yuh know dem by dere mad acts, and it makes yuh know that he is a madman. Who could for no reason atall chop up a man in a car."

The label is also affixed because of the content of one's speech:

"Madmen always talk a lotta rubbish. They don't make sense."
We have seen that the mad label is less strictly applied by villagers when describing 'mad behaviour' of their local madman. The stereotype is more structured than the acts themselves. Non-verbal communication between madman and community members is highly refined. Villagers can always tell when the madman is 'going off.'

The openness of the mad label means that a wide range of bizarre, amusing and foolish behaviour is accommodated within the community. The term 'mad' is used by others to vent their disapproval of a particular action or situation. It is used to describe individuals who indulge in mad acts; it is used in verbal play. It is only firmly affixed when it refers to or describes unpredictable, violent frightening or homicidal behaviour.

The primary cause of madness gathered from interviews with adult individuals revealed that 'studiation' is most frequently indicated. A semantic analysis of the term 'study' clarifies this finding. Worry, concentration and the activity of learning are the basic elements of study, which are believed to cause ill effects and madness in severe cases. Too much talking of any kind, on any subject is hazardous.

Enemies do on occasion 'interfere with people,' and even turn them mad or foolish. They usually accomplish this by giving their victims something to eat or drink, or they 'tamper' with their clothing.

However people are their 'own worst enemies.' Individuals reported cases of madness resulting from 'overstudy,' 'digging' at elusive dreams and worrying over them. Some individuals set themselves mad by believing that an enemy is 'working on them' or that their lovers or families are resorting to trickery or obeah.

Diet, injury lining colds, loss of teeth, masturbation, inheritance and wickedness are all causes of, or related to, madness. Lining colds affect
only women, but masturbation as a cause of madness is reported infrequently by young males, while loss of teeth is reported by older people. Wickedness is a primary cause of madness according to church-going Christains.

It is not difficult to understand the problems that patients encounter in every aspect of life during their recovery, when the general view of mental illness is that madness is permanent and pervasive. A madman can 'go off' at any time, and everything he does reflects this madness. Madmen do violent and frightening things which are troublesome. They are a danger to themselves as well as others.

The above attitudes may also contribute to the poor prognosis for recovery. The 1961 Census of Mental Hospitals in the Caribbean, reported that approximately 80% of all patients at the Barbados Mental Hospital have a favourable prognosis for recovery, with a prospect of long-term hospitalisation.

Imittedly this report is some years old, and much has been done to increase the percentage of cured persons. However the general tone of the report is relevant. Much more intensive research, as well as public education has to be done if significant results are to be achieved.

ese findings raise further important questions for Barbadians living in England. Questions concerned with the effect of acculturation on immigrants' traditional values, ideas and beliefs. Has immigration altered Barbadians' respondents' traditional/folk 'imagery of madness?' If yes, to what extent? What factors are responsible for the change?
The second study was conducted among Barbadians living in Reading and London, U.K. in order to compare their ideas and beliefs about madness with those of Barbadians living in Barbados.

A group of 40 persons were interviewed, 20 from Reading and 20 from London. The 'English sample' was matched with the Barbdian sample, and the Reading sample was matched with the London sample for sex, age and occupation, (See Table IIIa & IIIb).

The London sample was included in the study because the researcher wanted to compare/contrast the ideas and beliefs of the two groups. It was hypothesised that ideas and beliefs about mental illness held by Barbadians in Reading would be more consistent with those expressed by Barbadians in Barbados, than ideas and beliefs held by Barbadians living in metropolitan London.

The most frequent reported responses/statements are recorded below.

Findings - Studying Too Much

As noted in the first study the word study was given several meanings, for example, it can mean 'book study,' 'worrying,' 'thinking about or meditating.'

This was neatly put by one respondent who noted:

"To tell you de truth too much studiation and botheration can upset yuh. These days the children so hard ears dat they drive yuh crazy. I know a friend a mine who recently had a breakdown. She is always studying 'bout this and that, plus the man she got ain no good. Instead a fuhgettin' de good fuh noughing man, she spend a lotta foolish time thinking 'bout him."  (Reading female, age 47).
### Male Respondents of the London sample

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### Male Respondents of the Reading Sample

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### Female Respondents of the Reading Sample

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<tr>
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Another respondent:

"Yuh know when I was at home I never used to study to much yuh know. These days I find myself studying 'bout everything. Sometimes I study so much that I feel like I gine go out meh head." (London female, age 40).

Book Study

Diligent study has for many years been associated with madness. We usually associate brilliant people with eccentric behaviour. Studying too hard is associated with nervous exhaustion.

A respondent issuing a word of warning to me pointed out:

"I'll tell you this son; some Bajans are here and they want to grab at everything. They want to work and study and yuh know what happen, half of dem gone foolish and de other half give up." (Reading male, age 45).

A young respondent recalling his school days:

"There is this friend of mine called Tony who used to study too hard, when we were at school he always used to be studying. A few months ago I heard he went off." (London male, age 27).

People Can Harm Yuh

Another frequently reported cause of madness, was madness inflicted by the evil machinations of others. This belief is closely tied up with obeah and witchcraft.

The belief that 'people can harm each other' was reported mainly by respondents over 40 years, while the younger respondents in both samples reported 'evil deeds' of others as a cause of madness. They pointed out that they had heard such stories from their parents or grand-parents. Beliefs about
Obeah and its influence were not firmly held by most of the respondents, they remained sceptical. However one respondent, who had been mentally ill firmly asserted:

"I know a friend of mine who had a woman, she mess him up man. She gave him something wrong to eat and drink. My mother and grand-mother told me that people can work obeah on yuh. My aunt's husband is in Jenkins because someone did something to him. As a matter of fact that's how I had my first breakdown, someone put something in my room and everytime I go in de room It make me frighten. That's why I am away." (London male, age 25).

An elderly respondent violently expressing his considerable distrust of women because of their evil tendencies said:

"I don't know about anybody else, but let me tell yuh something. Yuh can't trust anybody, especially women. It nearly happen to me to. Women are dangerous so - and -so's. They always scheming. If they see yuh talking with another woman, they get jealous. If they can't get yuh one way they try to get yuh another. Some of them put things in yuh food and mess about with your clothes, so they can turn yuh foolish." (Reading Male, age 56).

Too Much Pressure

St young blacks put (social) pressure, or the stress and strain of modern living as the most frequently occurring cause of madness among all age groups the London sample, and especially among the young, 20-45 years old.

Living in a large city like Londén exerts considerable pressure on blacks of age groups. Even those London respondents who cited various 'folk' beliefs as causes of mental illness, include the stress and strain of living in London as one of the main causes of mental illness.
Two young respondents stated:

"Brother the place is rough man, especially for the black man. Think about it he can't get a good job. All duh offer him is a dutty job wuh de white don't want and duh expect we to do it. He cannot get a decent place to live and whereever he goes the police hassle him. Man dat's enough to drive yuh mad." (London female, "age 22).

Another said:

"Is the pressure de black man face in dis society man, that's why some of them freak out. It's sad though, but look at America, yuh doan see how the black man catch he ass there. In the 60's a lott a dem went mad." (London male, age 24).

The 'pressure' the black man experiences in Britain society has been repeatedly cited as a main cause of mental illness. Both by researchers, social administrators and policy makers.

As one respondent thoughtfully noted:

"It is the combination of several things, social stress in the society, discrimination, prejudice, a weak constitution and the rough experiences some black people had. Some of them came hoping to do well and they get disappointed." (Reading female, age 26).

As a middle aged respondent, resident in England for 20 years, reminded me:

"When I first came here things weren't so bad. True we had difficulties in finding some place to live, but dere were plenty jobs. These days things get really tough. Yuh can't get a job, a decent place to live, there is so much public harassment. Everything seems so crazy. These days dere are so many black people going mad, yuh never used to hear
about black people going off. And it is not only the older generation
a lotta young boys going off.
Yuh see dere is nothing fuh dem to do. They doan have any certificates,
and all de jobs they offer them is dirty, dirty jobs. I doan know
what's gine happen, things look really mad. Somebody gine have to do
something about this situation because I think things going from bad to
worse." (Reading female, age 65).

Some other causes of madness reported were:

(1) Bad treatment.

(2) Retribution.

(3) Bad or wild living.

(4) Not eating right, or living right.

5) People living in an environment where they can't get what they want.

6) Broken marriages.

7) Lining colds.

1) Bad Treatment

ad treatment usually refers to ill-treatment received by a woman at the
ands of her husband (legal or common-law) or lover. It is fairly common,
specially among the working class. for a woman to be beaten up and
erally ill-treated by her partner.

"You see too much bad treatment ain't good, it sometimes cause yuh
nerves to go." (Reading female, age 34)
(2) Retribution

Retribution is said to follow individuals who committed some form of unlawful act, or who willingly took advantage of a person or persons, when they were not able to defend themselves.

As one respondent warned:

"Some people go mad because they reap what dey sow. Some of dem do a little wickedness and expect to get away wid it. But God is not sleeping."

(Reading female, age 40).

(3) Broken Marriage

Here the socio-psychological pressure caused by broken marriages is cited by respondents as a cause of mental illness.

"I started feeling weak in the head - like if I was drunk - when muh husband left me. That ting really hurt me. After all I had done for that so-and-so, he pick up another woman. Boy, I was depressed fuh weeks, jus' couldn't get the food down. I like I had a lump in muh throat. Anyway I feeling much better now." (London female, age 30).

(4) Not Eating/Living Right

This expression refers to individuals who eat high in carbohydrates and low protein and other essential vitamins. Such individuals usually smoke and drink (alcohol) 'hard,' and don't take proper care of themselves.

One respondent cautioned:

"If you are not eating right, not looking after yourself, combing your hair, dressing right, eating a lotta bad food, and every night out smoking and drinking hard, yuh run yourself down, and before yuh know yuh gone mad." (Reading male, age 38).
(5) Lining Cold

Commonly called post-partum psychosis in Britain, a lining cold happens to
omen who leave their beds and walk on the street soon after having a baby.
This was cited by only one of the U.K. respondents who said:

"Yuh probably wouldn't know anything about this, but some women go
funny, act mad soon after dey have a baby. When I inquired why this
was, she replied,

"Well it's because they get up too soon after having de baby. They
don't allow the body to close back." (London female, age 35)

The various causes of madness were neatly summarised by one respondent
who noted:

"Dey used to say many tings that can cause yuh to go mad dat I don't
know where to start. I remember my mother telling me stories about
tings that happen to people when I was small. She said that if yuh
work too hard yuh can go mad, or if somebody work obeah on yuh or give
yuh something to eat. Have yuh ever seen some men in Barbados with
dere hair matty like it dropping out? Well what yuh tink cause dat?
Dey eat bad food.

Somehow madness mus' be in the family yuh know. However I think people
dese days go off because of too much tension. Things happen to yuh and
yuh keep it to yourself instead of talking wid someone. It build up
'till one day yuh jus' break down. Yuh see at home we would be able
to talk to people, but here everybody too busy minding dem business
and don't have time to talk to yuh. So tings jus' get too much."

(Reading female, age 33)
t was discovered that among the older women - 40+ - attitudes and beliefs about mental illness and its causes corresponded closely to those of the matched group in Barbados. Despite the fact that most of the women had been resident in the U.K. for over 15 years, their beliefs appeared to be as strong when they first arrived. They did not seem to have been influenced greatly by the media or any other information services. However, they were able to accept some of the reasons given as causing mental illness, such as the pressures of discrimination and certain kinds of stress.

Most of the respondents were able to cite cases of people they knew or were acquainted with being 'sent mad' by the evil intentions and malicious thoughts of their enemies; the older the respondent the more firmly these views were held.

The younger women in both the London and Reading group were more 'western' in their outlook, having been exposed more to modern, 'scientific' concepts of mental illness. They did not reject the beliefs of their parents/grandparents out of hand, but found that they stretched their credibility. Western, European-type ideas were more reasonable and they were able to relate stress to the causation of mental illness.

Unlike the matched group in Barbados, the over 40 males in both groups did not hold deep obeah beliefs. They held similar beliefs to the women in the British group but were not so vehement about them. It was commonly thought that women were the main instigators of mental illness. Women had the knowledge - which was handed down by their mothers - and the ability to turn people mad. The older men believed that women were able to put various concoctions in food that would send people crazy.
st of the younger men in both groups felt that 'pressure' was the major cause of mental breakdown. Pressure is an all-embracing term which encompasses the feelings and result of discrimination; the stress resulting from the ability to find a job; frustrated ambitions and the crushing weight of simply jjing to survive in an alien, and very often hostile land.

ese feelings are often expressed graphically in music and poetry, especially 'roots' reggae and the more popular black poets such as Linton Kwesi Johnson. The whole concept of pressure was vividly illustrated in a film of at name, directed by a West Indian, Horace Ove.

ing said all this, there was in the sample two young men who said when interviewed, that their illness had been caused by a malicious individual or individuals, interfering with their thoughts.

ditional/folk ideas about the cause(s) of mental illness were held more only by older men and women in the Reading group than in the London group. e tenacity to traditional ideas is due largely to the presence of a large mogenous and cohesive Barbadian society/community. Here, respondents, have eir near relatives and extended kin in the same locality/neighbourhood. ere is therefore a greater strength of traditional ideas and beliefs, which constantly being reinforced by one’s parents, grand-parents and older latives.

he other hand, in London, although there is a larger Barbadian population an Reading, there isn’t a Barbadian community. Barbadians are dispersed, rely does one find a Barbadian with parents and extended kin living in the e neighbourhood like it is in Reading. There is less reinforcement of trad- tional ideas and beliefs. Further, the pace of life and the peculiar nature of tropolitan society militates against the survival of folk ideas and beliefs.
However in both Reading and London, the effects of assimilation, acculturation and exposure to developed western ideology has diluted and in some instances altered the traditional ideas and beliefs respondents and other Barbadians had about (madness)/ the causes of mental illness.

It can be seen that although certain views are more extreme in particular groups, there is a degree of overlap, and it is possible to find people who believe in both the traditional and modern concepts of mental illness.

Ideas and beliefs about mental illness and the mentally ill do not suddenly appear in adult life, but are formed early on, as part of the process of socialisation. Children soon learn that the 'madman' is someone to be viewed differently from the rest of the population, either with fear, distrust and/or derision. Their attitude to the mentally ill is coloured by stereotypes presented by the 'adult world,' through parents, teachers and media.

We will examine the ways in which these ideas are developed and reinforced by studying two groups of children, ages 9-10 and 13-14 in Barbados and London, England.
Illymore, F.A.  
Barbadian Dialect, 1955.

Isher, L.E.  

Hilips, D.  
Rejection of The Mentally Ill. Influence of Behaviour and Sex. 
In this chapter I discuss the findings of my study on attitudes to madness/mad people among children aged between 9 and 14 years. The study consisted of a sample of children attending school in Barbados and in London, England.

The Barbadian sample was comprised of two groups:

**Group I** consisted of 16 children, 5 boys and 11 girls aged between 9 - 10 years attending a mixed school.

**Group II** consisted of 11 children, 6 boys and 5 girls aged between 13 - 14 years, attending the same school as the 9 - 10 group.

The London sample was comprised of two groups:

**Group III** consisted of 25 multi-racial children, all girls, aged between 13 - 14 years. These were classified below average achievement attending a comprehensive school in West London.

**Group IV** consisted of 19 multi-racial children, all girls, aged between 13 - 14 classified above average, attending the same school as the children in group III.

The objectives of the study were:

1. To find out the attitudes of a small sample of Barbadian school children to madness/mad people.

2. To see how these attitudes differed from those of adult Bajans, and

3. From those of a small sample of multi-racial children living in London.
Method of Enquiry

Before describing my method of enquiry it is necessary to briefly outline the constraints which severely limited the study.

Time, lack of finances and official "red tape" restricted my being able to interview a more representative sample of school children in Barbados and in London.

I arrived in Barbados to undertake my research during the summer vacation and returned to England a week after school commenced. During my two month stay in Barbados, I was unable to establish any meaningful discussion with the education authorities. It was therefore necessary for me to enlist the assistance of a friend who taught English in a mixed junior school.

A set of five questions were given to the teacher who supervised the children. The questions were to be answered in the form of an essay. The questions were:

Who or what is a mad-man?
How do mad people behave?
What kind of things mad people say?
What are your reactions to a mad person?
Do you know a mad person, if so, could you describe him or her?

A similar exercise was given to a sample of multi-racial children attending a comprehensive school in West London.

Here I wanted to match the samples for age, sex and ethnicity, but was unable to obtain official permission to carry out the study. Once again I contacted a friend who taught and was willing to assist in obtaining a sample, supervising and administering the questionnaire to the respondents.
The exercise given to the English sample varied slightly from that given to the Barbadian sample in that there were two additional questions. These questions were:

- Are your reactions to the mentally ill/a mad person, different from most people?
- What do you think society should do about mad people?

The Barbadian Sample

Group I

The 9-10 age group consisted of 16 children, 5 boys and 11 girls. Here are the main observations from 9-10 age group in response to the following questions.

Who or What is a Mad Person?

"A mad person is someone who has,

- a sick brain
- a bad brain
- a mixed up brain
- a weak brain, and
- no brain."

How do Mad People Behave?

"Mad people behave,

- foolish, silly and stupid, like idiots,
- as if they are out of their heads."

They break people's windows,

- look cruel and like to fight,
- act ignorant and drunk and do things they should not."
What Kinds of Things do They Say?

"They say things without meaning, like curse and talk a lot of bad language."

What are Your Reactions to a Mad Person?

Table I records the number of the sample giving non-enlightening responses about what they think about mad people.

Table I

<table>
<thead>
<tr>
<th>Statement</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mad people have no sense</td>
<td>4</td>
</tr>
<tr>
<td>Mad people have no brain</td>
<td>6</td>
</tr>
<tr>
<td>Mad people have no shame</td>
<td>1</td>
</tr>
<tr>
<td>Mad people act like idiots</td>
<td>2</td>
</tr>
<tr>
<td>Mad people are very ignorant</td>
<td>1</td>
</tr>
<tr>
<td>Mad people are foolish and funny</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td><strong>11</strong></td>
</tr>
</tbody>
</table>

Contact With the Mentally Ill

Table II records responses to the question.

Table II

"Do you know a mad person?"

<table>
<thead>
<tr>
<th>No.</th>
<th>Age-range</th>
<th>Sex</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
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<td>9-10</td>
<td>M</td>
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<td></td>
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<td></td>
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<td></td>
<td></td>
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<tr>
<td></td>
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<td>Yes = 6</td>
</tr>
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Summary

The 9-10 age group which was the youngest group, reported that a mad person was anyone who had something wrong with his brain; it was either, "sick" and/or "bad." They felt that mad people often behave in a very "foolish and stupid" manner as if they were out of their minds. They acted as if they were drunk and liked to talk "a lot of bad language."

Ten of the children had contact with the mentally ill. They viewed mental patients negatively and regarded them as objects of derision and amusement.

This was best summed up in two essays by Maurice Johnson and Marva Cummings. Maurice noted that,

"A mad man is someone whose brain is sick. Madmen behave like idiots. They curse and talk a lot of bad language. They act foolish and most people think they are funny."

While Marva observed that,

"A mad man is someone who has a sick brain. Mad men behave as if they are out of their heads. They say bad words, act ignorant and drunk. People think badly of mad people because they don't act right."

Group II

The second group consisted of 11 children, 6 boys and 5 girls. The main observations from this group were:

Who or What is a Mad Person?

"Someone who,
suffers from some kind of mental disease,
doesn't know what he is doing,
study a lot of things they shouldn't study."
Fifty percent of the sample reported, "Studying and thinking a lot," as the main cause of mental illness.

The pattern of response from Group II is different to that of Group I, and is similar to the adult population sample in Section I, Chapter 6.

How Does A Mad Person Act?

"A mad person acts,
insane,
funny and strange, and
wicked, like the devil."

Over 60% of the sample felt that a mad person acted funny and strange.

What Kind Of Things Do They Say?

"They curse and talk a lot of foolishness, say out of the way things without meaning."

Eighty percent of the sample reported that a mad person usually uses indecent language. This response was very similar to that reported by Group I - the 9-10 age group.

What Are Your Reactions To A Mad Person?

Table III records the response to this question.
Table III

<table>
<thead>
<tr>
<th>Statement</th>
<th>Response</th>
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<tr>
<td>&quot;Mad people,&quot;</td>
<td>4</td>
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<tr>
<td>should be put in hospital</td>
<td>1</td>
</tr>
<tr>
<td>have no brain</td>
<td>3</td>
</tr>
<tr>
<td>are fools</td>
<td>3</td>
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<td>non-response</td>
<td>3/11</td>
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</table>

Contact With The Mentally Ill

Table IV records response to this question.

Do You Know a Mad Person?

Table IV

Number of Barbadian school children in sample claiming contact with mad person.

<table>
<thead>
<tr>
<th>No</th>
<th>Age Range</th>
<th>Sex</th>
<th>Response</th>
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</thead>
<tbody>
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<td>13-14</td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Yes = 5</td>
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</table>

Commentary

There is a commonality of attitudes towards the mentally ill, in both groups. The attitudes of Group II are nearer to the attitudes of the adult population than Group I.

Nine of the eleven children in Group II knew someone who had been hospitalised and held negative views about them. They felt that the mentally ill
should be hospitalised because they acted like fools and were dangerous. These views are summarised in two essays written by two children from Group II. They noted that,

"A madman is a person who study a lot of things that they shouldn't study. Mad people do not know what they are doing or saying. They usually curse and talk a lot of foolishness. People think all madmen should be put out of the way, (in hospitals) and I agree."

"I think a mad person is a person suffering from some kind of mental disease. Madmen behave in a way that they shouldn't. They say out of the way things, act insane and are dangerous. Some people think that all mad men should be put in a place by themselves."

The English Sample

Here I reported the observations from the English sample. The 13-14 below average age group will be discussed first. The main observations to the questions were as follows:

Who/What Exactly Is A Mad Person?

"Someone who,

doesn't act normally,

acts strange,

is deranged in the mind, insane, crazy,

frenzied, irrational, angry and enraged."

Most of the respondents reported "not acting normally," as the best indicator of madness. Therefore, anyone not behaving as others expected was viewed as "crazy."
How Do Mad People Behave?

"They swear at you, carry dangerous weapons to injure you, they also try to commit suicide."

"They walk the road and talk to themselves."

"They sometimes go around threatening to kill people."

"They do silly things like sweeping the floor without a broom, for example, there is a woman down my road and she throws urine on the pavement, takes rubbish out of the dust-bins and puts it in her bag and takes it home."

"You can always tell when someone is mad, because they stare at you or sometimes laugh all the time."

"Mad people behave as though they don't know what they are doing, like when people are driving at full speed, a mad person would just walk out in the middle of the road, without waiting for the cars to stop."

"Talking to themselves" was the most frequently reported activity of a mad person.

What Kind Of Things Do They Say?

"They say stupid things, and go around shouting and swearing at people."

Are Your Reactions To A Mad Person Different From Most People?

"I feel sorry, like other people for them and thank God it isn't me. I would like to help them in any way. Something should be done for them. Most people feel sorry for them. I feel sorry for them because their life must be difficult, sometimes people call them all kinds of weird names."
Do You Know A Mad Person?

Table V

* Number of U.K. sample claiming contact with people hospitalised for mental illness.

<table>
<thead>
<tr>
<th>No.</th>
<th>Age Range</th>
<th>Sex</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>N=25</td>
<td>13-14</td>
<td>F</td>
<td>No = 9</td>
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</table>

*Yes = 16/25

What Do You Think Society Should Do About Mad People?

Here are the most frequently reported views.

"They should be put on an island with every comfort and some normal people should help them to live as comfortable and normal a life as possible. Locking them up only makes them worse."

"They should be helped, not locked up. There should be a convalescent home for mad people, so that it is like a holiday where they can learn and be given the right attention. They need to be happy again."

"They should not be locked up, but put in a place where there are others with the same sickness, a kind of place where they can't just walk out."

"They should be put in an isolation hospital until they find a cure for them."

"They should be left alone, it is not their fault that they are mad. Society should build a home for them with various sort of privileges."
"People should visit mad people and help them by asking them about their family, so that they can think of getting better and going back home."

**Commentary**

The most frequently reported was that society should put mad people in a home, where they could be looked after and treated with care.

Some of the reasons given for recommending home care or hospitalisation were:

"Most people do not look after themselves and would just rot away like wood."

"If they receive help they could not commit crimes or harm themselves."

"Some of them are curable and can easily get better if helped. If you leave them alone they worry more."

**Summary**

Group III, 13-14 years old in North London, regarded anyone who acts strange, as abnormal or mad. Mad people usually "walk the road and talk to themselves," or they sometimes try to harm themselves and others. They say stupid things and "go around shouting and swearing at people."

Most of the respondents felt sorry for the mentally ill and wanted to help them in any way they could. Sixteen of the twenty five respondents knew a mad person and felt that society should do more to help them.

These views were expressed in two essays recorded below,

(1) "A madman is a person who is deranged in the mind. He or she might be insane, crazy, frenzied, angry or have agitation of the mind. Mad people
behaves sometimes like little children. I know a madman and every day and night he says that there is a man outside with a gun who is going to kill him. It isn't really true it is just his imagination. Maybe that's how mad people behave, as if someone is ruling the mind, telling them what to do.

They do things and don't know what they are doing or saying. My reactions are no different from other people. Some people feel sorry for them like I do, but others think that a mad person should be locked up in a cell or away from the outside world.

I know a mad person, he is a coloured man around his late thirties. He says things and doesn't know he says them. Sometimes he may insult someone and the next morning or the next day when the person starts to tell him off he wouldn't know what they are talking about. The last time he came to our house he went into the kitchen, took the milk bottles and started banging them together; he said he was only trying to tidy up.

The government should not lock a mad person up in a cell, but try to help him. Maybe a psychiatrist might be able to help them, but there is no need to lock them up. They need freedom like the rest of us."

(2) "A mad person is someone who is deranged in the mind, or they could be insane or crazy. Mad people act in different ways, they could say unusual things or they could be a psycho and kill. Some mad people could just act normally and you would never know they are mad. Suddenly they would start swearing and shouting crazy things. If I saw a madman near me screaming and shouting I don't think I would run off but I wouldn't go up to him because if he is very mad he could attack you.

Where I used to live and when I was at my old school there was a man, he was old and he wore dirty clothes and he used to carry boxes, and he would sit on them talking to himself and some kids would go and make faces at him, and make him angry. I hate seeing people doing things like that.
don't think that mad people should be locked up. I know that they just
aren't go out and walk about in the street. I think they should be put in a
place where there are other people with the same sickness and get treatment."

roup IV, the 14-15 years old in London. This group was comprised of 19
children. Their observations in response to the questions were as follows.

Who Or What Is A Mad Person?

"Someone who,

is mentally disturbed and doesn't behave the same way as ordinary
people."

"Acts crazy or insane.

can't think straight and doesn't act in a way society will accept as
normal."

How Do Mad People Behave?

"They often have hallucinations, behave irrationally, speak to themselves
occasionally and are highly unpredictable and very dangerous."

"They sometimes walk the streets naked, eat out of dust bins and often
do things and don't remember what they have done."

What Kind Of Things Do Mad People Say?

"They say strange things, walk the streets shouting for no apparent
reason and often they make funny noises with their mouths."
What Is Your Reaction To Mad People?

"I sympathise with mad people, especially those who are alright and suddenly something happen that send them mad, they are the ones who could be helped."

"I feel sorry for them. Like most people I hate to hear people calling them names, it is not their fault that they are mad."

Table VI

Do You Know A Mad Person?

* Shows the number of English school children in Group IV claiming contact with a mad person.

<table>
<thead>
<tr>
<th>No.</th>
<th>Age Range</th>
<th>Sex</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>19</td>
<td>14-15</td>
<td>F</td>
<td>No = 11</td>
</tr>
</tbody>
</table>

*Yes = 8

19

What Do You Think Society Should Do About Mad People?

"Society should have more homes so that they can treat mad people."

"Society should not lock them up and throw away the key because they are human like the rest of us. Society should help them to live normal lives and not feel like outcasts."

"I think society is too harsh on mad people. They shouldn't be locked up from the outside world, but left alone in their own little community with other mad people."
"It is not fair for mad people to suffer, because they need medical treatment. They should be treated in a mental hospital. It may take a very long time for them to get better but it would be a bit safer for the public and them."

Summary

The 14-15 age group noted that a mad person was "someone who is mentally disturbed and doesn't behave like ordinary people. They say strange things and walk the streets talking to themselves."

All of the respondents felt sorry for mad people, "especially those who suddenly became ill," as a result of an unfortunate incident in their lives. Such persons it was felt needed help most and had the best prognosis.

Eleven of the nineteen respondents had no contact with a mentally ill person. However, they all felt that society was too harsh on mad people. Instead of locking them up they should be helped to "live more normal lives, like the rest of us and not feel like outcasts."

Two of the essays recorded below, which are representative of the others, describe the generally held views about the mentally ill.

One of the respondents did not believe there exists "such a thing as a mad person." Her observations are reported in the third essay.

(1) "A mad person is a person who doesn't act like any other normal human being. They act childishly and can do stupid things. Many of them can kill and not be aware of it. They behave in an irrational manner and are mentally disturbed. Many of them talk to themselves or mumble under their breath and even tend to twitch now and then. Others shout and scream out loud. Many of them have hallucinations about green men, fairies and other things that don't exist."
I feel sorry for mad people and most of the time it tends not to be their fault that they are that way. Although madmen can kill and cause grievous bodily harm, I still feel sorry for them because they are branded as murders and fiends. They may well deserve these titles but it is not their fault. Some people think that mad people should be locked away, kept in restraints and be as far away from civilisation as possible.

I don't think they stop and think about how they would feel if they were mad people locked away from friends and relatives in a place where they could only be seen occasionally.

Mad people have a special place where they are kept. This is called an asylum, such as St. Bernards Mental Hospital.

I once knew a man who was perfectly normal until two of his friends told him to try a drug called L.S.D. and cocaine. He did so and became addicted. From then on he turned mad. He would scream out loud and talk to himself, and at the age of 20 he died. He thought he saw little green men on top of his wardrobe. He tried to reach them, and pulled the wardrobe on top of himself. He was killed.

I think they should be put in a home, but not locked away like prisoners."

(2) "A madman is a person who doesn't behave the same way as ordinary people. There are different signs of madness. Some may go into a fit of laughter, crying or they might start shouting, screaming and kicking. Others will be scared of anything and lock themselves away or some may have a temptation to kill people or themselves. There are many kinds of madness. They say funny things that we do not understand or they mumble and talk to themselves.

I personally feel sorry for mad people. There are even some that could be helped, especially those that were not mad all their lives, during part of their lives something happened that made them go mad. I think that most of these can be helped. Others who were mad all their lives are harder to help.
of people who are normal make fun of people who are mad, or say that they don't like them. I think they are being selfish and don't realise that they are lucky to be normal and try to put themselves in a mad person's place and see how much they suffer.

People should have more homes than they do for mad people. They should try help to overcome their madness and look after those who can't be helped.

Only mad people who should be locked are those who do terrible things, like killing and can't be helped in no way."

"Personally I do not think that there's such a thing as a madman cause there is no specific madness. No form of madness takes hold of people exactly the same way.

People go what is referred to as 'mad' because they have been left on their own for too long. Some people go mad because they have been badly let down, some were born that way, and others obtain their madness through an accident or physical injury.

People in my opinion behave accordingly to how the madness has set in on them, some behave almost normal. If a person is almost totally mad they have irrationally."

Sources of Imagery - In Both Cultures

There were differences in the amount and type of information about mental illness held by children in the Barbadian and English sample. The children in the English sample used the term "mental illness", while the majority of those in the Barbadian sample used the term "madness." The former group displayed wider knowledge of mental abnormality than the Barbadians.

They also thought of mental illness as having a variety of causes, often originating in society.
Children in the Barbadian sample thought that the cause of madness was due to a malfunctioning of the brain, hence a mad person is seen as having a "sick brain," "bad brains," "a weak brain" and often no brain at all. Madness occurred mainly because of the person's own doing. "A mad person is someone who studies a lot of things he shouldn't study." This therefore causes him to have a "mixed up mind and to lose his sense." Since mental illness was caused by one's own actions there was very little sympathy for him.

The observations of both the 9-10 year olds, but especially the 13-14 year olds in the Barbadian sample were strikingly similar to those of their parents. Adults in Barbados view mental illness as being caused by the malicious intentions of others, personal weakness, but especially from "studying and thinking a lot."

For Group I, the 9-10 year old Barbadians, a mad person was regarded as someone who had something wrong with his head, brain or mind. This affliction caused him to behave "stupid and funny" and to abuse whoever he met.

Over 50% had contact with the mentally ill. They all held negative views about the mentally ill and regarded them as persons to be feared and jeered.

Group II, the 13-14 year old Barbadians expressed similar views to Group I, but expressed them differently. For them a mad person was anyone who suffered from any kind of mental disease.

The main cause of mental illness was given as "studying too much" or "someone doing yuh something" - a malicious act. Mad persons acted funny, used a lot of bad language and were unpredictable.
eventy percent of the Barbadian sample - Group I and II had some contact with a mentally ill person. Both groups there is some expression of sympathy, sorrow or willingness to help the mentally ill. However all the respondents reported some negative attitudes towards the mentally ill.

e views and attitudes of the school children are clearly mirrored in the adults, who regard all mad persons as undesirables. The adults are totally different about the mentally ill, even if such persons are members of their families. This can be seen in the society's attitudes towards the mentally ill persons who roam the streets of Bridgetown and the other commercial areas of the island. Social workers and community nurses have reported the stility family members exhibit towards a mentally ill relative.

The English sample, both Groups III and IV viewed a mad person somewhat differently than either group in the Barbadian sample. The 13-14 below average, and 13-14 above average, indicated that the behaviour their Barbadian counterparts viewed as "madness" they classed as "illness." The majority of children in the English sample viewed illness as arising from environmental as opposed to physical causes. Illness was seen to result from problems of living.

The children from the 13-14 below average groups, reported that people go mad because someone has died or they can't get a job. It is very hard for people in the world today." They regarded anyone who acted strange, rational, not normal as mad. Mad people were viewed as "nuts," "loony s," who walked the road talking to themselves and interfering with others by and others peoples property. All the respondents felt sorry for the mentally ill and were willing to help rehabilitate them in any way they could. However, they were fearful of mad people because they were
"One minute they seem quite harmless, in the next they turn nasty."

(U.K. female age 14)

though the children in the London sample disapproved of the behaviour of he mentally ill and felt unable to help, or interact with them - because f fear - there were many indications of general sympathy and lack of moral astigation. Children from the Barbadian sample were willing to have them put away" in Jenkins, the mental hospital.

more than half of Group III had some form of contact with the mentally ill. aren, whose mother was mentally ill describes her mother:

"My mother on the outside looks normal, but when she speaks and do anything she does it differently. Besides she is a religious maniac and pays more attention to God than anyone else. She is mentally disturbed."

ever children from Group IV had contact with the mentally ill than in any ther group. No reason could be found to explain the difference. However, sa, one of the girls from Group IV reported that her mother had "a ervous breakdown after having two operations one straight after the other d because they sent her out of hospital too soon. Plus coping with us at one didn't make things any better."

e first sign of her mother's ill health occurred one morning when she entered her mother's bedroom to give her breakfast. She recalled,

"My mother started shouting at me and jumping up and down on the bed cursing my dad. She suddenly started speaking patois, saying how she could see her mother with an angry face beating her. My mum started talking about how beautiful trees and flowers and everything that happened when she was living in Caricou (Grenada). It was very frightening, I couldn't believe it was my mum."
Some of the children from the 13-14 above average group demonstrated a wider knowledge of mental illness than was seen in the 13-14 below average group. Barbara, one of the children from the 13-14 above average group noted that,

"Most people think that madness is caused by heredity and cannot be helped, but I don't believe that. A person usually becomes mad because of a bad experience they had when they were small, like witnessing a crime or seeing their mother being killed. This leaves a scar on their brain for life and gradually through the years it begins to play on them."

Karen also pointed out that,

"Some people have turned mad as a result of certain bad things happening to them, others have been ill-treated until they finally turn mental, but all together madness is just a certain kind of accident, nobody turns mad on purpose."

However, Anita seems less sure about what madness is, she states,

"I don't really know what madness is but I think it is somebody who doesn't act in a way that our society will accept as normal, like shouting out in the middle of the high street for no good reason."

There is very little variance in attitude between Group III and IV.

For Group IV, 13-14 year 'above average' age group, a mad person is someone who is mentally deranged, behaves in an abnormal way and walks the streets talking to himself. Similar views were expressed by Group II, 13-14 in the Barbadian sample.

In spite of changing concepts of madness/mental illness, a significant liberalisation of attitudes towards the mentally ill, as regards personal
association, was noted among the children from both cultures (Barbados and England). The reluctance of the children to associate with the mentally ill - even if such a person is one's parent - can be seen as a reaction to strong fear for the safety of their person. This fear is based on the predictability of the mentally ill and their history of violent and irrational acts. It would appear that the association of the mentally ill with acts of violence and aggression is too strong to be overcome simply by reconceptualisation of such persons as sick.

The children in the English sample were more aware of the changing attitudes towards mental illness than their Barbadian counterparts. Living in a metropolitan society had provided them with exposure to changing social values, which had improved the level of their social consciousness.

The attitudes to the mentally ill in the wider society influenced the way in which they conceptualised mental illness. They felt that society wasn't doing enough for the mentally ill. They were against "putting them away" and "locking them up," unlike the 13-14 year olds in the Barbadian sample, who felt, "that all madmen should be put out of the way, (in hospitals);"

The respondents in Group III further recommended the building of more homes instead of hospitals, and employing more people to look after them so that they can have more freedom.

"Society should look after these people more carefully. They should not be left alone or locked up, they should be in a home and free to do what they like with someone supervising them. They should not be left alone with no friends or anyone to talk to." (Jennifer)

"It is up to the society what they do with mad people. It is not nice to see a mad person running about the streets and people laughing at them. They are human beings just like us and therefore they should be looked after."
The views of all the children in this group are neatly summed up by Carol, "The way they behave is not like us, but it cannot be helped. I feel sorry for them and the way society treats them. Life must be horrible for them. They should be well looked after, and not locked up in hospital."

Whilst the majority felt that they could not themselves make a friend of someone who was mentally ill, they wanted to help in some way, and many expressed the opinion that society was failing in its care for them.

This apparent contradiction whereby individuals displaying behaviour which is normally sanctioned strongly, are seen as needing help rather than punishment, can best be understood if we look at the concept of responsibility in modern society. This new concept of "individual responsibility" makes a distinction between those deviant acts which are seen as voluntary violations of norms and those which are seen as provoked by circumstances outside of the individual's control. Mental illness is seen by most people in modern western societies to be the result of the pressures of everyday living. Studies of the public's attitude towards the mentally ill have shown a change from a "high moral blame attitude to a low moral blame attitude." (Munally, 1961)

It has been suggested that the shift in attitudes towards the mentally ill and some deviant members of society has resulted from a change in our view of the nature of man as a whole. We have moved from a concept of man as a self-determined creature to one in which man is seen more or less at the mercy of social and environmental forces around him.

Oak (1973) has suggested further that, "The changes wrought so far by this emerging image of man have been reatest in those parts of our society which are most subject to being informed by social scientists. Ideas about how to treat the delinquent, the
poverty stricken, the mentally ill, the criminal, have changed radically over the last generation.... people may be mentally ill but they are no longer crazy."

The consequences of this broadening of the "sick" category are far reaching. The framework in which an anti-social act is perceived, becomes one of 'illness' rather than 'deviance.' The behaviour is seen as undesirable but the individual displaying it is not the subject of moral judgement.

The development of this concept can be observed in the children's ideas about mental abnormality. The 9-10 year olds (Barbadians) said that madmen "behave badly," "say bad words," and "should be put away." Here, the younger children saw not only the abnormal act as reprehensible, but also the individual who performs it.

However, the 13-14 year olds from the Barbadian sample and the English sample, while noting that madmen "behave in a sort of a way they should not," felt "sorry for them," because it "is not their fault that they get that way." Here, the older children - whilst regarding the behaviour of the mad man as undesirable - remove him from the moral sphere, and conceptualised the anti-social behaviour within an illness framework. The link between the two concepts occurs when the older children perceive the anti-social behaviour of the mentally ill, not due to his own action but resulting from external forces, such as environmental stress not of his own making.

When abnormal behaviour is seen as "illness" rather than "deviance" the treatment appropriate for dealing with the behaviour is not punitive as the 9-10 and most of the 13-14 year old Barbadian children suggested, but social or psychiatric. As the 13-14 year old English children emphasised, cure is best affected by "putting the mentally ill in a convalescent home"
reasons for the different information held by the Barbadian and English children may be suggested. Firstly the children in the English sample have different cultural milieu, one in which the media informs the child at an early age, of new words, ideas and concepts of "mental illness." The causes of mental illness portrayed in the media, in plays and so forth, are also very similar to the children's ideas on this subject.

Secondly, children in the Barbadian sample have considerably less exposure to the media, and less information about mental abnormality, new words and concepts. They receive their information primarily through hearsay, from adults, school friends and their own observations of the local "madman."

In Barbados, nearly every parish has its local madman ("village idiot") - someone who behaves oddly and who has had a period of hospitalisation at the mental hospital.

In Barbados the terms "madness" and "craziness" are in popular use across a large section of the population, irrespective of one's class position. The word is likewise incorporated into the vocabulary of the young children. It is therefore not surprising to observe that views about madness and madmen mirror those of the adults.

Moreover, whether the term "mental illness" is used, as in the case of the children in the English sample, or the terms "mad" and "crazy" as used by children in the Barbadian sample, it is important to note that both groups of children are in essence referring to the same phenomena. The behaviour they respectively ascribed to the mentally abnormal was basically the same.
Continual Reaffirmation Of The "Mad" Stereotypes

Though many adults become acquainted with the medical concepts of mental illness, and are exposed to mental health education programmes designed to move the stigma attached to the mentally ill, traditional stereotypes are not easily discarded, but continue to exist alongside the medical conceptions.

As was noted in the last section, all the children in the English sample believed that society locked up mentally ill persons.

A study by Nunally (1961) demonstrates that the image of mental illness in the mass media is highly stereotyped. In a systematic and large scale content analysis of television, radio, newspapers and magazines, he found a picture of mental disorder presented which was overwhelmingly stereotyped.

"Media presentations emphasized the bizarre symptoms of the mentally ill. For example, information relating to Factor I (the conception that mentally ill persons look and act differently from 'normal' people) was recorded 89 times. Of these, 88 affirm the factor, that is, indicated or suggested that people with mental health problems 'look and act differently.' Only one denied Factor I. In television dramas, for example, the afflicted person enters the scene, staring glassy-eyed, with his mouth widely ajar, blabbing incoherent phrases or laughing uncontrollably. Even in what would considered the milder disorders, neurotic phobias and obsessions, the afflicted person is presented as having bizarre facial expressions and actions."

Affirmation of the mad stereotype occurs not only in the mass media but directly in ordinary conversation, in jokes, anecdotes and even in conventional phrases. Such phrases as "are you crazy?" "You must be nuts," "top acting like a loony-bin," "it is driving me out of my mind," and literally thousands of others occur frequently in informal conversation.
This usage madness itself is seldom the topic of the conversation. Through verbal usage, the stereotype of madness is an inflexible part of the social structure. The phrase "running like mad" is used, the image which this conveys implies movement of a wild and uncontrollable variety. The question "are you out of your mind?" indicates that one has lost one's sense and is acting irrationally, contrary to one's "known" behaviour pattern.

This inadvertent and incidental imagery is similar to that contained in racial and ethnic imagery.

Why are these stereotypes so resistant to change? Cheff (1975) believes that they are functional for the current social order and tend to be integrated with the psychological make-up of all members of the society.

The belief that the public harbour negative stereotypes of the mentally ill is essential to the idea that psychological behaviour is simply a form of social deviance. Further it is suggested that negative stereotypes ill a strong psychological need for the predictability of social behaviour. Establishing the existence or the non-existence of these attitudes is important for understanding the role of the mentally ill in our society. For example, are the mentally ill regarded as being entitled to the sick role, or are they regarded as legitimate objects of punishment?

As has been shown from my observations of Barbadian society, the majority of both adults and children seem to regard the mentally ill as dangerous, violent, unpredictable objects of derision and amusement. Only behaviour which is threatening, violent and harmful to the community is labelled and punishable. The sick role is usually ascribed to persons manifesting physical disability.
e discussion has suggested that "everyone" in a society learns the symptoms of mental disorder vicariously; this is conveyed unintentionally, in everyday life. This imagery tends to be tied to the vernacular of each language and culture; this association may be one reason why there are considerable variations in the symptoms of mental disorder that occur in different cultures. It is further suggested that this imagery, which is embodied in the cultural stereotypes of madness, are learned early in childhood and continually reaffirmed, inadvertently in the mass media and in everyday conversation.
REFERENCE


PART II

- DESCRIPTION OF RESEARCH INSTRUMENTS.

(1) MIDDLESEX HOSPITAL QUESTIONNAIRE.

(2) SOCIOLOGICAL QUESTIONNAIRE.

(3) STRESS QUESTIONNAIRE.

- LITERATURE REVIEW OF STRESS AND MENTAL ILLNESS.

- MIGRATION AND MENTAL ILLNESS.
understanding any research it is essential to give much consideration to the research instrument being used. In this study the Middlesex Hospital Questionnaire was employed extensively. This chapter examines the development, reliability and validity of the MHQ as a research tool, therefore justifying its utility in this study preference to other types of psychological tests.

There are of course a large number of personality inventories available. One of the better known and more widely used inventories are the Maudsley Personality Inventory (MPI Eysenck, 1959), the General Health Questionnaire (GHQ Goldberg, 1972), and the 22 item scale (Langner, 1962). For my study I chose the Middlesex Hospital Questionnaire (Crisp and Crown 1966), a relatively new and less widely used personality inventory. It is necessary to explain my preference for the MHQ to the more widely used MPI, GHQ and the 2 item Langner scale.

The Maudsley Personality Inventory

The Maudsley and Eysenck Personality Inventories, with their subsequent modifications, are valid and reliable personality inventories, but consistent with the theory of personality organisation of its developer, assessment is limited to broad categories of 'neuroticism' and 'extraversion.' These broad categories do not fully describe the wide variability of psychoneurotic disturbances. (See Appendix I).
The General Health Questionnaire, "a Standardised Psychiatric Inventory" according to its author D. P. Goldberg was constructed to meet the following requirements:

1. "Psychiatric assessment should be made by an experienced psychiatrist in a realistic clinical setting.

2. The interview should be acceptable to individuals who may not see themselves as psychiatrically disturbed.

3. The content of the interview should be appropriate to the type of psychiatric disturbance commonly encountered in the community.

4. The interview should generate information about individual symptoms and signs of illnesses, as well as an overall diagnostic assessment.

5. It should discriminate between both mentally ill and normal individuals, and between patients with different degrees of psychiatric disturbance.

6. It should be relatively economical of time, so that large numbers of patients can be included.

7. The psychiatric assessment and clinical ratings should be reliable in the sense of being reproducible by different trained observers."

The interview schedule is divided into four sections. The first is unstructured and consists of sub-headings for a brief recording of the patient's present and past history.

The second part of the interview is a more detailed and systematic enquiry about the psychiatric symptoms the patient may have experienced. The symptoms are arranged in 10 groups, in the following order:-
(1) Somatic symptoms
(2) Fatigue
(3) Sleep disturbance
(4) Irritability
(5) Lack of concentration
(6) Depression
(7) Anxiety and worry
(8) Phobias
(9) Obsessions and compulsions
(10) Depersonalisation

Reasons for Not Using the GHQ

The GHQ as can be seen from its general design and content (See Appendix III) is very cumbersome and time-consuming, and therefore totally unsuited for community based study.

The GHQ is a lengthy instrument. The complete version contains 140 items and even the short version contains 60 items, (See Appendix III and IV). Although this is a reasonable length for a questionnaire when standing alone, it may prove too long when used in conjunction with other instruments/ measures in a full scale study.

The construction of the scale is such that it measures the extent to which the subject perceives that this present state is different from his usual state. The response scale for each question is typical of this kind, "not at all," more so than usual," "less than usual," "much less than usual." With a time scale of one's general health "over the past few weeks," it is quite
kely that established and chronic psychological disturbance will be missed. Further, the response scale is far too imprecise, and seems likely to create decision in the respondents' minds and lead to less accurate results.

Other versions of the GHQ have been prepared by Goldberg. The shorter version consists of 30, 20 and 12 items respectively (See Appendix IV). These changes in the original format of the questionnaire were done to save time and make the instrument more acceptable to respondents. However, Goldberg has admitted that the alterations have meant that less information be obtained, and therefore reliability and validity would suffer to a greater or lesser extent. Despite my intention to save time by using a short questionnaire, reliability and validity of the instrument to be used was of principle concern.

chrane (1977) using the 12 items of the GHQ on an immigrant Asian population, found it necessary to substitute some items from Goldberg's list of 20 "best items," to make up his 12 best items. He also found it necessary to change the response forms of the GHQ, "not at all," "no more than usual," "rather more than usual," "much more than usual," to a simple yes/no format, in order to simplify verbal administration.

One of the main requirements for which the GHQ was constructed was that, psychiatric assessment should be made by an experienced psychiatrist in a realistic clinical setting" (Goldberg, Cooper, Eastwood, Redward and ephard, 1970). This meant that non-practitioners would find some difficulty in using the instrument.

Other important reason for not using the GHQ was its unreliability in sting blacks. In a study done by Goldberg, Rickles, Downing and Hesbacher (1976), using the GHQ and the Symptom Check List -SCL -to compare patterns symptomatology on black and white respondents in America, the researchers tested that both questionnaires function better with whites than blacks;
possibly because they were constructed for the white population.

Having given some thought to the nature of the research, the ethnicity of respondents and the necessary alterations needed to make the GHQ suitable for the study, I decided against using it.

22 Item Langner Scale

Sometimes referred to as the "Index of Psychological Stress," the 22 item instrument represents an attempt to develop a short reliable method of assessing "where people lie on a continuum of impairment in life functioning due to very common types of psychiatric symptoms," (Langner, 1962 p. 269).

The 22 item scale consists of 22 closed ended questions which ask for self-reported psychological and physiological type complaints. The items were selected on the basis of their being able to discriminate between the "known 1" and "known well" groups (Langner, 1962 p. 271).

The 22 items were selected from the Neuropsychiatric Screening Adjunct (1950) and the Minnesota Personality Inventory, (Dalstrom and Welsh, 1960).

The 22 item scale was not constructed to detect organic brain damage, mental retardation or sociopaths, nor dimensions of anger, depression, anxiety, acting out, suspicion, hallucination, delusion formation, memory loss or concentration difficulty; it is not diagnostic and does not identify types of mental illness. Scale scores are obtained by a simple summation after item responses are dichotomised into "pathonomic" and "non-pathonomic" categories. Higher scores purportedly indicate mental illness.

There have been few epidemiological instruments used as widely as the 22 item scale.

Since its development by the Midtown Manhattan Researchers, the 22 item scale has been used by a number of researchers in different settings. Dohrenwend 66; Crandell and Dohrenwend 1967; Manis et al 1963 & 1974; Philips and
Before using the 22 item scale it was necessary to determine the validity of the Langner Scale. The critical question that had to be asked was, can the 22 item scale differentiate between the "known ill" and the "known well?" Is the best point of discrimination dividing the "sick" from the "well" between 3 & 4 symptoms of the scale?

Nis et al (1963) using the 22 item scale in a comparative study of five own groups: receiving ward patients; pre-discharge ward patients; college students; community residents and county residents; concluded (1963 p. 113) that, "for individual diagnostic purposes the 22 item scale is valid only for scores of 10 or higher. That is to say, there is a very high probability that individuals scoring 10 or above are mentally ill; unfortunately, the converse of this statement, namely that all individuals who are ill have high scores or that low scores indicate good mental health is not supported."

The conclusion that the 3 - 4 symptom cut-off point is not the best one to keep the false positive identification at a reasonable level.

Second study by Haese and Meile (1967) using the 22 item scale on a psychotic patient receiving ward ("known ill") and a community ("known well") group, concluded that for their data the best cut-off point for the 22 item scale is between 6 and 7 admitted symptoms. Dohrenwend and Crandell (1970; 13) found that the instrument (22 item scale) was unable to rank order iteration groups in terms of the degree of mental illness. They observed that although mental patients admitted a higher median number of symptoms than non-patient groups, out-patients scored higher than in-patients. They further found that the best cut-off point of the scale was as high as 10 and not lower than 7 symptoms.
Langner did not state clearly whether the quantitative aspect of the 22 item scale was supposed to indicate the degree of mental illness, i.e. the higher score, the more likely that the respondent is mentally ill.

Langner (1962; 269) notes that the scale was designed to provide, "a rough indication of whether people live on a continuum of impairment in life functioning due to types of psychiatric symptoms." This statement seems to imply that the degree of life impairment in life functioning is due to frequently occurring psychiatric symptoms. Is Langner seriously implying that the scale is designed to indicate the degree of mental illness?

The items for the 22 item scale were selected on the basis that they differentiate the "known well" from the "known ill." The selection procedure was done so that certain symptoms reflect the varying degrees of mental illness. The scale is, at best, composed of items which indicate very mild forms of psychological disorder.

Eiler (1973; 257) noted that "there is no evidence that the scale operationalises 'life impairment' in the individual as suggested by Langner, (1962)." The scale was not validated against any criterion variable that indicates life impairment other than the "known" mental illness rating. If the scale fails to satisfactorily identify the mentally ill, one is left with no basis for interpreting what the scale measures.

In addition, Dohrenwend (1966; 29) indicates that the scale items "may grossly under represent psychiatric symptoms among Negroes and Puerto-Rican respondents." Further, Roberts, Forthofer and Fabrega, Jr., (1977) in a study of the Langner Scale and acquiescence, noted that social acquiescence operates to confound responses to the Langner items.
summary, there seems to be a number of problems associated with the 22 item scale. It is unable to rank respondents in terms of the degree of mental illness; the 3-4 pathologic response level has been shown to be weak in discriminating the "mentally ill" from the "mentally well." The presence of symptoms specific items in the scale tends to produce weak results and there seems to be a lack of consensus as to what the scale operationalizes.

Finally, and most important of all, the 22 item scale tends according to the literature cited to grossly under represent psychological symptoms among groups.

Reviewing empirical validations of the 22 item scale Seiler noted; most troubling of all, however is the heavy reliance upon 'known group' techniques for the validation of the 22 item scale. It appears that use of this technique has resulted from not fully differentiating two different theoretical questions. The first question, the one upon which the 22 item scale's utility rests, is: Are respondents with some high number of symptoms represented in the 22 item scale mentally ill? The second question, which is tangential to the first is: So the mentally ill evidence some usually high number of the 22 item scale symptoms? If the answer to the second question is affirmative, that is that mental patients evidence a statistically abnormal number of symptoms, this does not imply that the answer to the first question is also affirmative, (i.e. that those living in the community who exhibit a statistically abnormal number of symptoms are also mentally ill). This is the fallacy of affirming the consequent 'known group' technique and this logic does not imply that the community residents with any symptoms are mentally ill. Thus these validation studies, which are the best currently available, present weak, if any substantiation for the assertion that the 22 item scale 'detects' mental illness in community residents. (Seiler, 1973, p. 255).
persons of the 22 item scale have not come to grips with the reality that any presumed symptom may or may not be indicative of an underlying disorder, depending on the context in which it is expressed.

In case the above comments do not persuade the reader that the 22 item scale does not measure mental illness, a demonstration follows.

Our items from the instrument are given below. All have been endorsed as indicating mental illness by the Midtown Manhattan respondents (Langner, 1962) and by Cochrane and Robertson, (1978). The items occupy respectively, the first, fourth, eight and tenth places on the instrument. Using Langner's original cutting point, positive reasons to any form question indicate that person is mentally ill. If you responded 'yes' to any of these four items you would be considered "mentally ill."

Are you a worrying type?
I have periods of such great restlessness that I cannot sit long in a chair.
Every so often I feel hot all over.
There seems to be a fullness in my head or nose much of the time.

For the reasons stated above the 22 item scale was not used in my study.

The Middlesex Hospital Questionnaire

The Middlesex Hospital Questionnaire (MHQ) (See Appendix V) is the psychological instrument used in my study in preference to the GHQ, and the 22 item Langner Scale. The MHQ was designed by A. Crisp and S. Crown of the Middlesex Hospital, London. The basic purposes of the MHQ as stated by the authors is, to obtain in five or ten minutes as approximation of the diagnostic information that would be gained from a formal clinical psychiatric examination. Further claim that "it is objective and possesses to an acceptable level the two basic psychometric necessities, validity and reliability." Follow-up and validation were done by Crown and Crisp (1966); Crown, Duncan and Howell (1970), and Cockett (1969). Further discussion on the validation and reliability of the MHQ will be presented later.
The Middlesex Hospital Questionnaire consists of 48 questions worded in ordinary language. The questionnaire can be easily administered by clerical personnel e.g. a secretary, to groups of people, or individually. To avoid respondents simply ticking 'yes' or 'no' without reading the questionnaire properly, the questions and answers were deliberately arranged so that the wording was different and their position on the questionnaire did not lie 'rectly under the other. "Yes" and "no" answers have been interspersed with other answers such as 'frequently,' 'never,' 'a little,' 'not at all,' 'airly,' 'very,' 'sometimes,' 'often,' 'at times' and other wordings.

Isp and Crown found that respondents tended to tick answers which were to the left or right. Hence, extreme answers such as 'never' and 'frequently,' were randomised so that they occurred both on the left and sometimes on the right.

The questionnaire was designed so that a total score can be obtained, providing a measure of general emotionality or 'neuroticism,' together with a profile of 6 sub-test scores.

The 6 sub-tests were designed to measure respectively, free floating anxiety (FA), phobic anxiety (PHO.), obsessionality (OBS.), somatic concomitants of anxiety (SOM.), depression (DEF.) and hysterical personality (HYS.).

The dimensions of each sub-tests are randomised throughout the questionnaire to disguise from the respondents the aims of the questions.

own and Crisps (Manual of the MHQ) define the dimensions of the 6 sub-tests follows.
The essence of free-floating anxiety is that the patient is afraid but, unlike normal fear there is no discernible object of which he is afraid. It consists therefore of dread, indefinable terror, tension without a cause panic.

Phobic Anxiety

With phobic anxiety the patient feels anxious in specific situations which he can name but, if these situations are avoided or not experienced he does not feel anxious.

Obsessionality

By obsessionality it meant excessive meticulousness, adherence to routine, punctuality, dislike of sudden change, need to control the environment, tendency to check and over check, and dislike of dirt.

Somatic Anxiety

By the somatic concomitants of anxiety are meant symptoms such as breathlessness, headaches or aches and pains which are neither regarded by the patient as a sign of definite illness as in hypochondriasis nor are they regarded with indifference or denial as in the frank hysterical conversion symptoms.

Depression

By depression is meant sadness of mood, difficulty in thinking clearly and slowing of actions and activity. These last two criteria may be called psychomotor retardation.
These with shallow, labile affections and dependent on others. These individuals crave love and attention, though unreliable and unsteady in their personal relationships. Under stress they may develop hysterical symptoms. They tend to over-dramatise situations.

Glossary of Mental Disorder 1968)

Corening

The score for each sub-test should be added up separately and entered in the appropriate place at the end of the test sheet in order A, P, O, S, D, H.

FA consists of questions 1, 7, 13, 19, 25, 31, 37, 43.

HO consists of questions 2, 8, 14, 20, 26, 32, 38, 44.

BS consists of questions 3, 9, 15, 21, 27, 33, 39, 45.

OM consists of questions 4, 10, 16, 22, 28, 34, 40, 46.

EP consists of questions 5, 11, 17, 23, 29, 35, 41, 47.

IS consists of questions 6, 12, 18, 24, 30, 36, 42, 48.

Development of MHQ

Idney Crown and A.H. Crisp, two consultant psychiatrists, found that in their department at the Middlesex Hospital there was a need for a "rapid quantification of common symptoms and traits relevant to the conventional diagnostic categories of psychosomatic illnesses."

One of the British scales fulfilled this requirement and they therefore decided to design and validate a self-rating scale adapted to these categories.

The authors, constructed a number of questions covering five groups of symptoms and traits. These were free-floating anxiety, phobic anxiety, obsessive compulsive traits and symptoms. These questions were circulated, uncategorised,
independently to two psychiatrists and a non-medical clinical psychologist, who were asked to categorise the questions according to the five groups mentioned above - free floating anxiety, etc. These independent assessors were also asked to criticise unclear wording and to suggest further questions. A preliminary form of the test was drawn up, consisting of 60 questions, 0 in each of the five categories and an additional 10 questions which were considered valid, but for which no category could be agreed upon. However, these additional questions were later dropped.

**HQ - First Study in Preliminary Form**

A preliminary study was carried out by the authors to determine the feasibility of the project. The test was administered by a departmental secretary to 90 consecutive out-patients attending the Middlesex Hospital Academic psychiatric Unit, and to 100 "normal" persons, (nurses, physiotherapists and medical students). The out-patients mentioned above came from two sources: from general practitioners and from other departments of the hospital. See Table I).

The majority of the patients suffered from psychoneurotic illnesses, "psychosomatic" disorders, such as - essential hypertension, ulcerative colitis, hyperthyroidism, duodenal ulcers, asthma, migraine, etc, and/or personality disorder (drug dependency, sexual perversion, etc). Nine patients were suffering from organic states (epilepsy, etc) or major psychoses. The authors further included a separate sheet in the patients notes at the preliminary interview. This was to enable the clinician to rate the patients symptoms under the same broad headings that were listed on the test form (i.e. free-floating anxiety, etc) as absent, mild, moderate or severe. This rating was completed for 52 patients.

It was shown from this preliminary test that the normal and neurotic were differentiated at a statistically higher level. (Table I, Crisp and Crisp, 1966: 918).
<table>
<thead>
<tr>
<th></th>
<th>Anxiety</th>
<th>Obsessive</th>
<th>Somatoform</th>
<th>Physic</th>
<th>Free Floating</th>
<th>Depression</th>
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<tr>
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<td>4.9</td>
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<td>2.1</td>
<td>1.7</td>
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<tr>
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<td>1.7</td>
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<td>0.7</td>
<td>0.6</td>
</tr>
<tr>
<td>CR</td>
<td>2.5</td>
<td>1.2</td>
<td>1.1</td>
<td>1.2</td>
<td>1.2</td>
<td>0.6</td>
<td>0.4</td>
</tr>
</tbody>
</table>

Note: CR = Critical Range

Percentages of patients above the critical range: Anxiety 75%, Obsessive 30%, Somatoform 40%, Physic 30%, Free Floating 25%, Depression 50%

* Table 1

Scores on the sub-test and clinical rating were also statistically associated, except for the PHQ sub-test, in which the personality was 0.13 (Table II Crown and Crisp, 1966:220).

**Second Study - Final Form**

The final form of the test was designed, in which the best items were retained, and an 8 item hysteria (HYS) scale was added. This made up the present 8 item scale.

In the second study the 48 item scale was administered to 62 unselected patients from the same population of the psychiatric out-patients, and 109 normal subjects. (See Table III). The latter group consisted of nurses and medical students. The same method of validation were used as in the first study, with a third method, in which the inter-correlation between the sub-tests were calculated.

From figures in Table III Crown and Crisp 1966:919, it can be seen that each sub-test of the scale differentiated between normal subjects and patients, at a highly significant level statistically.

**Validation of the MHQ**

The "normal" group, consisting of nurses and medical students, was not a satisfactory control group in a number of ways. It included too many males and the I.Q. level of nurses and medical students are relatively higher than the average population. Further validations were therefore needed.

Crown, Duncan and Howell (1970), presented extensive data on a very large male industrial sample, together with correlations with age, sex and social class. Further standardisation data for psychoneurotic patients was derived...
<table>
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*HIG (Preparatory Form) Relationship of Score to Sub-Tests Clinical Rating*

Table II
rom new groups of male and female out-patients attending the London Hospital psychiatric Department, Crown (1969) and Cockett (1969a) provided data on a ample of young male delinquents.

Through the co-operation and interest of the United Kingdom Atomic Energy Authority (U.K.A.E.A.) it has become possible to evaluate the test more comprehensively and to obtain stable norms, (Crown, Duncan and Howell, 1970).

A large sample of "normal" men were also provided by a General Practice study, by Crisp and Priest (1969). The U.K.A.E.A. group were aged between 12-56 years; the sample was fairly typical of the male working population of the country. The General Practice male group were aged between 35-70 years. (See Table IV). The main comparisons were made between the "normal" groups and the sample of psychoneurotic patients derived from the psychiatric out-patients department of the London Hospital (Crown, 1969).

It can be seen from Table IV that on nearly every sub-test the scores of the out-patients differed greatly from the U.K.A.E.A. group of "normals."

In another study Crisp and Liarkos (1969) studied a hospital sample of 24 psychoneurotic patients. This mixed in-patient population had higher means in every sub-test, than a sample of 62 psychoneurotic out-patients, (Table IV.)

Norms for both men and women were obtained from a large General Practice female sample (Crisp and Priest 1969) and two smaller samples. One was a U.K.A.E.A. group of 36 employees, and the other was a group of 49 midwives (Crisp and Stonehill, 1969).

Comparing the male and female sample of the U.K.A.E.A. the K.H.Q. scores on 5 out of 6 sub-tests, there are significant differences between the male and female populations. The women score significantly higher on FFA, HYS., and PHO., and lower on OBS., and SOM.
| Age Range | Mean Age | SD | No. | Sex | Dep | Obs | Obs | Age Descripti
|-----------|----------|----|-----|-----|-----|-----|-----|----------------|
| FEMALE    | 16-25    | 2.28| 0.76|     |     |     |     | FEMALE
| MALE      | 16-25    | 2.28| 0.76|     |     |     |     | MALE

**Note:** The above table represents a comparison of mean ages and standard deviations for different groups. The data is presented in a tabular format with columns for age range, mean age, standard deviation, number of subjects, sex, depression, and observational data. The table highlights the differences in age distributions between female and male subjects within the specified age range.
group of 49 midwives (Crisp and Stonehill, 1969) shows a similar pattern to the U.K.A.E.A. female group. However, the midwives tended to score higher in OBS and SOM than the U.K.A.E.A. group; this might have been due to differences in background and profession. The authors further found that the scores of psychiatric out-patient women compared with out-patient men (Crown 1969) showed no significant differences. In 5 out of the 6 sub-tests, the psychiatric out-patient female group was significantly different from the U.K.A.E.A. female group and the midwives group. (See Table IV).

From the validity studies outlined above, it seems fair to conclude that the HQ effectively differentiates between normal persons and psychiatric out-patients. The HQ was not designed to be used with groups suffering from schizophrenia; it therefore makes no claims to be useful in detecting syphoses from neuroses. Further evidence of the validity of the MHQ for use with individuals in the community who have experienced stress is presented in Crown et al (1977) and Stringer et al (1977).

Further evidence of the reliability of the MHQ in distinguishing patients from normals in predicted directions comes from a study by Crisp, Gaynor, and Slater (1978). The MHQ has also been found to be valid and reliable in a Hebrew translation, for use with patients and others in Israel (Asberg and Shalif, 1978).

None of the studies conducted by the authors has age been an important variable in relationship to scores on the MHQ. Crown and Crisp (1966) correlated the total score on that test with the age of their out-patient group. These patients varied in age from 18-64 years (mean 34.8). The correlation was 0.01.
the U.K.A.E.A. group (Crown, Duncan and Howell, 1970), there was a statistically significant difference between the older and the younger men on only two sub-tests. The older ones scored higher on OBS. and DEP. Crisp and riest (1969) in their General Practice Study did did a detailed breakdown of the figures by age (Table V). Ages ranged from 35-70 years. They found that there were no systematic relationship between age and score on either sub-test, for men or women. The authors therefore concluded that although specific scores may be minimally related to age in certain groups, generally age is not an important variable in connection with scores on the MHQ.

Social Class

The effect of social class on the MHQ was established by Crown, Duncan and well's study (1970). The U.K.A.E.A. male group was divided into two groups, manual and non-manual. The non-manual group consisted of men in social class 1, 2, & 3; the manual of men in class 3, 4 & 5. It was observed that the non-manual scored significantly higher on the FFA and HYS. sub-tests, and lower on the OBS. than the manual group. On the other three sub-tests scores were identical, (Table VI). The investigators therefore concluded that it is reasonable to suppose that social class had no significant influence on the scores of the MHQ. A similar conclusion was drawn by Crisp, Ralph, Guinness and Harris (1978) following the investigation of a fresh general population sample.

Reliability

The authors employed three methods of assessing the reliability of the MHQ. The first method repeat reliability was done by Crown et al (1970). Repeat reliability figures were established for 129 men, re-tested with a one year interval between. The reliabilities (product moment correlation were as follows):-
It was concluded from this study that the quantities measured by the MHQ were relatively stable over time. However, they further noted that coefficients were varying between 0.68 and 0.77 still allowed for variations on individual scores.

The second method to establish reliability was used by Cockett (1969a). He employed three groups of his "normal" (non-psychiatrically disturbed) delinquents, he obtained three independent random samples of 50 normals. These were the first 50, the middle 50 and the last 50 received. Each group as examined for average profiles on the MHQ. It was observed that the three samples were very similar.

The third method employed to establish reliability was used by Crisp and Brown (1966). Reliability coefficients were calculated using the split-half method separately for 62 patients and 43 controls (nurses). These are shown in Table VII. The internal consistencies of FFA., PHO., DEP., and SOM. sub-scales were considered satisfactory, whilst those of the OBS. and HIS. sub-scales were low.

The concept of "split-half" reliability applied to a clinical sub-test of personality traits, raises many questions about the rationale of using this method to determine the reliability of a test form such as the MHQ. The authors noted that the nature of such traits as OBS., SOM. and PHO. are specific and often unifocal. A patient may be found to be phobic or obsessional on two or three questions, but not on the remaining questions. Using the concept of "split-half" reliability is likely to render the sub-test unreliable. A fourth method used a factorial analysis. Bagley (1980).
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* * Significant at 0.01 level

** Significant at 0.05 level

Mean difference between means

Standard error of difference

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**TABLE 4**

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Comparison of manual and non-manual staff in authority survey

Table VI

Significant at 0.01 level
Significant at 0.05 level
Significant difference between means
Difference between means

on manual
on non-manual

In general

Descriptive statistical analysis
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Table VII

HCO (Preliminary Reliability Coefficients, Split-half, Correlated for Shortening)
ne of the grounds for rejecting alternative measures of mental health is that they have been shown to have various difficulties with black populations. No study of the MHQ carried out with Barbadian women resident in Britain (Robertson, 1975) indicates the general usefulness and validity of the scale or use with a black population in England. Robertson found that Barbadian women who had endured problems over separation from children had significantly higher scores on a number of the MHQ sub-scales. She reported that results from the MHQ accorded with data obtained in lengthy open-ended interviews by a psychiatric social worker.

Summary

Extensive standardisation data on "normal" and "patient" samples of both sexes have been presented for the MHQ. The most important feature of evaluation of the MHQ is that stable means and standard deviations have been established.

The repeat reliability coefficients of the sub-tests are relatively high, higher than the split half reliability coefficients demonstrated on Crown and Crisp's (1966) "normal" sample. The MHQ has been shown to be reliable enough to give clinical significance to changes in a person's psychopathology.

Age and social class have been shown to have no particular relevance in the clinical use of the test. The test seems suitable for Barbadians living in England.
Comparison of MHQ., Sub-Scales in Mental and General Hospitals In-Patients

In Barbados.

During my period of research in Barbados, I decided to test further the reliability of the MHQ on an inpatient population at the mental hospital - Jenkins. I selected for my sample all first admissions, age 18-70 to Jenkins ing a six week period.

obtain the subjects for my sample contact was made with the Head of the Works Department, whose office kept a record of all admissions and discharges. The majority of admission to Jenkins are re-admissions. See Appendix, Table XXI). Most patients have an average of three admissions a three years period. New admissions constitute a small proportion of total admissions. Patients are admitted to Jenkins in four different ways:

) Referral by General Practitioners.

) By being presented at the out-patients clinic by relatives or guardian.

) Referral - through the courts, for assessment or treatment.

) Referral by Chief Prison Officer - prisoner serving sentence admitted for treatment.

ost of the patients admitted to Jenkins are diagnosed as suffering from some form of psychotic illness. Such diagnoses as depression, hysteria and other forms of neurosis are quite rare. Some of the reasons for this occurrence will be discussed later. Another interesting feature of the psychopathology of patients admitted to Jenkins is the short period of in-patient stay. I have missed no less than 10 new admissions because of the very short period of hospitalisation: it is quite common for a patient to spend only a week in hospital.
Middlesex Hospital Questionnaire was administered to 33 first admissions to Jenkins over a period of six weeks. As stated earlier the number of first admissions over the six weeks period was more than 33 patients, but the very short period of hospitalisation meant that 6-10 patients were missed.

The sample comprised of 23 male patients and 10 female patients. Of the 23 male patients, 12 came from Tamarind House (T/H), 7 from Grassfield Ward (G/W) and 4 from 'A' Ward. The 10 female patients came from 'G' Ward. (See Table X). (See Chapter II for a discussion of the nature of these admission wards).

Nature of Interview

All patients in the sample were interviewed by the researcher. At no time were they allowed to read the questionnaire. It was necessary to take this precaution as the coding scores were already inserted in the questionnaire (MHQ). It was felt that if the test-form was given to the respondents with the scores inserted it would bias their responses to the questions.

Most of the patients in the study - and others admitted to Jenkins - are diagnosed as suffering from paranoid psychosis, schizophrenia or some other form of psychotic illness. (See Appendix V for psychopathology of patients in this study). This however is not to say that neurotic illnesses are absent; what one finds is a predominance of psychotic behaviour. An examination of patients' case-notes revealed that reasons given for admission usually centred around the occurrence of psychotic or psychotic like behaviour. The predominance of these psychotic features tends to mask neurotic disorders. The doctor therefore tends to treat the psychotic manifestations instead of the underlying neurotic disorder.
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**N.H. C. In-patient Population:** Percent admissions to Barbados Mental Hospital (Jenkings)
his observation is not a criticism of the medical personnel - of whom there are only 4 for a 700 hundred bed hospital - but rather an objective appraisal of the realities of psychiatry as practised in Barbados. The psychiatrists are so occupied treating psychotic behaviour across a wide spectrum, that often the subtleties in diagnosis are overlooked unknowingly, and only the very obvious depression or hysterics are observed.

Psychotic behaviour compared with other forms of mental disorders, presents the biggest danger to the individual and to society. The doctors are under pressure from society to give preference to the treatment of psychotics.

**Results**

The MHQ was designed to measure neurosis and not psychosis. It was therefore quite interesting to discover a high degree of neuroticism in a diagnosed psychotic sample. It seems to indicate that there were more patients suffering from various forms of neurosis than were diagnosed.

The scores of the psychiatric in-patient group of first admissions, compared with the 'normal' women (Crown, Duncan and Howell, 1969); and Crisp and Tonehill, 1969 (See Table X), shows a striking difference. All the MHQ sub-scales significantly differentiated the mentally ill from the English normals. Further comparison between the Barbadian psychiatric in-patient group, (first admission), and the English psychiatric in-patient group, suffering from diagnosed neurosis, Crisp and Liarkos, 1969) further established the validity of the MHQ. On all the six sub-scales, the psychoneurotic patients are significantly different from the psychiatric in-patient first admission) group.
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Study of In-Patients in Four Medical Wards

Other important data is provided by a study on an in-patient population from our medical wards of the Barbados General Hospital - locally known as the Queen Elizabeth Hospital, (QEH). In this study a group of 25 patients were sampled, 12 male and 13 female. The four wards contained more than the sample of 25 patients. It was necessary to select the patients on the basis of their physical health. Some patients had recently undergone surgery and others were too unwell to be interviewed. Selection of the patients was supervised by the senior ward sister. (See Table X). The scores of an in-patient in the QEH (See Table XI) compared with 'normal' females, from studies provided by Crown, Duncan and Howell, (1970) and Crisp and Stonehill (1969) show striking differences. The direction of the differences clearly shows the MHQ to be successful in picking persons experiencing stress and anxiety associated with physical illness.

Further comparisons between the in-patient sample from Jenkins and the sample from the four medical wards of the QEH shows great variation over the whole range of the test-form. The in-patient group from Jenkins scored high on the FFA and Dep., while the in-patient group from the medical wards of the QEH score significantly higher on PHO., OBS., SOM., and HYS. scales. These scores are probably in keeping with the various aspects of the patients' physical illness. The sample from the medical wards displayed more neuroticism than the diagnosed psychotically disturbed patients from Jenkins. It should be noted to that there may be a strong overlap between physical illness and psychiatric illness in some Caribbean populations, (Burke, 1972).

As stated earlier, the MHQ was not designed to pick up psychosis; therefore the low scores recorded for the psychiatrically disturbed do not point to the validity of the MHQ. All the MHQ sub-scales significantly differentiated the ill population from the 'normals;' only the FFA and the DEP. sub-scales
differentiated the diagnosed psychiatric in-patients from the medical in-patients. (See Table X).

In summary it seems fair to conclude, from the basic standardisation data that the MHQ efficiently differentiates between persons and various groups with clinical and sub-clinical neuroses. Its ability to differentiate psychotic in-patients from other groups is less clear. However, as an instrument for use in community studies of non-psychotic illness, and as a general measure of mental health, the MHQ has many advantages over instruments such as Eysenck's Personality Measure, Goldberg's Psychiatric Screening Test and Langner's Measure of Mental Health.

MHQ Means In Barbadian Samples

Following extensive further work in collecting data on the Middlesex Hospital questionnaire (MHQ) - data which indicated further reliability and validity or the scale - Crown and Crisp published a new manual in 1980, giving fresh formative data. The scale was renamed the "Crown - Crisp Experimental Index," although the original form remains unchanged. Since much of the analysis that follows was carried out and written before the publication of this new manual, I have continued to refer to the scale as the MHQ.

A crucial comparison is that between MHQ means for my Barbadian samples, in Barbados and Reading, and the latest and definitive normative group presented by Crown and Crisp (1980). This is given in Table XII. It will be seen that norms for the group in Barbados, and the English adult normative group (randomly sample from G.P. lists in a Cotswolds town) are very similar. Few significant differences emerge, and those that do imply better mental health for the Barbadian group in Barbados. What is more marked in these results is the relatively poorer mental health in the group of Barbadians living in Reading. Barbadian males in Reading are particularly likely,

Standard deviations are given in brackets.

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<td>2.56 (2.6)</td>
<td>3.39 (3.3)</td>
<td>3.45 (3.0)</td>
<td>3.68 (3.2)</td>
<td>3.45 (3.0)</td>
<td>2.96 (2.6)</td>
</tr>
<tr>
<td>Hysteria</td>
<td>(to)</td>
<td>(to)</td>
<td>(to)</td>
<td>(to)</td>
<td>(to)</td>
<td>(to)</td>
<td>(to)</td>
<td>(to)</td>
<td>(to)</td>
<td>2.56 (2.6)</td>
<td>3.39 (3.3)</td>
<td>3.45 (3.0)</td>
<td>3.68 (3.2)</td>
<td>3.45 (3.0)</td>
<td>2.96 (2.6)</td>
</tr>
<tr>
<td>Somato</td>
<td>(to)</td>
<td>(to)</td>
<td>(to)</td>
<td>(to)</td>
<td>(to)</td>
<td>(to)</td>
<td>(to)</td>
<td>(to)</td>
<td>(to)</td>
<td>2.56 (2.6)</td>
<td>3.39 (3.3)</td>
<td>3.45 (3.0)</td>
<td>3.68 (3.2)</td>
<td>3.45 (3.0)</td>
<td>2.96 (2.6)</td>
</tr>
<tr>
<td>Neurotic</td>
<td>(to)</td>
<td>(to)</td>
<td>(to)</td>
<td>(to)</td>
<td>(to)</td>
<td>(to)</td>
<td>(to)</td>
<td>(to)</td>
<td>(to)</td>
<td>2.56 (2.6)</td>
<td>3.39 (3.3)</td>
<td>3.45 (3.0)</td>
<td>3.68 (3.2)</td>
<td>3.45 (3.0)</td>
<td>2.96 (2.6)</td>
</tr>
<tr>
<td>Phobic</td>
<td>(to)</td>
<td>(to)</td>
<td>(to)</td>
<td>(to)</td>
<td>(to)</td>
<td>(to)</td>
<td>(to)</td>
<td>(to)</td>
<td>(to)</td>
<td>2.56 (2.6)</td>
<td>3.39 (3.3)</td>
<td>3.45 (3.0)</td>
<td>3.68 (3.2)</td>
<td>3.45 (3.0)</td>
<td>2.96 (2.6)</td>
</tr>
<tr>
<td>Free-floating Anxiety</td>
<td>(to)</td>
<td>(to)</td>
<td>(to)</td>
<td>(to)</td>
<td>(to)</td>
<td>(to)</td>
<td>(to)</td>
<td>(to)</td>
<td>(to)</td>
<td>2.56 (2.6)</td>
<td>3.39 (3.3)</td>
<td>3.45 (3.0)</td>
<td>3.68 (3.2)</td>
<td>3.45 (3.0)</td>
<td>2.96 (2.6)</td>
</tr>
</tbody>
</table>

A Comparison of MhG (GHQ) sub-scale mean scores in Barabadian and UK Groups

Table X

TABLE
comparison with Barbadian males in Barbados, and English males, to manifest rather high levels of phobic anxiety, obsessionality and hysteria. particularly interesting feature of these results is the relatively poor mental health of the men in the Barbadian sample in Reading, compared with the men. In Barbados, (as in the English normative group) women have significantly poorer mental health than men; this is not the case in the Reading Barbadians, where levels of mental health in overall terms, are not significantly different between the sexes.

at is it about the role of Barbadian males in Reading that disposes them to such poor levels of mental health? This question will be explored extensively later chapters.

own and Crisp have not utilised total scores on the six syndrome scales in their work, but since Bagley (1980) has shown that the sub-scales contribute a general factor of psychoneurosis. I have used the total MHQ score in chapters that follow as an important dependent variable.

appears that, despite a peculiarly Barbadian view of "Madness," and its nature and causes, the MHQ in Barbados measures dimensions of mental health which are quite similar to those of the English normative population studies Crown and Crisp (1980).

continuing the analysis of the research instrument, the next chapter will examine the development and use of the sociological questionnaire devised by the researcher, and the stress inventory devised by Holmes and Rahe and adapted Cochrane and Stopes-Roe (1977).
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The development of the sociological and stress questionnaire

One of the instruments used in the study was a sociological questionnaire which was designed primarily to find out what socio-demographic variables/factors are causally associated with poor mental health in a Barbadian population.

Our initial response was to find a suitable questionnaire which was already signed and tested. The sociological questionnaires in current use, were only specific in design, that is, they inquired into housing stress, relative deprivation or some other sociological dimension. We were unable to find a structured questionnaire which was suitable for a study of poor mental health, of a black immigrant group. It was therefore necessary to devise a specific questionnaire.

The sociological questionnaire was designed around a set of hypotheses, these re:

1) that immigrants who enter a new and different culture are likely to experience stress of various kinds.

2) immigrants who have infrequent or no contact with their relatives and friends are likely to feel isolated and experience poor mental health.

3) a high degree of family contact, neighbourhood and community interaction provides immigrants with social support and is positively associated with good mental health.
4) religious commitment and affiliation acts as a support mechanism, providing immigrants with a communal organisation, through which shared life experiences are exchanged.

5) the longer immigrants are resident in the host society, the more settled and acculturated they become, and the less likely they are to experience poor mental health.

6) frustration, disappointment, 'goal striving stress' resulting from the on-attainment of planned personal goals will result in immigrants experiencing poor mental health.

7) experiences of racial hostility and social rejection are likely to foster feeling of alienation and insecurity in immigrants, and will be reflected in poor mental health.

For the first pilot study 15 persons (West Indians) were interviewed. After each interview the respondents' views and opinions about the questionnaire was solicited. For example, the interviewee was asked some of the following questions:

1) Did you understand the questions clearly?

2) Were any of the questions ambiguous?

3) Was the questionnaire too long?

Views and answered questionnaires were analysed and a second pilot study conducted.

The second pilot study was comprised of 5 respondents from the first pilot study and 15 other respondents - all of whom were West Indians. From the two pilot studies, the present sociological questionnaire resulted.
Stress Questionnaire - Development

To complement the Psychological Questionnaire (MPQ) and the Sociological Questionnaire, a stress questionnaire was employed. After a careful study of the available research instruments for measuring stress, I selected the Life Events Inventory (LEI). It was the most reliable, very easy to administer and had been used by R. Cochrane et al. on ethnic minorities in Britain.

The LEI was devised by R. Cochrane and A. Robertson (1973). It originated from "The Schedule of Recent Experiences" which was devised by Holmes J.H. and Rahe R.H. (1967).

One of the first list published was by Holmes and Rahe and contained 43 life change events, (Holmes and Rahe, 1967). After distilling data from thousands of interviews of people admitted to a hospital with various physical diseases, the events which were reported to have occurred over the past few years prior to the onset of disease were analysed. These events were organised into categories dealing with health, work, family, personal life, social and community relations and finances. The Holmes and Rahe list of life events was designed to sample from those key areas of life adjustment, rather than to cover all the possible life change events. The theme of this list of events was that of change from a previous 'steady state' of life adjustment. (Holmes and Rahe, 1967; Rahe et al, 1964). (See Table 1)

Each event was assigned a weight which supposedly reflected the degree of disruption that would be caused. These weights were expressed as "life change units" (LCU's) and individual's scores on the S.R.E. being the sum of the LCU's of the one reports having experienced.

The original weights were obtained in a rather arbitrary fashion. Originally samples of 25 people were asked to act as judges and to assign a number between 1 and 100 to each event on the S.R.E. to indicate the amount of turmoil, upheaval and social adjustment that would result by its occurrence.
<table>
<thead>
<tr>
<th>Rank</th>
<th>Life Event</th>
<th>Mean Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Death of Spouse</td>
<td>100</td>
</tr>
<tr>
<td>1</td>
<td>Divorce</td>
<td>73</td>
</tr>
<tr>
<td>2</td>
<td>Marital Separation</td>
<td>65</td>
</tr>
<tr>
<td>3</td>
<td>Jail Term</td>
<td>63</td>
</tr>
<tr>
<td>4</td>
<td>Death of close family member</td>
<td>63</td>
</tr>
<tr>
<td>5</td>
<td>Personal injury or loss</td>
<td>53</td>
</tr>
<tr>
<td>6</td>
<td>Marriage</td>
<td>50</td>
</tr>
<tr>
<td>7</td>
<td>Fired at work</td>
<td>47</td>
</tr>
<tr>
<td>8</td>
<td>Marital reconciliation</td>
<td>45</td>
</tr>
<tr>
<td>9</td>
<td>Retirement</td>
<td>45</td>
</tr>
<tr>
<td>10</td>
<td>Change in health of family member</td>
<td>44</td>
</tr>
<tr>
<td>11</td>
<td>Pregnancy</td>
<td>40</td>
</tr>
<tr>
<td>12</td>
<td>Sex difficulties</td>
<td>39</td>
</tr>
<tr>
<td>13</td>
<td>Gain of new family member</td>
<td>39</td>
</tr>
<tr>
<td>14</td>
<td>Business readjustment</td>
<td>39</td>
</tr>
<tr>
<td>15</td>
<td>Change in financial state</td>
<td>38</td>
</tr>
<tr>
<td>16</td>
<td>Death of close friend</td>
<td>37</td>
</tr>
<tr>
<td>17</td>
<td>Change to different line of work</td>
<td>36</td>
</tr>
<tr>
<td>18</td>
<td>Change in the number of arguments with spouse</td>
<td>35</td>
</tr>
<tr>
<td>19</td>
<td>Mortgage over $10,000</td>
<td>31</td>
</tr>
<tr>
<td>20</td>
<td>Foreclosure of mortgage or loan</td>
<td>30</td>
</tr>
<tr>
<td>21</td>
<td>Change in responsibility at work</td>
<td>29</td>
</tr>
<tr>
<td>22</td>
<td>Son or daughter leaving home</td>
<td>29</td>
</tr>
<tr>
<td>23</td>
<td>Trouble with in-laws</td>
<td>29</td>
</tr>
<tr>
<td>24</td>
<td>Outstanding personal achievement</td>
<td>28</td>
</tr>
<tr>
<td>Number</td>
<td>Event</td>
<td>Frequency</td>
</tr>
<tr>
<td>--------</td>
<td>--------------------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>6</td>
<td>Wife begin or stop work</td>
<td>28</td>
</tr>
<tr>
<td>7</td>
<td>Begin or end school</td>
<td>26</td>
</tr>
<tr>
<td>8</td>
<td>Change in living conditions</td>
<td>25</td>
</tr>
<tr>
<td>9</td>
<td>Revision of personal habits</td>
<td>24</td>
</tr>
<tr>
<td>0</td>
<td>Trouble with boss</td>
<td>23</td>
</tr>
<tr>
<td>1</td>
<td>Change in work hours or conditions</td>
<td>20</td>
</tr>
<tr>
<td>2</td>
<td>Change in residence</td>
<td>20</td>
</tr>
<tr>
<td>3</td>
<td>Change in schools</td>
<td>20</td>
</tr>
<tr>
<td>4</td>
<td>Change in recreation</td>
<td>19</td>
</tr>
<tr>
<td>5</td>
<td>Change in church activities</td>
<td>19</td>
</tr>
<tr>
<td>6</td>
<td>Change in social activities</td>
<td>18</td>
</tr>
<tr>
<td>7</td>
<td>Mortgage or loan less than $10,000</td>
<td>17</td>
</tr>
<tr>
<td>8</td>
<td>Change in sleeping habits</td>
<td>16</td>
</tr>
<tr>
<td>9</td>
<td>Change in the number of family get-together</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Change in eating habits</td>
<td>15</td>
</tr>
<tr>
<td>1</td>
<td>Vacation</td>
<td>13</td>
</tr>
<tr>
<td>2</td>
<td>Christmas</td>
<td>12</td>
</tr>
<tr>
<td>3</td>
<td>Minor violations of the law</td>
<td>11</td>
</tr>
</tbody>
</table>
of the items used, marriage, was assigned an arbitrary weight of 50; the idea being that this would establish an anchoring point at the middle of the scale that would act as a common frame of reference for all the edges.

The instrument has been shown to be reasonably reliable (Casey 1967) and has been extensively used in studies of the antecedents of illness. (Thomas C. and Hendrie H.C. Environmental Stress In Primary Depressive Illness, chs, Gen. Psychiatric 26.130 (1972); Rahe K.H., Meyer M., Smith M., arai G. and Holmes J.H. Social Stress And Illness Onset. Journal of Psychosomatic Research 8,35 1964; Hendrie H.C. Paraskeva F.D., Baragar F.D. d Adamson J.D. Stress immunoglobulin levels and early polyorthrist's Journal of Psychosomatic Research 15,19 (1971); Rahe R.H. and Lind E. Psychosocial factors and sudden cardiac death: a pilot study Journal Psychosomatic Research 15, (1971).

Measurement of Recent Life Event/Change

England, Brown and Briley formulated an inventory of life change events rived from interviews with individuals developing acute episodes of schizophrenia, (Brown and Briley, 1968). Paykel, Prudoff and Uhlenhurt (1971) tended Holmes and Rahe's list to 60 life change events. Meyers, Lindenthal d Pepper formulated a list of 62 events based on items from the work of lmes and Rahe, and Antonovsky and Katz (1971). Rahe subsequently expanded his original list of 54 events, some of which had two or four options, making the actual number 76 events, (Rahe, 1975). Cochrane and Robertson (1973) revised the Holmes and Rahe scale, expanding it to 55 events, dividing into 3 sections and renaming it the Life Events Inventory, (LEI).
The first section of the LEI contains 35 items which are applicable to all respondents. The second section has 16 items for individuals who are or were married, while section three contains four items for individuals who have never been married.

Most recently, B.H. Dohrenwend and B.P. Dohrenwend (1978) composed a life change list of slightly over 100 items. Though the Dohrenwends completely thought the issue of sampling, completeness and working life events, their list proved to be very similar to previous lists. These similarities can be seen in Table 1, where the current Rahe list is presented next to the Dohrenwend list.

Despite its wide use in America, Cochrane found that the SHE had several standing deficiencies which considerably reduced its usefulness as a search tool. He noted three main deficiencies:

1) Many of the items on the SHE were not completely appropriate to a general measure of recent life stress. Some were trivial (e.g. Christmas), others were only relevant to a small number of people (e.g. major business adjustments—merger reorganisation, bankruptcy, etc). Still others were ambiguous (e.g. major change in financial state—a lot worse off or a lot better off than usual).

2) The SHE was not comprehensive or consistent in the items included. The original events were said to have been "empirically derived from clinical experience." It was felt that this list could be supplemented by other events obtained from a systematic inquiry into the kind of stressful events that befall people, to produce a more comprehensive measure of recent life stresses.

3) No published weights derived from groups on which the instruments were often used were available. Weights were not available from patients from other groups most likely to have extensive experience of the amount stress events cause.
<table>
<thead>
<tr>
<th>TABLE 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>RAHE LIST</td>
</tr>
</tbody>
</table>
| 1. An illness or injury which:  
  (a) kept you in bed a week or more, or took you to the hospital?  
  (b) was less serious than described above?  
  2. A major change in eating habits?  
  3. A major change in sleeping habits?  
  4. A change in your usual type and/or amount of recreation?  
  5. Major dental work? |
|  
| DOHRENWEND LIST |
| Health |
| 1. Physical illness?  
  2. Injury?  
  3. Started menopause?  
  4. Physical health improved?  
  5. Unable to get treatment for an illness or injury? |
| Work |
| 1. Changed to a new type of work?  
  2. Changed your work hours or conditions?  
  3. Had a change in your responsibilities at work:  
    (a) more responsibilities?  
    (b) less responsibilities?  
    (c) promotion?  
    (d) demotion?  
    (e) transfer?  
  4. Experienced troubles at work:  
    (a) with your boss?  
    (b) with co-workers?  
    (c) with persons under your supervision?  
    (d) other work troubles?  
  5. Experienced a major business readjustment?  
  6. Retired?  
  7. Experienced being:  
    (a) fired from work?  
    (b) laid off from work?  
  8. Taken courses by mail or studied at home to help you in your work?  
(continued)
### TABLE 1 (continued)

<table>
<thead>
<tr>
<th>RAHE LIST</th>
<th>DOHRENWEND LIST</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Financial</strong></td>
<td><strong>DOHRENWEND LIST</strong></td>
</tr>
<tr>
<td>1. Taken on a moderate purchase, such as a TV, car, freezer, etc.?</td>
<td>1. Started buying a car, furniture, or other purchase on the installment plan?</td>
</tr>
<tr>
<td>2. Taken on a major purchase or mortgage loan, such as a home, business, property, etc.?</td>
<td>2. Took out a mortgage?</td>
</tr>
<tr>
<td>3. Experienced a foreclosure on a mortgage or loan?</td>
<td>3. Foreclosure of a mortgage or loan?</td>
</tr>
<tr>
<td>4. Experienced a major change in finances?</td>
<td>4. Repossession of a car, furniture or other items bought on the installment plan?</td>
</tr>
<tr>
<td>(a) increased income?</td>
<td>5. Took a cut in wage or salary without a demotion?</td>
</tr>
<tr>
<td>(b) decreased income?</td>
<td>6. Suffered a financial loss or loss of property not related to work?</td>
</tr>
<tr>
<td>(c) credit rating difficulties?</td>
<td>7. Went on welfare?</td>
</tr>
<tr>
<td></td>
<td>8. Went off welfare?</td>
</tr>
<tr>
<td></td>
<td>9. Gained a substantial increase in wage or salary without a promotion?</td>
</tr>
<tr>
<td></td>
<td>10. Did not get an expected wage or salary increase?</td>
</tr>
<tr>
<td></td>
<td>11. Had financial improvement not related to work?</td>
</tr>
<tr>
<td><strong>Home and Family</strong></td>
<td><strong>Home and Family</strong></td>
</tr>
<tr>
<td>1. A change in residence?</td>
<td>1. Moved to a better residence or neighborhood?</td>
</tr>
<tr>
<td>(a) a move within the same town or city?</td>
<td>2. Moved to a worse residence or neighborhood?</td>
</tr>
<tr>
<td>(b) a move to a different town, city or state?</td>
<td>3. Moved to a residence or neighborhood no better or no worse than the last one?</td>
</tr>
<tr>
<td>2. A change in family &quot;get-togethers&quot;?</td>
<td>4. Unable to move after expecting to be able to move?</td>
</tr>
<tr>
<td>3. A major change in the health or behavior of a family member (illness, accidents, drug or disciplinary problems, etc.)?</td>
<td>5. Changed frequency of family get-togethers?</td>
</tr>
<tr>
<td>4. Major change in your living conditions (home improvements or a decline in your home or neighborhood)?</td>
<td>6. Remodeled a home?</td>
</tr>
<tr>
<td>5. Death of a spouse?</td>
<td>7. Spouse died?</td>
</tr>
<tr>
<td>(a) child?</td>
<td>9. Family member other than spouse or child died?</td>
</tr>
<tr>
<td>(b) brother or sister?</td>
<td>10. Close friend died?</td>
</tr>
<tr>
<td>(c) parent?</td>
<td>11. Married?</td>
</tr>
<tr>
<td>(d) other close family member?</td>
<td>12. Trouble with in-laws?</td>
</tr>
<tr>
<td>8. A change in the marital status of your parents?</td>
<td>14. Married couple got together again after separation?</td>
</tr>
<tr>
<td>(a) divorce?</td>
<td>15. Divorced?</td>
</tr>
<tr>
<td>(b) remarriage?</td>
<td>16. Birth of a first child?</td>
</tr>
<tr>
<td>9. Marriage?</td>
<td>17. Birth of a second or later child?</td>
</tr>
<tr>
<td>10. A change in arguments with your spouse?</td>
<td>18. Adopted a child?</td>
</tr>
<tr>
<td>11. In-law problems?</td>
<td>19. New person moved into the household?</td>
</tr>
<tr>
<td>12. A separation from spouse:</td>
<td>20. Someone stayed on in the household after he was expected to leave?</td>
</tr>
<tr>
<td>(a) due to work?</td>
<td>21. Became pregnant?</td>
</tr>
<tr>
<td>(b) due to marital problems?</td>
<td>22. Abortion?</td>
</tr>
<tr>
<td>13. A reconciliation with spouse?</td>
<td>23. Miscarriage or stillbirth?</td>
</tr>
<tr>
<td>14. A divorce?</td>
<td>24. Found out that cannot have children?</td>
</tr>
<tr>
<td>15. A gain of a new family member:</td>
<td>25. Relations with spouse changed for the worse, without separation or divorce?</td>
</tr>
<tr>
<td>(a) birth of a child?</td>
<td>26. Relations with spouse changed for the better?</td>
</tr>
<tr>
<td>(b) adoption of a child?</td>
<td>27. Marital infidelity?</td>
</tr>
<tr>
<td>(c) a relative moving in with you?</td>
<td>28. Person moved out of the household?</td>
</tr>
<tr>
<td>16. Wife beginning or ceasing work outside the home?</td>
<td>29. Serious family argument other than with spouse?</td>
</tr>
<tr>
<td>17. Wife becoming pregnant?</td>
<td>30. Lost a home through fire, flood or other disaster?</td>
</tr>
<tr>
<td>18. A child leaving home:</td>
<td>31. Built a home or had one built?</td>
</tr>
<tr>
<td>(a) due to marriage?</td>
<td>(continued)</td>
</tr>
<tr>
<td>(b) to attend college?</td>
<td></td>
</tr>
<tr>
<td>(c) for other reasons?</td>
<td></td>
</tr>
<tr>
<td>19. Wife having a miscarriage or abortion?</td>
<td></td>
</tr>
<tr>
<td>20. Birth of a grandchild?</td>
<td></td>
</tr>
</tbody>
</table>
TABLE 1 (continued)

<table>
<thead>
<tr>
<th>RAHE LIST</th>
<th>DOHRENWEND LIST</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. A major personal achievement?</td>
<td>1. Started school or a training program after not going to school for a long time?</td>
</tr>
<tr>
<td>2. A change in your personal habits (your dress, friends, life-style, etc.)?</td>
<td>2. Changed schools or training programs?</td>
</tr>
<tr>
<td>3. Sexual difficulties?</td>
<td>3. Graduated from school or training program?</td>
</tr>
<tr>
<td>4. Beginning or ceasing school or college?</td>
<td>4. Had problems in school or in training program?</td>
</tr>
<tr>
<td>5. A change of school or college?</td>
<td>5. Failed school, training program?</td>
</tr>
<tr>
<td>6. A vacation?</td>
<td>6. Did not graduate from school or training program?</td>
</tr>
<tr>
<td>7. A change in your religious beliefs?</td>
<td>7. Took a vacation?</td>
</tr>
<tr>
<td>8. A change in your social activities (clubs, movies, visiting)?</td>
<td>8. Was not able to take a planned vacation?</td>
</tr>
<tr>
<td>9. A minor violation of the law?</td>
<td>9. Increased church or synagogue, club, neighborhood, or other organizational activities?</td>
</tr>
<tr>
<td>10. Legal troubles resulting in your being held in jail?</td>
<td>10. Went to jail?</td>
</tr>
<tr>
<td>11. A change in your political beliefs?</td>
<td>11. Started a love affair?</td>
</tr>
<tr>
<td>13. An engagement to marry?</td>
<td>13. Engagement was broken?</td>
</tr>
<tr>
<td>15. Girlfriend (or boyfriend) problems?</td>
<td>15. Assaulted?</td>
</tr>
<tr>
<td>16. A loss or damage of personal property?</td>
<td>16. Robbed?</td>
</tr>
<tr>
<td>17. An accident?</td>
<td>17. Accident in which there were no injuries?</td>
</tr>
<tr>
<td>18. A major decision regarding your immediate future?</td>
<td>18. Involved in a lawsuit?</td>
</tr>
<tr>
<td></td>
<td>19. Accused of something for which a person could be sent to jail?</td>
</tr>
<tr>
<td></td>
<td>20. Lost drivers license?</td>
</tr>
<tr>
<td></td>
<td>21. Arrested?</td>
</tr>
<tr>
<td></td>
<td>22. Got involved in a court case?</td>
</tr>
<tr>
<td></td>
<td>23. Convicted of a crime?</td>
</tr>
<tr>
<td></td>
<td>24. Acquitted of a crime?</td>
</tr>
<tr>
<td></td>
<td>25. Released from jail?</td>
</tr>
<tr>
<td></td>
<td>26. Didn’t get out of jail when expected?</td>
</tr>
<tr>
<td></td>
<td>27. Took up a new hobby, sport, craft or recreational activity?</td>
</tr>
<tr>
<td></td>
<td>28. Dropped a hobby, sport, craft or recreational activity?</td>
</tr>
<tr>
<td></td>
<td>29. Acquired a pet?</td>
</tr>
<tr>
<td></td>
<td>30. Pet died?</td>
</tr>
<tr>
<td></td>
<td>31. Made new friends?</td>
</tr>
<tr>
<td></td>
<td>32. Entered the Armed Services?</td>
</tr>
<tr>
<td></td>
<td>33. Left the Armed Services?</td>
</tr>
<tr>
<td></td>
<td>34. Took a trip other than a vacation?</td>
</tr>
</tbody>
</table>

SOURCE:

Dohrenwend, B.P. and Dohrenwend, B.S. 1978
The S.R.E. Revised

The SRE was revised in two stages by Cochrane and Robertson.

Stage I

In Stage I a modified version of the SRE was administered to 125 psychiatric patients in Edinburgh. Eighty-four of these patients were admitted to hospital following an unsuccessful suicide attempt, the remaining sixty were consecutive admissions to five wards of a mental hospital. Schizophrenic, depressive, alcoholic, neurotic and personality disordered patients were represented in the sample. Following the administration of the questionnaire, patients were asked to report if any other events had happened to them in the previous year. A total of 59 new events were collected. Many events were not relevant. Many of the events collected were incorporated into the schedule by adding items which covered the specific event in a more general way.

Stage II

Weights for the items on the revised schedule were obtained from three sources:

1. a group of university students,
2. a group of psychiatrists and psychologists, and
3. a group of patients.

The patients were obtained from the sources described in Stage I. About 0% of the patients interviewed were unable to complete the questionnaire. For all three groups instructions were identical.

These were,

"would you please rate the amount of turmoil, upheaval and social readjustment that would follow each of the events listed below. Rate each
item on a 1 - 100 scale. With 100 standing for the maximum disruption.

an item marriage is assigned an arbitrary score of 50, so please rate
he others on a comparative basis with this. Thank you.

ollowing editing and revising, a new instrument emerged - the Life Events
ventory, (LEI).
able III contains the items on the LEI, together with the mean weightings
btained from three groups and the overall mean taken from three groups.
e coefficients are: Patients and psychiatrists 0.82; patients and students
.74; and psychiatrists and students 0.94. The coefficient of concordance
or all three groups is 0.89. All four coefficients were significant beyond
he 0.01 level.

Table I shows that not all the events will necessarily have a negative effect.
Items such as marriage, going away on holiday, are presumably happy events.
thers, such as moving house, new jobs, a new line of work and pregnancy,
ay be either pleasant or unpleasant, or even neutral events. The LEI is
esigned to quantify the amount of turmoil, disturbance and upheaval that
people are subjected to rather than just unpleasant experiences. Some of
the events are under the control of the subject himself, for example,
riage, abortion, and moving house. Others are outside his control, for
ample, death of a spouse and new neighbours. A large group of events
emain where it is impossible to decide, for example, unemployment and
orce.

The LEI has three distinct advantages over the SRE. It is more comprehensive
ore consistent in the kinds of events included, and has weights derived
rom groups most likely to have experienced the events involved.

Our examined the stress questionnaire and given reasons for its use, we
ill now begin to identify the concepts of stress and the way in which it is
TABLE III

The Life Events Inventory

Entries obtained from several groups for items on the Life Events Inventory

<table>
<thead>
<tr>
<th>Section I. All respondents</th>
<th>177</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of Students</td>
<td>79</td>
</tr>
<tr>
<td>No. of Parents</td>
<td>42</td>
</tr>
<tr>
<td>Total</td>
<td>177</td>
</tr>
<tr>
<td>00</td>
<td>00</td>
</tr>
<tr>
<td>----</td>
<td>----</td>
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<tr>
<td>67</td>
<td>13</td>
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<tr>
<td>65</td>
<td>25</td>
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<tr>
<td>69</td>
<td>00</td>
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<tr>
<td>62</td>
<td>42</td>
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<tr>
<td>65</td>
<td>99</td>
</tr>
<tr>
<td>62</td>
<td>72</td>
</tr>
<tr>
<td>98</td>
<td>22</td>
</tr>
<tr>
<td>47</td>
<td>69</td>
</tr>
<tr>
<td>48</td>
<td>28</td>
</tr>
<tr>
<td>65</td>
<td>75</td>
</tr>
<tr>
<td>63</td>
<td>69</td>
</tr>
<tr>
<td>60</td>
<td>94</td>
</tr>
<tr>
<td>65</td>
<td>72</td>
</tr>
</tbody>
</table>

**Explanations:**

- **Marital separation**
- **Breach of faith**
- **Marital separation**
- **Death of spouse**
- **Trouble or behaviour problems in own children**
- **Trouble or behaviour problems in own children**
- **Son or daughter left home**
- **Embarrassed with other relatives & in-laws**
- **Increase in number of arguments with spouse**
- **Increase in number of arguments with spouse**
- **Marriage**
- **Sex difficulties**
- **Mistreatment**
- **Mistreatment**
- **Serious physical illness or injury requiring hospital treatment**
- **Serious physical illness or injury requiring hospital treatment**
- **Serious physical illness or injury requiring hospital treatment**
- **Serious physical illness or injury requiring hospital treatment**
- **Serious physical illness or injury requiring hospital treatment**
Items in parentheses were added after the main study. Items derived from schedule of recent experiences.
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renwend, B.P. and Dohrenwend, B.P.


Kaye, L., Masuda, M. and T.H.


CHAPTER 3

A REVIEW OF THE LITERATURE ON STRESS AND MENTAL ILLNESS
CHAPTER 8

REVIEW OF LITERATURE ON STRESS AND MENTAL ILLNESS

tress" is a term that has been linked to varied concepts and operations (e.g., and Trumbull, 1967; Dodge and Martin, 1970; Henikle 1973; Jarvis 1968; Lazarus 1966; Askster 1974; Levine and Scott 1970; Moss 1973 and Grath 1970). For some researchers it is a stimulus, for others, stress lies inner strife and for others still it is an observable response to stimulus or situation. Thus the use of the term is somewhat hazardous cause of the lack of concensus on it's definition.

spite of these limitations, all the studies on stress (life events) and chiatric impairment have been mainly concerned with determining whether or t there is a relationship between the occurrence of life events - which can stress producing - the patterning of such events, and the degree of chological impairment.

life events affect the mental health of a population?

the literature, the temporal aspect of stress is often confused, the concept is employed in at least three different ways.

Stress as background; social context, social environment, social situation, essence or lack of support, living conditions.

Stress as the pace of daily living; level of usual experience life events changes, happenings or occurrences.

Stress as acceleration; rate of change in level of experience accumulation experiences, "the straw that broke the camel's back."

e Midtown and Stirling county studies presented the clearest documentation date that in large and representative populations, social situations, les and statuses have definite characteristics that are themselves stress-
ese two studies shifted attention from life time experiences as a determinant current mental health, (Langner and Michael 1964) to the role played by current experiences. The pace of daily life refers to the flow of experience the event inventories, (Dohrenwend, B.P. 1974; Holmes and Rahe 1967; ers 1972; Paykel 1974) directed to quantify this aspect of stress.

e second concept of stress lies in the alteration of the usual pace of life, th implication that each person has a usual or habitual level, and that artures from this are the sources of stress.
ese have been quantified (Holmes and Rahe 1967) comparing either samples people or time spans varying in degree of life change. Study of changes of the pace of life events in relation to mental health was pioneered by herman (1965) and Dohrenwend B.P. (1960) and was developed in studies by ers (1972, 1974) and the Yorklea study.

third concept of stress implies acceleration in the frequency of urrence of events beyond tolerance level. No one - to my knowledge - has t studied this concept.

Midtown study, Langner and Michael (1964) employed only a small number indications of current life experiences, but Henkje and co-workers, (1958, 4), Henkje and Wolff (1958) produced considerable evidence which showed t a person's definition of life situation is an important determinant of h mental health and illness, respectively. In other words, the respondents epition of his current life experiences as stressful has been shown to be essential component of the response pattern. This has been the central me in the London studies of schizophrenia and depression conducted by e Brown et al 1972.
Epidemiological studies, the classic investigation was that of Myers, dental and Pepper (1971). They interviewed one adult from each of the 8 households selected at random in New Haven, Connecticut. Individual life change events and total events all showed highest prevalence rates in the most psychologically disturbed of Myers sample; intermediate life change prevalence rates were found in the moderately impaired third of the group, and lowest life change prevalence was found in the healthiest third.

Ebers et al (1972) repeated the study two years later on 770 members of their original sample and found that persons increases in recent life change level tended to show worsening of their mental status.

A second major epidemiological study was that of Dohrenwend B.P. et al (1974). These investigators studied a large random sample of Washington Heights residents in New York City. They also looked at the effects of social class on life experience, and found that lower class subjects appeared to have more recent life changes than middle class individuals, mainly because lower social class subjects reported proportionately more socially desirable life events. Highest correlations were found between subjects recent life change events (over a period of one year) and indications of psychological disturbance for lower class subjects. Dohrenwend B.P. (1973) (1974) examined retrospectively reported life change unit scores, over six month period in thousands of U.S. and Norwegian sailors and found correlations between 0.22 and 0.36. Thus concluding that epidemiological studies in this area are consistent.
Clinical Studies

One of the most instructive clinical life change and depression studies are those of Paykel (1974) and Jacobs et al (1974) which examined patients' recent life changes prior to admission to hospital, or to an out-patient facility, for depressive disorders. They found that patients attending an out-patient clinic reported significantly higher recent life change scores over the period six months than did controls, but not as those reported by inpatients. Patients with highest recent life change scores were depressives who manifested suicidal ideation.

OWN et al (1973) studied a group of 114 depressed women living in London and compared their recent life histories to a community sample of women suffering from depression. They observed that a four-fold increase in highly threatening events occurred over nine months prior to the onset of depression. Nevertheless, Klerman (1974) estimated that no more than 20% of those confronted with loss and separation developed a clinical depression, and Paykel (1973) concluded his literature review by noting that life events can be only partial causes of depression and that the etiology in any one person is likely to be multiple.

OMPSON et al (1972) found that recent life change events identified prior to admission for endogenous depression were equal in number to those seen prior to reactive depressions. Vinoken and Selzen (1975) confirmed that in their clinical studies that recent life changes are increased in subjects' lives or to depression, and that this relationship is due largely to recent life change events which are socially undesirable.

NER et al (1975) found that school children with histories of parental death were significantly more anxious and depressed than matched controls. In his study of elderly individuals, Parkes et al (1970) found that a depressive reaction was commonly associated with a post-bereavement setting.
The best known study of the relationship between life change and schizophrenia, that of Brown and Briely (1968). These investigators studied a group of patients with acute onset of schizophrenia. They noted that a peaking of life change events occurred during the final three weeks prior to onset for the schizophrenic patients.

Hawartz and Myers (1977) in a study of 132 schizophrenics who had been previously hospitalised but were living in the community of New Haven, reported at the overall correlation between life events and current psychiatric impairment was seen to be weaker in the schizophrenic group than in the community group.

Statistical studies which have attempted to relate the onset of schizophrenia with psychological stress have not produced evidence consistent with such as expectation. For example, hospital admissions for psychosis were not increased in England during the blitz. Hempill R.E. (1941); Hopkins, F. (1943) and Wis, A. (1942). Moreover the hypothesis that emotional upset may precipitate hizophrenic symptoms does not seem to be sufficiently tested by studying those extreme situations prevailing during war and confinement in concentration camps, Helweg Larsen, P. (1952) and Niembinski, M. (1946). The majority of persons who become schizophrenic do so in the absence of much stress.

Einberg and Durell (1968) in their analysis of stress as a precipitant of hizophrenia, studied the role of adjustment to military service in precipitating schizophrenia. Data was gained by reviewing the service record of every non-commissioned soldier in the U.S. Army who was hospitalised for schizophrenia during the period 1956-60.
Einberg and Durell (1968) found that the rate of schizophrenia was markedly increased in the early months of military service as compared with the second year. The case records of two samples of patients were reviewed in order to determine whether the detection of chronic cases would have accounted for these findings. However, there was some evidence that detection of chronic cases occurred to a somewhat greater degree in the early months.

They concluded that the hypothesis which was most consistent with their data, that emotional stress associated with the necessity of making a social adaptation was effective in including the onset of schizophrenic symptoms, Einberg and Durell are unable to conclude that military service caused psychotic behaviour in men who would otherwise not have succumbed. This therefore suggests that only those men who showed some predisposition for schizophrenia, and who might have broken down in civilian life, become psychotic when confronted with the stress produced by military service.

**Life Change and Neurosis**

oper and Sylph (1973) studied episodes of neurotic illness in a general medical practice, and found that the neurotics reported twice the life change events as did the controls. Recently Tennant and Andrews (1978) found in a community sample of adults in Sydney, Australia, a significant relationship between patients' recent life change experienced and the onset of neurotic disturbance.

Most Western cultures life changes perceived by individuals as stressful may play a part in the onset of psychological disturbance. We will continue briefly discussing cultural stress factors.
Cultural Stress Factors

Although cultures vary in both form and content, a generalised framework underlies cultural relativity. Some anthropologists, such as Murdock (1945); Kluckholn (1953) and Levi-Strauss (1953) have endeavoured to identify the basic universal elements of this generalised framework which derives from the fact that every single culture must cope with identical basic human needs, tendencies and circumstances such as certain biological and psychological needs and mechanisms - the helplessness of infants, sexual dichotomy and differences in age, social and linguistic communication.

No culture has succeeded in solving these problems without coercion of varying forms and degrees. Many coercive practices are common place and include such activities as child rearing practices, initiation rites, and schooling are among the best known techniques used to compel individuals to conform to certain social rules. In most, if not all cultures, the negative effect of tensions arising from these constraints is somewhat lessened by psychological compensation for culturally standardised behaviour, by training to tolerate them, by cultural mechanisms which serve as outlets and by culturally institutionalised social niches for deviants and "marginal" individuals. For example, reversal rituals (Turner 1969) festivals, funeral rites, drinking, provide socially sanctioned outlets or as Wallace (1964) puts it, "cathartic strategies" for cultural tensions.

Nevertheless, such cultural mechanisms can only mitigate cultural factors of stress. They do not eliminate them.
From this generalisation two major questions arise:

1. Are there cultures which are more pathogenic than others?
2. Are there specific dimensions of culture which are more pathogenic than others?

The first question cannot be clearly answered. It could be assumed that simple cultures, where constraint and suppression of psychological drives are less numerous and intense, will stimulate less anxiety and less psychological disturbances than complex societies. For example, the Ifaluk culture of Micronesia has been described as practically devoid of anxiety producing stimuli, and as without "discordance between sectional goals and sectional means". (Spiro, 1963). Yet hostility and anxiety characterise Ifaluk individuals, and mental illness is not uncommon among them, so the first assumption is not always correct.

On the other hand there is some evidence, based on epidemiological studies, that some societies breed more mental illness than others. Leighton et al (1963) have found that proportionately more Canadians of rural Nova Scotia, than Youraba of Nigeria, suffer from mental disease. However, because of the ubiquity of most types of mental disease, it would be hazardous to classify cultures as more or less pathogenic in respect of mental disease in general. Another important factor in the relationship between stress and mental illness is sex differences.

Sex Differences in Illness Behaviour - A Response to Stress

Sex differences in illness behaviour have long been recognised (Ebrunuch, B and English 1973). However empirical studies on what these differences are, and
Theoretical explanations of why these differences exist have been noted by Nathanson (1975). Information of sex differences in illness behaviour has been noted from a variety of sources, including feminist literature, (Chesler, 1972; Sassman, 1970; Sociological and social psychological literature, Mechanic; Robinson 1971 and medical literature, Steinberg 1970 and McDonald 1972). Nathanson (1975) noted that women utilised services of physicians and hospitals more frequently than men. Gove and Tudon (1973) further observed that more women are mentally ill and more women utilise psychiatric facilities than men.

A number of different explanations have been given for the relationship between sex and illness behaviour. Most of these fall within one of three different perspectives on illness behaviour. The first perspective sees illness behaviour as a product of socio-cultural conditioning, (Mechanic 1973) and women are conditioned to be more sensitive to symptoms than men, and that women's roles are more compatible with the sick role than are men's roles. The second perspective conceptualises illness as it is related to stress and coping (Mechanic 1973). This perspective further claims that stress is related to illness and as women are under more stress than men, they are more often ill than men.

Women when distressed and ill, seek medical care more readily while men do not, and lastly, women cope with stress by being ill and seeking medical care, (Tessler et al 1976).

The third perspective is that sex differences in illness behaviour are due to psychological factors.

The purpose of this chapter, I am mainly concerned with the third perspective, which views illness as it is related to stress and coping.
Sler et al (1975) have noted that distress is a causal factor in illness that individuals experiencing high levels of stress will have high rates of illness. There is a good deal of research linking high levels of stress to the presence of physical as well as mental illness in women, (McDonald 1972; Bentzen 1963; Melges 1972). Little (1970) has suggested that women see the environment as more threatening than do men, and this puts them under greater stress and causes them to be more sensitive to symptoms of illness than men. According to Gove and Tudor (1973) the higher rates of mental illness among married women, as opposed to married men, are due to roles inherent in their roles. They claimed that the following five types of stress are experienced by married women.

Housewives have no sense of gratification outside the family.

The role of housewife is frustrating.

The role of the housewife is unstructured and invisible.

Working wives have less satisfactory jobs than their husbands.

The role expectations for women are diffuse and unclear.

There are some conflicting research findings which show that levels of stress are higher among males. Such findings have used to explain a number of transitions in boyhood and manhood - for example, juvenile delinquency and personality disorders respectively, (Bentzen 1963). Waldron (1976) has related to the stressful nature of male roles and their contribution to stress and illness behaviour.

There has been a limited number of studies done on sex differences in illness or conditions of stress. Most of the studies in this area are not designed to measure stresses that affect only females (Melges 1972, Bardwick 1973).
ile others have examined stress and help seeking for female illness
conditions, (Mc Donald et al 1972, Paige 1973). We need more research that
designed to find out whether or not patterns of illness behaviour differ
re men and women under stress.

Conclusion

e results of epidemiological community studies of the prevalence of mental
sorder indicate that a significant proportion of the population is
psychiatrically impaired. rates may vary according to the research definitions
psychological impairment. However, all studies indicate that nearly 20%
the population is markedly impaired, with the proportion of mildly
aired nearly 80%. Some researchers, (Dohrenwend et al 1975) question
ese findings, suggesting that the proportion of symptomatology reported in
idemiological field studies may be caused by stressful events contemporary
the situation, and therefore may be temporary rather than true manifestations
deep, persistent psychological disorders.

e association between individuals life changes during the six months to one
ar preceeding illness onset has been documented repeatedly. However life
anges alone do not exert a primary effect on illness onset. What effect
ey exert is influenced by the way in which the individual perceives them,
well as the individual's social support, psychological defences, coping
abilities and illness behaviour characteristics. (Rahe and Arthur, 1978).

those individuals who experience stressful life changes, there are more who
not report illness symptoms than there are who do. Therefore a major
earch question is, how do the majority of individuals tolerate their stress
changes and remain 'healthy'. A great deal of research needs to be done
the area of individual's stress tolerance characteristics.
He (1979) suggests that 'questionnaires need to be developed which will reliably and validly measure subjects biological assets and liabilities, their social support systems, their past and current life satisfactions, their psychological coping abilities and their illness behaviour characteristics.' An attempt has been made to add stress tolerance variables to life stress and illness studies. A study in Sydney, Australia, included measures of a person's social support and their psychological defence into life change and psychological disturbance measure (Andrews et al, 1978). The researchers found that persons with low stress, high social support and mature psychological defences, had only 12% psychiatric impairment rates compared with a 3% rate persons with high stress, low social supports and immature defences. Further research in this direction is needed.

It has shown from the literature review on stress and mental illness, that the degree of stress associated with a particular life event or events is an important/causal factor in the degree of psychological impairment experienced. Further, the way in which individuals perceived their situation - the significance attached to the life event - was of great relevance to the extent to which the event becomes stressful.

Ass, social environment, sex differences, changes of various kinds in the life style or living patterns were all shown to have a potentially stressful effect.

From the review of the literature the following hypotheses, which would be tested later, were formulated.

Hypotheses

1) Individuals in the lower class reported more stressful life events/psychological disturbance than individuals in the middle or upper classes.

2) Individuals who live in socially deprived situations - for example, bad housing conditions, and unemployment - experience more stressful life events
Psychological disturbance than do socially better off individuals.

) Individuals who experience separation, bereavement and severe disruption their social support network are more likely to report stressful life events and psychological disturbance than those with their social support network intact.

) Individuals who experience difficulty in making social and cultural adaptation (to a foreign society) experience more stressful life events than those who adapt readily.

) Women experience more stressful life events than men.
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CHAPTER 9

EMIGRATION FROM BARBADOS TO THE U.K. - HISTORY, AREAS OF SETTLEMENT,
PROBLEMS EXPERIENCED
Emigration From Barbados To U.K. - History, Areas of Settlement

Problems Experienced

History

Among Caribbean territories Barbados is classified as a small island with a high population density (approximately 1,430 persons per square mile). Emigration from Barbados has traditionally dominated the movement from the Caribbean as a whole, to the extent that Lewis (1968: 228) refers to the 'Barbadian person exporting economy.' In the early years of the movement Roberts, citing figures for the rate of migration from Barbados concludes:

"But for emigration on a relatively large scale Barbados already densely settled - 1844 (with 740 persons per square mile), might by now have reached a disastrous state of overcrowding, relief from which would have been possible only by widespread starvation, disease and death." (Roberts, 1955: 245). (For a more detailed account of emigration from Barbados, see Roberts, 1955).

Between 1904 and 1921, the movement of workers from the island to help build the Panama Canal, contributed significantly to a substantial decline in population. Between 1904 and 1921 more than 2.3% of the population left each year (Lowenthal, 1957: 455). Because most of the migrants were young adults, the movement also had the secondary effect of contributing to a reduction in births in Barbados, "......from more than 7,000 a year in 1895 - 1904 to less than 6,000 in 1911 - 1915....." (Lowenthal, 1957: 455).

Early coloured migration to Britain consisted of slaves from Africa brought from the West Indies by planters returning home. In 1772 the fourteen or fifteen thousand slaves who were freed either went to Sierra Leone, returned to the West Indies or stayed in England and worked at a trade. By the end of the nineteenth century, coloured settlements were
ound in dock areas of London, Cardiff, Bristol, Liverpool, Hull and the
orth and South Shields. Students, who had been coming to Britain for
wo hundred and fifty years, usually returned home.

The third phase of migration started when thousands of West Indians went
to Britain to help during the Second World War.

The fourth phase started after the 1952 McCarran Act which stopped West
Idians migrating to the United States, as well as deteriorating economic
onditions in the West Indies. caused another wave of migration to
ritain. In 1951, 1,750 West Indians came to Britain.

United Kingdom

uring the 1950's, the migration policy was followed in two ways. Firstly
hrough the sponsored emigration scheme and secondly through the loan
cheme.

ponsored Scheme

ie first scheme was started in 1950, when 20 Barbadians were sent to
ritain to work as orderlies in British hospitals. No further recruitment
ook place until 1954, when 29 nurses were sent to Britain. From 1955 on-
ards the numbers steadily increased, reaching almost 3,839 workers by
960. Table II shows further information on Government Sponsored
migration to the U.K. for the period 1950-72.

ie year 1960 witnessed a marked increase in the number of Barbadians
aving the island on Government Sponsored Schemes. The number of
igrants for the years 1960 was 1,011, which was more than double the
umber of persons - 464 - who left during 1959. This increase was
tributed to the opening of new avenues of employment and the widening
f those already in existence. There was an increase in the number of
The years 1960-65 were characterised by fluctuations in the number of emigrants leaving B'dos. The year 1960 marked the high water period, in which the number of emigrants increased from 20 in 1955 to 1,011 in 1960. After 1963 the number of government sponsored schemes fell dramatically from 1,499 emigrants in 1963 to 972 in 1964. This decline was attributed to the absence of recruitment to the British Army, and a reduced quota required by the London Transport Board.

There was also a reduction in the number of independent emigrants, from 2,489 in 1962 to 1,591 in 1963. The decrease resulted from the introduction of the 1962 Commonwealth Immigration Act which prohibited the entry of emigrants who were not in possession of entry certificates of work vouchers. Sponsored emigration to the U.K. increased by 26% from 218 in 1969 to 274 in 1970. In 1969 the recruitment comprised 112 nurses, 59 workers for the London Transport, 43 for work with Lyons, 3 maids and 1 laundry worker. With the ever tightening network of immigration controls in the U.K. sponsored emigration suffered further setbacks. The amount of persons recruited for employment fell to only 83 in 1971. These were 58 nurses and 25 Lyon workers.

The decline in sponsored emigration continued in 1972 with only 62 persons recruited for nursing in the United Kingdom.
<table>
<thead>
<tr>
<th>Year</th>
<th>No. of Emigrants</th>
</tr>
</thead>
<tbody>
<tr>
<td>1950</td>
<td>20</td>
</tr>
<tr>
<td>1954</td>
<td>39</td>
</tr>
<tr>
<td>1955</td>
<td>361</td>
</tr>
<tr>
<td>1956</td>
<td>835</td>
</tr>
<tr>
<td>1957</td>
<td>650</td>
</tr>
<tr>
<td>1958</td>
<td>464</td>
</tr>
<tr>
<td>1959</td>
<td>1,011</td>
</tr>
<tr>
<td>1960</td>
<td>978</td>
</tr>
<tr>
<td>1961</td>
<td>1,315</td>
</tr>
<tr>
<td>1962</td>
<td>1,499</td>
</tr>
<tr>
<td>1963</td>
<td>972</td>
</tr>
<tr>
<td>1964</td>
<td>1,350</td>
</tr>
<tr>
<td>1965</td>
<td>420</td>
</tr>
<tr>
<td>1966</td>
<td>336</td>
</tr>
<tr>
<td>1967</td>
<td>214</td>
</tr>
<tr>
<td>1968</td>
<td>218</td>
</tr>
<tr>
<td>1969</td>
<td>274</td>
</tr>
<tr>
<td>1970</td>
<td>83</td>
</tr>
<tr>
<td>1971</td>
<td>62</td>
</tr>
</tbody>
</table>

Source: Barbados Economic Survey.
The repayment of these loans caused considerable hardship to many migrants who also had to make remittance to their families from their small weekly wages. In those cases where loans were in arrears, the government often applied pressure on the guarantors in Barbados, to sell their property to recover the loan.

Despite financial difficulties in obtaining loans, plus a reduction in the numbers recruited through government schemes, immigration kept a steady pace. Table IV shows the number of non-sponsored emigrants to the U.K. between the period 1955-1969.

**Table IV**

**Non-Sponsored Emigration to the U.K. 1955-1969**

<table>
<thead>
<tr>
<th>Year</th>
<th>No. of Emigrants</th>
</tr>
</thead>
<tbody>
<tr>
<td>1955</td>
<td>2,181</td>
</tr>
<tr>
<td>1957</td>
<td>1,417</td>
</tr>
<tr>
<td>1958</td>
<td>889</td>
</tr>
<tr>
<td>1959</td>
<td>2,434</td>
</tr>
<tr>
<td>1960</td>
<td>3,330</td>
</tr>
<tr>
<td>1961</td>
<td>5,552</td>
</tr>
<tr>
<td>1962</td>
<td>2,498</td>
</tr>
<tr>
<td>1963</td>
<td>1,591</td>
</tr>
<tr>
<td>1965</td>
<td>851</td>
</tr>
<tr>
<td>1969</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>20,748</td>
</tr>
</tbody>
</table>

Source: Labour Department, Barbados.
The second scheme through which Barbadians emigrated to the U.K. was known as the loan scheme. The loan scheme was very restricted. In order to qualify for a loan, the prospective migrant had to show first, proof that he had an offer of employment abroad, secondly, offer satisfactory collateral and thirdly, have a local guarantor. Most emigrants were unable to meet these three conditions, hence the majority of loans were taken by people who travelled under official recruitment schemes.

Between 1955-1960, the Barbados Government lent $1,691,644 British West Indian Dollars (£352,417) under the scheme, of which BWI dollars 1,118 were repaid by 1960, (See Table III, below).

Table III
Barbados Emigration Loan Scheme, 1955-1960

<table>
<thead>
<tr>
<th>Year</th>
<th>No. of Loans</th>
<th>Amt. of Dollars (W.I. dollars)</th>
<th>Av. Loan (W.I. dollars)</th>
<th>Pounds</th>
</tr>
</thead>
<tbody>
<tr>
<td>55</td>
<td>456</td>
<td>142,533</td>
<td>313</td>
<td>65</td>
</tr>
<tr>
<td>56</td>
<td>1,394</td>
<td>486,074</td>
<td>349</td>
<td>73</td>
</tr>
<tr>
<td>57</td>
<td>891</td>
<td>303,394</td>
<td>341</td>
<td>71</td>
</tr>
<tr>
<td>58</td>
<td>487</td>
<td>170,340</td>
<td>352</td>
<td>73</td>
</tr>
<tr>
<td>59</td>
<td>525</td>
<td>175,536</td>
<td>334</td>
<td>70</td>
</tr>
<tr>
<td>60</td>
<td>1,052</td>
<td>412,763</td>
<td>392</td>
<td>82</td>
</tr>
<tr>
<td>Total</td>
<td>4,805</td>
<td>1,690,644</td>
<td>352</td>
<td>73</td>
</tr>
</tbody>
</table>

Sources: Labour Department, Barbados.
The 1962 Commonwealth Immigration Act - its effect on Barbadian Emigration

The threat of the 1962 Commonwealth Immigration Act, created the feeling among prospective migrants that their one remaining chance of escaping from grinding poverty was being denied. Others felt that they may be permanently cut off from their families and friends. The movement had a 'ratchet effect' - the more people who emigrated the more others are encouraged to do so.

The Immigration Act of 1962 considerably reduced the numbers migrating. The reduction was short-lived. Immigration during the early seventies remained constant. In the late 70's immigration was reduced to a trickle with practically no one seeking employment in Britain. This was due to a number of domestic factors. In England there were fewer opportunities, unemployment had risen, both among the native-born and among foreigners. Racial tensions had increased, and the British government introduced more restrictive immigration laws. In Barbados, independence produced more and better opportunities for social and economic advancement. The government was more concerned with keeping its skilled workers in the country and offered them more attractive jobs.

In 1963, the then Labour Commissioner was seconded to the newly created post of Liaison Officer to the Barbados Welfare and Liaison Service in the U.K., this has now been merged with the Barbados High Commission. London Transport which was the main employer of government sponsored migrants, entrusted the Labour Departments with the administration of tests normally given to entrants recruited in the U.K. and with the processing of successful candidates, so that on arrival the recruits were ready, after a two week orientation course, to assume their duties. Facilities for the loan of passage money were provided for these recruits and for any other emigrants given proof of employment. Student nurses had similar facilities to those of London Transport.
In 1964 the demand for catering staff promised to excel all others, but the 1965 amendment to the Commonwealth Immigration Act brought this to a halt. The closing of the outlet to the U.K. had been a great loss; up to 1966 over 9,000 Barbadians had migrated under sponsorship to the U.K. and when account was taken of the number of dependents, relations and friends who joined them, it was no wonder that the population of Barbados in 1961 showed a decrease of 619 persons over the previous year.

**Reasons for Migration**

**Length of Stay**

People who take jobs in other countries do so for periods of varying lengths. At one extreme there are those, such as entertainers, who work in a country for only a few weeks. At the other are migrants who definitely intend to settle in another country at the time they move, and who actually remain there. Migrants may stay in their country of destination for shorter or longer periods than they originally intended. For example, some return home sooner than they planned because they find it difficult to adapt to a new environment.

Bohning (1972) suggests that the great majority of migrants in Europe are what he describes as "poly-annual migrants," that is people who plan to work for a few years in a richer country than their own, before returning home to enjoy the savings they have accumulated. He notes that such poly-annual migrants often stay longer than they had planned - and may all be joined by their wives and families - because they find it harder to accumulate savings than they had anticipated and because they acquire the norms and values of a consumer society.

They may eventually settle in the country of immigration or at least remain there until reaching retirement age.

There is some evidence which may suggest that new Commonwealth immigrants
including Barbadians - to Britain correspond to this pattern. Furthermore, in the case of Barbadians and other West Indians, there is a reluctance to return home because of the limited job market. Many Barbadians working in the service industries, such as London Transport, British Rail, Lyons, Nursing and other ancillary jobs, would find themselves unemployed if they returned home.

Lawerence (1974) quotes the results of various surveys in the 1960's, which show that less than a fifth of New Commonwealth immigrants intended to settle when they first came here, and that though the proportion planning to do so had increased by the time they were interviewed, the great majority still intended to return home.

Many Barbadian immigrants still have strong links with their home country, for example, sending remittances to dependants there and taking extended holidays to visit them.

The extent to which Barbadians actually return home will depend on various factors, including their success in Britain and the economic situation at home. Restrictions on immigration may not only prevent new immigrants from entering the country but may also discourage others from leaving. This is because they know it would be very difficult to come back into Britain if they are not successful in re-establishing themselves in their home countries. The fact that they have children who are being educated, and who in many instances, were born in Britain is often a further reason for New Commonwealth immigrants staying here. The attitudes of the growing number of young black people who have spent most of their lives here are likely to be different from first generation immigrants, who arrived after reaching working age.
Factors Causing Migration

A number of studies have shown that the bulk of migration to Britain from the West Indies - Barbados specifically - since the war has had economic causes, in particular relative earnings and unemployment levels in the British West Indies and difficulties in filling unattractive jobs in economically advanced Britain.

Some Studies of the Causes of Migration to Britain from the British West Indies

As early as 1959 Senior related the increase in Britain's black population to changes in the supply of labour. In his view the unfavourable effects of emigration to the Old Commonwealth on the expanding post-war economy, together with a long term decline in Britain's rate of natural increase had declined to produce a declining rate of growth in the labour force. As a result in only two of the previous ten years (1945 & 1952) had the numbers of notified unfilled vacancies at mid-year failed to exceed the number of unemployed.

In a survey between 1961 & 1964 of firms employing West Indian immigrants, Wright (1968) found the main reason they gave for doing so was a shortage of labour. A number of firms had at first turned to foreign white workers in an attempt to overcome their labour shortages and had later engaged black workers because they could not recruit enough white workers from abroad. British employers recruited workers in the West Indies, especially Barbados, in the 1950's. See Appendix VII.

Views on the relative importance of the push factors such as high unemployment (and underemployment) and low earnings in the West Indies, and of the pull factors of a high demand for labour and high earnings in Britain differ.
For example, Davison (1968) found an "unmistakeable" negative relationship between the per capita income of various West Indian Islands and the rate of emigration. But Peach (1968) considered the high rate of population growth substantial unemployment and low earnings in the West Indies were permissive rather than determining factors. He considered that the main reasons for West Indian migration was the demand for labour in the U.K. Over the period 1956-60 fluctuations in arrivals reflected fairly closely changes in the numbers of notified unfilled vacancies and the proportion of women migrants rose when labour demand was high. He quoted evidence that most West Indian immigrants had contacts in the U.K. before going there; the following passage comes from the 1960 Economic Report for Jamaica.

"Throughout the years since the movement of workers to Britain started it has proved sensitive to conditions in that country and it is likely that reports and letters received from Jamaicans in the U.K. now represent the determining factor so far as the level of migration is concerned."

Each (1968) noted that the relationship between labour demands in the U.K. and immigration was upset by the pressure to restrict immigration which eventually resulted in the Commonwealth Immigrants Act 1962. As a result of that pressure there was substantial immigration, to beat the curbs, despite the fact that labour demand was declining.

Awareness (1974) suggests that push factors were the more important. Replies given by New Commonwealth immigrants to the question; Why they had left their home countries and come to Britain? 54% of West Indians, 6% of Indians and 77% of Pakistanis gave economic reasons as the main actors.
Whatever the relative weights that are given to push and pull factors, it is clear that the substantial differences between employment opportunities and earnings in the U.K. and the New Commonwealth has been the major reason for New Commonwealth migration to Britain.

Areas of Settlement

The majority of Barbadians who came to England in the 1960's were sponsored by the British service industries and settled mainly in London. They settled in such areas as Brixton, Lambeth, Paddington and Brent - notably the Stonebridge/Neasden areas. These areas were chosen because of easy access to the British Rail and London Transport depots at which they worked. Other reasons for settling in these areas were; proximity to friends and relatives who had previously emigrated and because the British Rail authorities usually found accommodation for its black workers in these areas.

However they tended generally in the early years of settlement to move from areas of temporary recession to areas of continued labour shortage. This meant that they settled in industrial cities and large towns rather than in docks and port areas, and were much more concentrated in urban areas than the native population on the whole.

Many Barbadians still live in the districts in which they first settled, for example, Lambeth and Brent have respectively over 2,000 Barbadians residents. However there is evidence that large numbers of Barbadians have moved from "established settlements" to single family housing in "better" and less concentrated areas. A large number of Barbadians are now living in Reading, moved there from Paddington and other areas of North Kensington.
Some idea of the geographical patterns of settlement, of the degree of concentration and overcrowding, of household characteristics and amenities, and of mobility, can be derived from the 1961 General Census report and 1961 10% census report on Commonwealth Immigrants in the Connurbations.

Problems Experienced

Emigrants from Barbados confronted problems similar to those experienced by other West Indian groups; the problems discussed below are therefore not uniquely Barbadian.

Employment

The majority of Barbadians who emigrated to England, did so through Government sponsored schemes. This system helped to cushion Barbadian immigrants from many of the difficulties other emigrants experienced in seeking employment. However for those Barbadian immigrants who weren't sponsored, job finding proved to be a harsh experience in which prejudice was rife.

A decade later, in spite of the establishment of various monitoring institutions, for example, the Community Relations Commission, and laws against discrimination in jobs on the grounds of race, racial discrimination in employment is still evident.

In April 1977 the Political and Economic Planning researchers, published a report which showed that a large majority of people considered the colour of a man's skin sufficient justification to deny him the fundamental rights of shelter and livelihood. P.E.P. had carried out a survey of racial discrimination in three fields - housing, employment and credit facilities - and concluded that the differential treatment and experiences of black immigrants as against other majority groups (such as Cypriots and
Hungarians) leave no doubt that the discrimination is largely based on colour. The investigation of employment opportunities showed that the majority of employers would not accept coloured staff even when properly qualified. Owners and managers of employment bureaus estimated that 90% of their clients would not accept coloured office staff. It revealed also that the majority of employers rejected the possibility of promotion for coloured workers because of the resentment they expected from their white staff.

The pattern is not of violent prejudice, but of institutional avoidance. But since, increasingly the personal worth of a man is elevated by reference to his work, this discrimination increasingly marked black people as incapable of better jobs and therefore of less value to society.

**Housing**

Like most newcomers to a foreign country, Barbadian immigrants gravitated towards or were 'forced' into private sector accommodation, usually 'furnished,' in zones of transition or lodging house areas, such as sections as Brixton, North Kensington and Lambeth. These areas contained many large formerly middle class Victorian houses, often on leaseholds nearing their end, which have experienced steady social and structural degeneration since the end of the 1914-18 war. The housing accommodation was the worst and often the cheapest available. The immigrants could not afford better accommodation because more often than not they had to make weekly or monthly remittances home to their families who were dependent on them for maintenance.

Further difficulties awaited the coloured immigrants when they attempted to move out of their squalor. Whatever type of housing coloured immigrants sought, they encountered considerable discrimination or severe handicaps.
According to the Milner-Holland Report (1965) on housing in London, only 11% of privately let property is both advertised and does not specifically exclude black people. Whenever this small section of the private letting market which is in theory open to coloured applicants was tested, it was discovered that in practice two thirds excluded them. When English, Hungarian and coloured testers called on sixty advertised properties, some 45% resulted in discrimination against the coloured tester. The landlords all admitted that they discriminated.

The picture was just as dismal when black people tried to buy houses. Twenty-seven out of forty-two estate agents tested discriminated, and confirmed that in certain type of areas people were not prepared to sell houses to black people and that building societies were reluctant to give them mortgages.

Much background material has now become available about the housing and living conditions of immigrants in such areas as Notting Hill and Paddington. Readers are referred to the North Kensington Survey conducted by the Centre of Urban Studies (See London Housing Needs) and Pearl Jephcott's study of Notting Hill for the North Kensington Family Study - 'A Troubled Area.'

**The Police**

We pass now to the police and the relations with black people. Black people usually have to live where they can, rather than where they prefer. Where they have to live is usually in city areas with a long history of criminal activity such as Brixton and Notting Hill Gate. Not surprisingly some black people take part in crime and in the same way that some white people do.
results are too easy to predict, given that policemen like the rest of society tend to classify people into groups.

Social Implications

During the past two decades emigration to the U.K. has been on a larger scale than to Canada or the U.S.A. This large movement of people has been both beneficial and detrimental to Barbados.

The most significant area to be affected by emigration was the family - the young child, the adolescent and the adult.

The Young Child

The young child was adversely affected by parental deprivation - however adequate the parents might have been. The traditional position of the father as provider was threatened, physical and emotional support for the other was removed. Nevertheless the nature of Barbadian society was such that grand-parents, and others members of the extended kin adjusted to these alterations in the family structure. The absence of the mother was, however, the greatest blow to the young child.

It was the experience of the social work department that there were a number of mothers who left without making adequate arrangements for their children - some were left with grand-parents whom they had known from infancy, while others were left with strangers or relatives or friends who often had children of their own.
Adolescents did not suffer in the same way but rather from losing their
rents when they are trying to cope with the strains to which adolescence
brought them, and they experienced grave feelings of insecurity without
their parents present to provide guidance and emotional support; often there
was little or no correspondence between parents and child. Another aspect
the problem was the constant change of guardian. Frequently there was
breakdown in the financial arrangements, disagreement between relatives,
requests from parents for a change, or change in circumstances causing
relatives to wish to take the children over from the guardian. There was
so the matter of the uncontrollable behaviour of a child which could lead
the guardian not wanting to continue looking after that particular child.
A number of changes caused insecurity in the child. In many cases the
Social Welfare Department advised parents in the U.K. to arrange for their
children to join them, but the cost was high. Furthermore, after March 1968,
children over 14 years were not permitted to go to the U.K. to join a
single parent, except in special circumstances. This imposed great hard-
ship on Barbadian children because of the high proportion of children born
t of wedlock.

Adult

considering the social implications of emigration for the adult, there
are three major aspects; financial maintenance, marital relations and
psychological disturbance. One of the economic benefits of emigration was
the volume of remittances sent home. However, since 1955, the Social
Welfare Department has had many clients seeking assistance in persuading
husbands (or fathers of children) to contribute in supporting their
dependents. There were frequently long waits and women often had to be
ferred to the public assistance office. There were also problems of
guardians who were not related to the children, receiving little or no
towance from the parents overseas, naturally this imposed strain on the
ief services. In the case of married couples, where the husband failed
o meet his obligations it was possible for the wife to take legal action, but in the case of unmarried women there was no machinery for the initiation of enforcement of court orders. Marital relations frequently suffered as a result of lack of communication due to one partner going abroad. Sometimes, in the case of a wife joining her husband, the latter had acquired a degree of sophistication which made the wife feel adequate, of course were the position reversed, the husband felt similarly adequate. The resulting stresses and strains led more often to the wife’s return to Barbados.

Migration has been a stressful process for many Barbadians. Unaccustomed to urban impersonal living and racial discrimination, they have become disillusioned and disappointed. They have experienced ‘goal striving stress’ in a climate of limited opportunity, expectations and aspirations have not been realised. Bottoms (1968) has suggested that the Mertonian model of shortfall between expectations and means of fulfilling these expectations provide a useful explanatory model for deviant behaviour among immigrants. Inard’s review of research (1964) in the field of anomie theory shows that deviant reaction to anomie can be in the nature of mental illness.

These are some of the consequences of emigration - the question was whether migration was a desirable phenomenon from the Barbadian point of view, or whether the price that had to be paid was too high. On the one hand here was the easing of population pressure, more job opportunities, a significant wage differential and a large annual remittance to families in Barbados. On the other hand, there was a loss of young members of society, disintegration of family life, behaviour problem in young children, parental deprivation and an increase cost to Government in maintaining families of migrants. On a personal level many immigrants have suffered severe social and psychological problems, which in many cases have led to mental illness. There were no objective criteria for measuring the advantages and disadvantages of emigration.
In brief, immigration led to the disruption of social networks, family ties, resulting in social isolation, cultural deprivation, physical and emotional changes which expose the immigrants to psychological disturbance.
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CHAPTER 10

MIGRATION AND MENTAL ILLNESS

THEORIES OF MIGRATION AND MENTAL HEALTH/ILLNESS.

A REVIEW OF THE LITERATURE ON MIGRATION AND MENTAL ILLNESS.

A REVIEW OF RECENT RESEARCH ON WEST INDIAN MIGRATION AND MENTAL DISORDER.
CHAPTER 10
MIGRATION AND MENTAL ILLNESS

The relationship between migration and mental health has been widely discussed in social science literature (Brody, 1970). No empirical comparison has been made of the various migratory theories which propose to explain the influence of migration on mental health. The lack of comparative research hinders an assessment of the relative merits of competing theories and prevents a synthesis of empirical data pertinent to those aspects of migration most responsible for increasing mental health problems among migrants.

Position is similar to Kantor's:

"Migration, in and of itself, does not precipitate the development of mental illness. Migration, however, does involve changes in environment which implies adjustments on the part of the immigrant. These adjustments may be reflected in improved or worsened mental health. There are conditions, nevertheless, under there is an influenced risk of the development of mental disturbance among immigrant groups. These conditions can be specified in terms of characteristics of the sending and receiving communities, characteristics of migrants, and circumstances under which the migration occurs." (Kantor, M. 1969)

By viewing the relationship between migration and mental health in this way the four theoretical formulations: social isolation, cultural shock, goal-striving stress and cultural change - can be regarded as frameworks which seek to identify the most stress-producing life changes experienced by the migrant, and their potential impact on his mental health.

All four theories assume that the process of setting up in a new society is stressful and that the tensions produced by attempts at adjustment begin
sociocentism upon the immigrant's arrival.

Social Isolation

The theory of social isolation was first proposed by Faris (1934) and later developed by Faris and Dunham (1939).

The theory postulates that migration involves not only physical separation from the homeland, but also separation from one's orienting set of mutual rights, obligations, and networks of social interactions, thereby causing disruptive experiences associated with immigration. Migrants often experience strong feelings of loneliness, alienation (Handlin, 1951) and socialization (Jaco, 1970), low self-esteem, and an inability to cultivate and sustain social relationships (Weinberg, 1966). Jaco (1954) documented a negative impact of social isolation in Austin, Texas, where he found more schizophrenia in an area where persons show less contact and communication with one another. Of course, he did not show that persons who break down with schizophrenia are more isolated than those who do not.

ohn and Clausen (1954) in their study of a sample of schizophrenics and manic-depressives—first admissions to mental hospitals from Hagerstown, Maryland, concluded that their data did not support the hypothesis that social isolation in adolescence is a predisposing factor in either schizophrenia or manic-depressive psychosis. They considered that those cases showing social isolation, indicated that a person's interpersonal difficulties were so great that he could no longer continue to function in the locale—in other words, he takes isolation as a way out.

wenthal (1964) found that isolation per se was neither decisive nor significant in the onset of mental illness among the aged group. Weinberg (1966) suggested that situational isolation precipitates mental illness, and that one's subjective interpretation of isolation may predispose one to mental illness. Thus the theory of isolation suggests that a severe limitation of contact and communication with the wider society causes
The immigrant great stress in the performance of social roles that he does lay and might directly or indirectly contribute to the onset of mental illness.

Cultural Shock

The second theory contends that the immigrant's most severe problem is caused by cultural shock. The concept of 'culture shock' has frequently been proposed to explain associations between migration and mental illness. This concept implies that psychological difficulties such as severe role discontinuities, value conflicts and social disorientation are experienced by migrants into a social environment very different from their country of origin; the concept has never been adequately defined.

Andlin (1951) believed that immigrants experienced shock because of severe feelings of personal inefficiency, normlessness, role instability and role displacement. Einstadt (1954) on the other hand, suggested that migrants are disturbed by living in an unstructured, incompletely defined society. Oberg (1960) pointed out that since value conflicts cause an immigrant to misinterpret cues of social interaction, daily life cannot be taken for granted, it becomes, instead a host of insurmountable problems.

It is assumed that 'shock' varies directly with both the degree of socio-environmental differences and the rapidity of adjustment. Murphy (1965) reviewed the literature on this issue and stated that:

"There is a tendency to treat the stresses of migrational experiences as the most likely explanation, with selection playing a secondary role."

The lack of consistent findings in studies of migration and mental illness suggests that the notion of cultural shock has limited explanatory value. Some studies have reported higher rates of mental illness for migrants than for natives, (Kleiner and Parker, 1966); and some have found no differences in rates, regardless of migratory status (Murphy 1965).
Malzberg and Lee, (1956) thoroughly reviewed the literature dealing with relationships - including their own studies - and concluded that most differences associated with migration,

"Have been based on scanty or other wise inadequate data, and not even the fact of higher incidence of mental disease among migrants is not firmly established, much less the theories as to cause."

Two large scale studies of this problem, one using a negro sample drawn from a large urban centre (Kleiner and Parker, 1966), and the other analysing the white population of New York State (Malzberg 1967) reported higher rates of mental illness for natives than for migrants. These findings suggest that culture shock either is not a useful explanatory concept, or that it is associated with mental disorder only in particular situations.

Srole et al (1962) conducted a study in New York City which provided additional evidence that does not support the culture shock hypothesis. They found higher levels of psychiatric symptoms among individuals who came to New York City from other large cities, than among immigrants from rural communities. Regardless of the different emphasis, the cultural shock theory posits that these immigrants entering a society very different from their own will find it more difficult to adjust to than will immigrants with a similar cultural background. The theory also suggests that the shorter the immigration period, the greater the shock, making mental distress more likely, but as the immigrant becomes acculturised, his propensity towards mental illness is reduced.

Goal-Striving Stress
The theory of goal-striving stress delineates a unique aspect of the immigrant's adjustment problem, that of unfulfilled aspiration. Defined as the discrepancy between the immigrants aspirations and his achievements.
Parker and Kleiner and Needelman (1969) agreed that psychological stress due to cultural shock may be balanced by a lower degree of goal-striving stress, which has been found to be directly related to mental disorder. In a study of black migrants to Philadelphia, Parker and Kleiner (1966) reported that those coming from an urban background possessed a higher level of goal-striving stress than those from the rural South. Furthermore, both groups displayed smaller degrees of goal-striving stress than the native Northern blacks, which Parker and Kleiner (1966) believed resulted from the fact that,

"The urban environment consists of more heterogenous and differentiated groupings than is generally true for communities in the rural South. The existence of a more differentiated status hierarchy, as well as 'success ethos', creates an environment in which new reference groups emerge, stimulating higher levels of aspirations and stress associated with goal-striving." (Parker and Kleiner, 1966).

The goal-striving stress concept leads to the following predictions; that among foreign immigrants from less industrialised societies, the first generation will experience lower goal-striving stress than their descendants. The newly arrived immigrants generally hold a high level of aspiration which they strive hard for achievement. In contrast their descendants may continue to strive as hard as their parents but suffer a setback - they descendants tend to have a much higher level of aspirations due to the socialisation experience in the new society. The descendants believe that they possess opportunities for success equal to those of the dominant group members, but in fact cannot overcome the consequences of not being accepted as social equals, as well as other forms of de facto discrimination. The difficulty of becoming upwardly mobile produces higher degrees of goal-striving stress, and can be regarded as a contributory factor leading to mental illness.
Cultural/Social Change

The Cultural Change theory hypothesises that cultural and social relocation has a disruptive effect on the psychological orientation of migrants undergoing acculturation. Studies by Hallowell (1942), Abel and Hsu (1949) and Vogt (1951) documented personality disturbances among American natives and some ethnic groups on the Rocshach Test. In a study on sub-group differences among second generation American Greeks, Papajohn and Speigel (1971) showed that the impact of acculturation on mental distress was a joint function of sex and social class, but that the position of a sub-group on the acculturation continuum alone was not related to the degree of stress. It was rather, the degree to which American value of orientations were internalised that counted for the psychological stress.

Proponents of the cultural change theory state that the adoption of host, that is the country of domicile, core values, involves a fundamental disruption of and shift in the cognitive, effective and evaluative modes of behaviour which were patterned by the immigrant's native culture. Such changes are believed to be particularly stressful and disturbing, because of the worth of the immigrant's native cultural orientation, which has long served as a behavioural guide. This is now seriously challenged and probably devalued, by the competing values of the host country. Seward (1964) observed that such cultural change promoted family disorganisation and adversely affected the personality of family members. Furthermore, Derbyshire (1969) indicated that Chicano youths tend to identify with their own culture under the pressure of adopting the dominant American culture.

In discussing problems of acculturation in Western industrial societies, social disorganisation is the critical intervening variable, in the relationship between various forms of social/cultural change and mental health or illness. Individual failures in conflict resolution, marital
difficulties, social isolation, (Curle and Trist, 1947; Jaco, 1954) incon sistences in social status (Jackson, 1962) conflict in cultural status, have all been implicated as sources of emotional disturbance or of major mental disorders. As with Durkheim's (1933) concepts of anomie, a variety of concrete patterns can manifest the same fundamental structure of disorganisation and, provided the pattern fits the general criteria, it is likely to be associated with higher rates of mental disorder. A common feature of definitions of disorganisation is the failure to reach a minimal level of goal-attainment or role-fulfillment by an individual. Such failure in goal-attainment or role-fulfillment can always be traced back to a lack of integration between individual patterns of adaptation and the demands, expectations and opportunities in the immediate environment.

The cultural/social change theory, which posits that the greater the acculturation, the greater the psychological distress, directly conflicts with the cultural shock hypothesis.

Social Selection

Another hypothesis on the social psychological level has centred on the general selection. The central questions are: Do persons who migrate from one place to another have a higher rate of mental disease than persons who live out their lives in a given community? If they do, is the higher rate caused by persons who are prone to a given mental disease moving around, or is the higher rate caused by the fact that migrating persons are subjected to more severe stress than persons that have stayed home?

Arising from this central question are four hypotheses, these four are:

1. That certain persons because of personality inadequacies or propensity to mental disease, have a tendency to 'drift' into certain socio/economic groupings, sub-cultures or city areas.
2) That visibility of, and tolerance for, mental disorder vary with the
titudinal structure of different types of communities.

3) That certain persons because of their psychic needs to break their social
ties tend to select and segregate themselves in areas — cultural or spatial —
marked by anonymity.

4) That as the size of the city decreases, rate differentials between
ocio-economic areas tend to disappear.

At this point we will examine several of the more significant epidemiological studies in this area to show the manner in which these studies have used the hypotheses for negation or validation of the rate differentials that they have reported.

aco (1951) study of the distribution of mental disease in Texas and the
llingshead - Redlich (1954) study of the prevalence of treated mental
ese in New Haven were two of the first studies to design a series of
tistical hypotheses with which they purport to test for validity.
aco (1951) began his study of three hypotheses:
1) The probability of acquiring a psychosis is not random or equal among
b-groups of the population.

2) Inhabitants of different areas exhibit different incidence of psychoses.

3) Persons with different social attitudes or affiliations have different
idence of psychoses.

aco found that his evidence gives support to his three central hypotheses.
never his high rates for both male and female among professionals and
mi-professionals cannot be easily explained away by the "marginal status"
posedly enjoyed by this group in Texas. Again his low rates among
Spanish-Americans for both males and females are expected and contrast other sharply with the high rates frequently reported for various ethnic groups in the Northern States. Jaco, suggested that this might be because of the fact that the Spanish-Americans are well integrated into the dominant Anglo-American group and also have a very protective kinship system. It may also be explained by the hypothesis that the visibility and tolerance for mental disorders in this group are at variance with the dominant Anglo-American group.

Eaton and Weil (1955) had findings that conflicted with Jaco's. Eaton and Weil showed that rates of mental illness among the Hutterites were not significantly different from the rates in other cultures. They found that the Hutterite community was more tolerant and tended to excuse mentally ill individuals more readily than other communities. The Hutterites seemed to have more secular as well as religious methods for dealing with mentally ill individuals.

Hollingshead and Redlich (1958) adopted a different focus from Jaco's. They were concerned with examining prevalence, diagnosis and treatment of mental illness as it relates to class. Their hypotheses were:
1) The prevalence of treated mental illness is related significantly to an individual's position in the social class structure.
2) The types of diagnosed psychiatric disorders are connected significantly to class structure.
3) The kind of psychiatric treatment administered by psychiatrists is associated with the patient's position in the class structure.

Hollingshead and Redlich's organised data give support to their hypotheses, their study is largely of prevalence and our main concern must be with incidence rates, for these should give some clues as to whether
social factors have some relationship to the etiology of mental disease. However, the expectancy would be that if social class factors have some relevance for etiology, one would expect that incidence rates for a given disorder would have a significantly inverse relation to class structure. Further, one would have to establish that the higher rates of persons in the lowest class is made up of persons who originated in that class.

Hollingshead and Redlich do have several tables of incidence rates constructed from those persons who entered treatment for the first time during their six months' observation period. However, the rates do not vary inversely with class.

Some data from England serves as a challenge to the New Haven study. In an address to the British Sociological Association Morris (1959) pointed to a study which classified a national sample of schizophrenics, aged 25-34, by occupation and social class, on the basis of an examination of birth certificates. There was an excess of schizophrenics in Class V, but their fathers were distributed rather evenly over the five classes. This seemed to indicate that the patients experienced a downward movement because of their illness and to explain the excess in Class V. Thus, here in this study the schizophrenic illness operates on a selected factor or from the opposite angle, the social system functions to place these men in Class V.

Lilli Stein (1957) conducted a study of class and schizophrenia. It is relevant here because her findings also contradict some of the American results. She proceeded by selecting from East London Boroughs (E) outstanding for their high proportion of men in Classes IV and V, and five West London Boroughs (W) outstanding for their high proportion of men in Classes I and II. The results ran contrary to those found in American cities. She noted that the W Boroughs had significantly higher rates in partially all age and sex categories as compared to the E Boroughs.
This held true, in general, for schizophrenia and psychoneuroses; it was less marked in the manic-depressive groups. She concluded that there was a significant increase of schizophrenia, and cautioned that these results must be qualified because of the radical differences between E and W Boroughs in the sex ratio, numbers of persons living alone, types of private household and the origins of the population. These differences signify that a single index of social class may not be too meaningful.

In another study from England, Carstairs and Brown (1956) attempted to get at the incidence and prevalence of psychiatric disorders in two different types of communities, Rhondda - a coal-mining region and Vale - an agricultural region. They found that in Rhondda psychiatric cases were more heavily concentrated than in the non-miner group. This the investigators regarded as due to adverse selection. They concluded that the linking of social pressures to psychiatric disorders must wait until an analysis of the social structure and value system of the community has been completed.

Ødegaard has been one of the most constant proponents of the social selection hypothesis. From his earlier study, Ødergaard (1936), of emigration, where he emphasised the tendency of the psychiatrically vulnerable to migrate, to his more recent analysis of psychiatric cases in relation to the occupational structure of Norway, Ødergaard, (1956) has generally attempted to show that social selection versus environmental stress provides the most enlightening explanation for the rate differentials in various social structures. His findings that the high rates of manic-depression are in the more favoured occupational groups are in conformity with the American results, but the mechanism of social selection is more evident for schizophrenia and for the psychoses with epilepsy and mental deficiency.
Høblad (1948) also supports Ødergaard's social selection hypothesis when he shows that his sample of seamen have higher rates of psychopathy and schizophrenia when compared with non-seamen in naval training.

I have pointed to these studies to illustrate the application of the social selection hypothesis when applies to certain rate differentials in selected social structures. It seems much clearer in application, when dealing with occupational, marital status and specific institutional structures, than it is when applied to social classes or geographical areas. In the latter, the problem is much more complex although even here the social relation hypothesis must be considered. It is an hypothesis that explain significant rate variations as due to the manner in which a given social system functions through time, and in its functioning tends to sort out and sift persons into class and community positions.
A REVIEW OF THE LITERATURE ON MIGRATION AND MENTAL ILLNESS

The study of migration and mental illness is by no means a new area of research. Social scientists and psychiatrists have studied the relationship between migration and mental illness from as long ago as the 1930's and have largely concluded that migration does have some influence on the onset of mental illness in immigrants. The degree to which the environment has a greater or lesser impact on the onset of mental illness has been the area in which findings have been mixed and inconclusive.

In order to avoid some of the errors of previous reviewers of literature on migration and mental illness it is necessary to make a clear distinction between different types of migrants. Often comparison on the incidence and prevalence of mental illness are made between internal migrants and those from overseas. Such cross comparisons, can be misleading, because the experiences and social and cultural milieu of each type/class of migrant is often different. I have therefore divided my review into three sections.

The three main groups of migrants are:

a) The internal migrants - who travel state to state, or country to country.
b) The refugee - who is forced to migrate because of socio-political reasons.
c) The immigrant - usually a person 'forced' by the socio-economic conditions of his country to migrate.

A brief review of the literature relating mental illness in each group will outline the danger inherent in a cross comparison.

Internal Migration

Evidence of a possible relationship between internal migration and mental illness is mixed and inconclusive. Most studies have shown that migrants have higher rates of admissions to mental hospitals than the native born. These findings have been unable to tell us whether such rates are due to
self-selection or stress brought on by social change. Malzberg and Lee (1956) studying first admissions to mental institutions in New York during 1939 - 41 found that (1) migration from overseas was associated with almost no excess of mental hospitalisation over the native born. (2) migrants from other states in the United States had higher rates of mental hospitalisation than those born in New York and (3) the incidence of hospitalisation was higher in those migrants who were outside New York State for five years previously, than those who were within the state at the time; a higher proportion of the former was admitted within a year of their arrival.


Findings in the opposite direction have been reported as early as 1945 by Ødergaard (1945) in a study covering all first admissions to mental hospitals in Norway during 1926-35. He observed that Norwegians migrating within Norway had lower rates of mental hospitalisation than the non-migrant Norwegians. In a further study Astrup and Ødergaard (1960) examining the periods 1916-30 and 1931-45 reported similar findings. He also found that the admission rate was higher among foreign born inhabitants of Norway.

These findings contradicted Ødergaard (1945) earlier findings and tend to support Malzberg's and Lee's (1956) findings. An investigation by Martin et al (1971) into mental illness among new estate dwellers, in a new housing estate outside London, found a higher incidence of mental illness among new arrivals than those who were living there much longer. A similar study by Hall (1966) in Sheffield, was unable to show any relationship between moving house, new residency and mental illness. Further results supporting Hall's findings were found by Wilner et al (1960) in Baltimore, Taylor and Chave
Refugee

The refugee unlike the internal migrant is unable to determine either when he migrates or how he migrates. The psychological effects of forced migration have clearly been demonstrated by many studies. Krupinski et al. (1973) found a higher incidence of schizophrenia in a study of Eastern European refugees admitted to Victoria Mental Hospital in Australia.

In an earlier study Krupinski et al. (1965) demonstrated the incidence of mental illness among those groups that had had wartime experiences (imprisonment, tortures, loss of family and special hardships). A larger proportion of those experiencing wartime experiences were refugees from Eastern Europe. Table 1 shows the relationship between wartime experiences and mental illness.

The Hungarian uprising of 1956 provided a unique opportunity to study refugees of 82 consecutive Hungarian refugees referred to the Maudsley Hospital with psychiatric disorders. Mezey (1960a) found that 50% suffered from a personality or neurotic disorder, 28% an affective disorder, 17% from a schizophrenic disorder and 5% from an organic disorder.

Mezey concluded that except for the affective disorders, it was difficult to attribute any etiological importance to the stresses of immigration, as opposed to pre-existing maladaptation in the causation of psychiatric disorder.
### Table I

Wartime Experiences According to Sex and Country of Birth

**Proportion of Patients**

<table>
<thead>
<tr>
<th>Wartime Experiences</th>
<th>British</th>
<th>Western European</th>
<th>Southern European</th>
<th>Eastern European</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Males:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severe</td>
<td>8.2%</td>
<td>20.8%</td>
<td>2.4%</td>
<td>25.3%</td>
<td>14%</td>
</tr>
<tr>
<td>Moderate</td>
<td>67.2%</td>
<td>33.3%</td>
<td>30.9%</td>
<td>43.9%</td>
<td>51.2%</td>
</tr>
<tr>
<td>None</td>
<td>24.6%</td>
<td>45.9%</td>
<td>66.7%</td>
<td>30.8%</td>
<td>34.8%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

| **Females:**        |         |                  |                   |                  |       |
| Severe              | 1.4%    | -                | 4.0%              | 62.8%            | 22.0% |
| Moderate            | 8.3%    | 63.3%            | 27.6%             | 30.2%            | 27.3% |
| None                | 90.3%   | 36.7%            | 68.4%             | 7.0%             | 50.7% |
| **Total**           | 100.0%  | 100.0%           | 100.0%            | 100.0%           | 100.0%|
The basic difference between an immigrant and a refugee is, that the former can choose his destination but the latter cannot. Many studies have demonstrated high rates of psychiatric disorders among both types of migrants.

Spitzka (1880), Kiernan (1886), Bannister and Hektoen (1887), were the first group of researchers to record a high incidence of mental illness among the foreign-born. Their findings were rendered unreliable because they failed to make allowances for differences in age distribution in the two populations.

In 1919, Pollock and Nolan studied 9,000 first admissions for dementia praecox to the New York State hospital, during the period 1912-1948. They found that the foreign-born had a higher incidence of schizophrenia, (ratio being 75.2 per 1,000 for the natives and 161.4 per 1,000 for the foreign-born) than the native-born. It was the first study to concentrate on first admissions and to show the high incidence of schizophrenia among immigrants.

Tredway (1925) studied 70,000 first admissions to American State Mental Hospitals. He found that the British, Germans and Scandinavians had higher rates of psychoses than the native-born.

Dayton (1940) studied 89,190 first admissions to mental hospitals in Mass..... between 1917-1933. He found that the foreign-born inhabitants of Mass..... ith foreign parents had higher rates of mental illness than the native-born f foreign parents and native-born with mixed parents. The native-born of ative parents had the lowest rates. Within all groups, men had higher admission rates than women.

alevi (1963) studied the rates of first admissions to mental hospitals in israel, by country of birth, diagnosis, age and by group. He found that
migrants from Asia and Africa had higher first admission rates than the local born Jew. Immigrants from Europe and North America had proportionately no more mental hospitalisation than local-born Jews. In contrast, Murphy (1959) studied first admission rates to mental hospitals in Singapore and found that immigrants had lower rates of hospitalisation than native-born.

Cade and Krupinski (1962) presented a study based on admissions to the Royal Park Psychiatric Hospital, Melbourne, and they noted a significantly higher incidence of depression among all migrants than among the Australian born, and of schizophrenia and schizo-affective diseases among migrants from Eastern and Southern Europe. The latter finding was reaffirmed by a study of Krupinski and Stroller (1965), based on first admissions to all mental institutions and out-patient clinics in 1962. However, these findings did not show whether migration was the cause or consequences of a psychiatric disorder.

Krupinski et al (1965) in a detail study of the social, economic and cultural factors which influence the incidence of mental disease among migrants, sampled every migrant admitted to the psychiatric hospital, Royal Park from July 1961, till June 1962 and concluded that (1) the incidence of mental disorders in male migrants is due partly to the migration of single unstable men, who breakdown in the first years of their economic and financial struggle, and to a lesser degree to the difficulties which professional and semi-professional men meet in obtaining recognition of their qualifications and work in their pre-migration field.

(2) the breakdown in female migrants are mostly due to their lack of assimilation, and (3) difficulties at work did not seem to contribute to the higher incidence of mental disorders in migrants, nor did financial difficulties.

Kraus (1969) in an investigation about the difference between the major immigrant groups and the Australian born population in psychiatric
hospital, reported that the admission rates for patients with "schizophrenia and paranoid states" were found to be consistently higher for immigrants (excepting those from the United Kingdom and Greece) than for the native population. Admission rates for the "depressive psychosis" were higher for males born in U.K. and males born in Netherlands, rates for "neuroses and psychosomatic disorders" were higher for all Yugoslav immigrants, for males born in New Zealand and Germany, and for females born in Hungary.

Dohrenwend and Dohrenwend (1969, p. 41) and Lee (1958, p. 149) explain the higher rate of mental disorders among immigrants by the hardships of immigrant life as well as by selective migration of the genetically handicapped. The socio-political nature of emigration from North Africa (Bensimon-Donath, 1971, 1970; Chouraqui, 1968), after the independence of Morocco, Tunisia and Algeria rule out the latter explanation.

Engelmann et al (1972) found that the mental hospital of a small group of immigrants from North Africa and France (N = 35) did not differ significantly from that of a French Canadian group. He concluded that moving from one country to another did not seem to necessarily provoke a high degree of stress in an average population. However, it seemed to affect those immigrants whose mental health was already precarious. The major flaw in Engelmann's conclusion is: How does he know who has a precarious mental health? No mention is made of psychological testing before immigration therefore it is impossible to delimit those who are more likely to break down after immigration.

Like Englemann et al (1972) Murphy (1974) found that French Canadians complain more than English Canadians of psychosomatic troubles. Lasry (1977) also found in cluster comparisons, that North Africans, French Canadians and Mexicans express about twice as many psychosomatic symptoms as the English speaking group.
Lasry and Sigal (in press) have shown that the global stress score and the anxiety score of immigrants having resided more than eight years in Canada are significantly lower than those of immigrants having resided there less than eight years. The anxiety average of the early immigrants is also equivalent to that of the native French Canadian urban group of Engelsmann. The difficulties encountered by immigrants in the early phase of their adaptation created a high degree of stress and anxiety. As the difficulties are ironed out, as the economic conditions improve, the anxiety diminishes to the level of the surrounding population.

There seems to be overwhelming evidence supporting the view that immigrants have higher rates of mental illness than native-born. These findings have all been derived from first admissions to hospitals and therefore do not take into account mental health in the community. Krupinski et al (1970) have shown that neither psycho-neurosis in adults nor behaviour disorders in adolescents were present to a more significant degree in the foreign-born than in the Australian born in Heyfield. Similar conclusions were arrived at by Srole et al (1962)

We have briefly reviewed the literature on mental illness and migration, in order to show that within each category of migrant (i.e. internal migrant, refugee and immigrant), these are different findings. These findings are mixed and inconclusive. In most articles written on the subject of mental illness and migration, comparisons between findings are not made within a particular category but rather across categories, for example, comparing the findings of internal migrants with that of immigrants from overseas. This reduces the degree of reliability one places on the conclusion.
Psychiatric services in the English-speaking Caribbean countries are so different from those found in Britain, that it is almost impossible to compare admission rates for native-born West Indians in the West Indies with those of West Indian immigrants in England or those of native-born English patients. In most of the countries psychiatric patients are still admitted almost entirely on order. Barbados, Jamaica and Trinidad are a few countries with mental hospitals which admit voluntary patients.

However, studies carried out there, tend to show that psychiatric morbidity in the West Indies is not very different from that found in other countries which are more advanced technologically.

Yes (1961) reported on the incidence and features of psychosis in Jamaica over a twelve year period (1949-61). He found a first admission rate of 50 per 100,000 of the population in 12 years. He is doubtful of the accuracy of his findings, as an index of the psychiatric morbidity in view of the reluctance of Europeans, East Indians and Chinese in Jamaica to consult a doctor about mental illness and the fear of comittal to a mental hospital. These people may have alternative ways of getting treatment or the mentally ill, they can easily purchase private medical treatment and never appear in the medical hospital statistics.
It was generally held by social scientists that very few West Indian migrants entered mental hospitals. Davison (1966) noted that Ruck (1960) observed, from a sample of 400 cases revised by the Family Welfare Service, that only 15 West Indian immigrants required mental hospitalisation. Skone and Cayton (1957) were only able to locate one individual requiring mental hospital admission from a population of 505 West Indians, located in a survey in West Bromwich. Pinsent (1963) in a study of morbidity among 127 West Indians and a similar number of English patients in a general practice in the industrial area of Birmingham, noticed that the West Indians had higher illness rates, including mental illness, than the English control. Pinsent's findings challenged the formerly held assumption that mental illness was not significant in the West Indian population. However, Pinsent's findings have been differently interpreted. Gordon (1965) states that Pinsent "drew attention to the higher attendance rates of Englishmen with mental illness," while Bagley (1969b) states that "West Indians were found to have illness rates ...... twice those of the English controls." A closer and more detailed examination of Pinsent study shows Bagley's conclusion to be accurate.

Kiev (1963) studied the beliefs and delusions of ten psychotic West Indian patients in London. He observed that there was a common acceptance among West Indians that God and the devil have a personal control over their health. A belief in the existence of ghosts and spirits, and the influence of obeah, was quite common, even among those who had never had any mental illness. The difference being, an abnormal reaction to these beliefs by the mentally ill, differentiated them from the 'normal' West Indian.
Tewfika and Okasha (1965) studied the pattern of mental illness in 129 West Indians (79 men and 50 women) at an English mental hospital. They found a relative excess of paranoid illness, with somatic and persecutory symptomatology among West Indians when compared with an English control. When a comparison with figures from the mental hospital census for the West Indians was made, paranoid illness was assumed to be probably similar to the pattern of mental illness seen in the West Indies. The increase in the incidence of illness is attributed by the authors to the difficulties of adapting to a new environment.

Gordon (1965) studied mental illness in 112 West Indians requiring admission to Long Grove Hospital over a period of 3 years, 3 months. He found a high occurrence of paranoid illness, similar to that of Tewfika and Okasha (1965). He noted that the most striking feature of the group was the low incidence of personality disorder and neurosis. He concluded that the relative prominence of schizo-effective illnesses, (paranoia) is a common reaction of most immigrant groups to being placed in an alien culture. Other stress producing factors were, separation from close relatives or family in 70% of cases, difficulty in finding adequate housing, and the stress following the change in the customary roles of the West Indian woman. In a series of 300 consecutive first admissions to the mental hospital in Barbados, schizophrenia was diagnosed in 43% of cases (Webb, 1961). This figure corresponds closely with the figure of 41.1% arrived at by Gordon. Webb observed that stress factors were negligible.

Kiev (1965) studied the prevalence of mental illness over a six months period in 83 West Indians (36 men and 47 women), and a similar number of English patients attending a group practice in Brixton. This comparison revealed that the West Indian men had a significantly higher rate of mental illness than English men. The excess of mental illness in women was not as marked as in men, a finding in contrast to Pinsent, (1963) who found higher rates for West Indian women. Pinsent's more careful study may account for
the difference in findings. Kiev while noting that West Indian men had higher rates of illness than West Indian women, failed to explain this phenomena. He only suggested that a change from a pastoral to an urban life involved stress. Contributory stress factors were, the absence of stable kinship system to care for the children and the absence of extensive social controls which are prevalent in the West Indies. While stress factors can have some effects, they do not explain why in New York, where the pressure of living is reputedly greater than London, there should not be similar or greater consequences of mental strain. Evidence based on a survey conducted by Thomas-Hope (1977) at the source of migration, reveals a strong association between migration to Britain and vulnerability to mental and physical illness. The association is less significant when compared with the United States and Canada. It is therefore likely that the higher incidence of mental illness among West Indians in Britain, may be explained in terms of level of dissatisfaction, frustration and the loss of self-confidence, due to failure in achieving economic and educational goals. Thomas-Hope (1977) in a study on 'retrospective satisfaction' using samples of 100 persons from each of 3 British cities, 3 American cities and Toronto, noted that while 41% of the London sample indicated that they regretted their decision to migrate, only 12% of the New York sample and 20% of the Toronto group were dissatisfied. In contrast 53%, 85% and 74% of the London, New York and Toronto sample were satisfied (See Table 2).

Hemsi (1967) studied first admission of West Indian and English patients to mental hospitals in the London Borough of Camberwell and Lambeth. Forty West Indian patients were located and showed higher rates than those of the native-born. These were 31.8/1,000 and 30.4/1,000 for West Indian men and women respectively and 9.5/1,000 and 12.2/1,000 for native-born men and women. Hemsi found schizophrenia to be a common illness among West Indian men, and affective disorders common among West Indian women. This finding is similar to those of earlier researchers.
### Table II

**Distribution of Sample According to Levels of Satisfaction**

(On a 5 points scale)

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>London</td>
<td>30</td>
<td>23</td>
<td>6</td>
<td>9</td>
<td>32</td>
</tr>
<tr>
<td>Notts/Leics</td>
<td>31</td>
<td>13</td>
<td>2</td>
<td>13</td>
<td>41</td>
</tr>
<tr>
<td>Birmingham</td>
<td>35</td>
<td>24</td>
<td>6</td>
<td>2</td>
<td>39</td>
</tr>
<tr>
<td>New York</td>
<td>47</td>
<td>38</td>
<td>3</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Hartford /Boston</td>
<td>62</td>
<td>23</td>
<td>0</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>Toronto</td>
<td>46</td>
<td>28</td>
<td>6</td>
<td>0</td>
<td>20</td>
</tr>
</tbody>
</table>

Figures given are %'s of the total for each sample.

1. Very satisfied.
2. Fairly satisfied.
3. Not sure.
4. Fairly satisfied.
5. Very satisfied.
Ochrane (1977) in his study of mental illness in immigrants in England and Wales noted that the "total mental hospital admission rates for immigrants in Britain are varied and for the New Commonwealth or coloured groups, are the same as, or lower than British rates," internal migrants from another part of Britain to England and Wales have high total rates of mental hospital admissions, in general, immigrants have higher rates than do natives for admission to mental hospitals for schizophrenia and related disorders. However, he further warned that such findings should be accepted with caution because of the major difficulty in assessing the validity of using mental hospital admission as an index of mental illness.

It is accepted that mental hospitals under-represent "true" rates of mental illness (Srole et al., 1962; Phillips, 1966), the question then becomes, do mental hospital admissions differentially under-represent for different migrant groups? There is very little evidence on this point.

Ochrane and Stopes-Roe (1976) in a community survey of psychological symptoms among Asian immigrants to Britain, obtained results consistent with those in later study (Cochrane 1977); namely that West Indians had nearly as many symptoms as native controls, whereas Pakistanis reported significantly fewer than average.

Community studies on problems in children of different ethnic origins (Rutter, 1974; Kallarakkal and Herbert, 1976) have shown that West Indian children have less (behaviour problems) in family and home settings, but more than indigenous children when teachers rating are considered.
Discussion

There is little that can be said about the prevalence and incidence of psychiatric illness among West Indian immigrants to Britain. Most of the surveys mentioned above have been small and based largely on hospital admission. These findings have shown a high incidence of psychotic illness - schizophrenia - among West Indian men, much higher than had been expected. They suggest that West Indian immigrants are not immune to mental illness, as was earlier believed. There has been paucity of community based research, which is likely to improve our understanding of the psycho-social problems of West Indian emigrants.

References have been made in the literature to a few studies done in the West Indies, but they are far from adequate and in no way shed a great deal of light on the matter. Webb's findings on Barbados are highly questionable because of his methodology; a comparison of 330 first admissions to mental hospital with 330 controls taken from General Hospital. What is badly needed is a comprehensive study of mental health in the Caribbean, both by country and areas. Without such research, attempts at comparing U.K. findings with those of the Caribbean will remain unreliable.

A significant factor which has been omitted from British research on mental ill-health among West Indians, is the relationship between 'goal-striving' and mental illness. In America, this has been shown to be a significant actor in mental disorder. Recent research by Goldberg and Morrison (1963), Turner and Wagenfield (1967) have shown that schizophrenia is peculiar to lower social classes. This occurs because schizophrenics apparently tend to drift downward in social scale.
However, it is not adequate for the authors to point out that schizophrenia occurs frequently among the lower classes without properly explaining whether the illness first occurs in the middle class and then 'drifts' to the lower classes or whether they are referring to a mental and physical deterioration of the individual which then uncovers the illness. Schizophrenia is an illness of insidious onset which gradually inhibits the individual's capacity to plan and think ahead. It is therefore possible to assume that schizophrenics are unable to carry out the elaborate planning involved in emigrating. Ødegaard (1939) hypothesises that embryonic schizophrenia are likely to migrate on a priori assumption that schizophrenia is an endogenous disease and its sufferers are a restless and unstable population, who can only be marginally influenced by social factors. This hypothesis does not help us to understand the high incidence of schizophrenia among West Indian men.

Most immigrants were from the working classes and as earlier stated, were mainly skilled or semi-skilled persons, between the age of 24-40. Emigration therefore involved complex financial plans, e.g. saving, negotiating a loan either from the government or from private sources and making arrangements for families left behind. If schizophrenic, it is therefore unlikely that such individuals would be able to emigrate. The evidence does not support Ødegaard's hypothesis.

Parker and Kleiner (1969) in a study, the object of which was to test the relation of the degree of psychosis and neurosis to 'Goal-striving;' in the negro population, observed a significant difference with regards to goal-striving between the mentally ill and community samples. The mentally ill had significantly more 'low esteem' and higher levels of aspiration, i.e. they set themselves higher goals than the non-mentally ill. The highest rates were found in those who were upwardly mobile, and more goal-striving was found in the psychotics than in the neurotics. Bagley (1969) showed that goal-striving is significantly associated with schizophrenia. Table III
shows the goal-striving score of three groups.

<table>
<thead>
<tr>
<th>Goal-striving Score</th>
<th>West Indian Schizophrenics</th>
<th>West Indian Community Controls</th>
<th>English Schizophrenics</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>5</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>One or More</td>
<td>12</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>17</td>
<td>17</td>
<td>17</td>
</tr>
</tbody>
</table>

West Indian schizophrenics vs West Indian Community Controls, p 0.05
West Indian schizophrenics vs English schizophrenics, p 0.01

These findings are similar to those of Parker and Kleiner (1969) about Afro-Americans. Bagley (1969) further showed (See Table 4) that schizophrenics rates for West Indians - British Caribbean - were much higher than the native-born British.

There are two models that one can use to account for these findings: the migration or self-selection model and the stress model. The first model implies that some migrants have a latent illness which later becomes manifest when subjected to socio-cultural change. It further suggest that such individuals migrate because they are considered deviant in their society. This model is inadequate in explaining mental illness among West Indians.

Evidence produced by Bagley (1968, 1969) and Hashmi (1969) on coloured immigrants in Britain favours the stress model which clearly shows the significance of environmental stress as a factor in mental illness. Bagley (1969) considered the following environmental stresses:
"(1) overcrowding - a density of two or more persons per room, (2) poverty - household income, after allowance for rent, at less than 140% of Supplementary Benefit scale (See Bagley 1969 for definition), (3) bathroom and toilet facilities shared with other households, (4) accommodation built before 1917, (5) insecurity of tenure under the 1965 Rent Act (i.e. furnished rented accommodation) and (6) subject's usual working days more than 12 hours."

Table 9 shows that West Indians undergo more stress than native-born and that these stresses are not only associated with schizophrenia but with being members of an ethnic group. Given the factors that Africans are exposed to similar stresses, it can be assured that similar conclusions can be drawn about Africans.

Table IV

<table>
<thead>
<tr>
<th>Chronic Environmental Hazards</th>
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<tbody>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Number of Hazards</strong></td>
</tr>
<tr>
<td>----------------------------</td>
</tr>
<tr>
<td>None</td>
</tr>
<tr>
<td>One or More</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

West Indian schizophrenics vs West Indian Community Controls, p .05
West Indian schizophrenics vs English schizophrenics, p .01
Research on mental illness among West Indian migrants in Britain is complicated by the fact that very little is known about the factors differentiating migrants who go to America and Canada. Is mental illness among West Indians in New York and Toronto as high as it is in Britain? If not, why? Are migrants in these cities exposed to similar stresses as those in London? These are just a few of the interesting questions for further research. Thomas-Hope (1977) has attempted to answer some of these vital questions in her study on "The Adaptation of Migrants from the English speaking Caribbean in select urban centres of Britain and North America."

She noted that in Britain, West Indians are more widely dispersed than in North America. Approximately 90% of the West Indian population live in North Eastern cities, especially New York. In Canada, the main areas of West Indian settlements are in Toronto and other cities in Ontario. In Britain large West Indian population can be found mainly in the Greater London area, Birmingham and industrial cities in the Midlands.

The West Indian population in Britain is comprised of a large number of unskilled workers; in contrast, in the United States and Canada it is made up of skilled and professional persons, e.g. nurses, trained technical, electrical workers and secretaries. A proportion of the number of skilled persons in North America, are West Indians who first emigrated to Britain, qualified and then migrated to Canada because of higher wages.

Contrary to Thomas-Hope (1977) implication that West Indian migrants in Britain tend to aspire "predominantly within a working class framework," it has been my experience that West Indians both in Britain and North America have similar middle class aspirations. The status conscious nature of West Indian society pre-conditions them to such aspirations. What somehow separates the West Indian in Britain from his peer in North America is the difficulty in Britain, relative to the ease and quickness in the United States with which the different groups achieve their aspirations.
The reasons behind West Indian migration today is the same as it was in the 1920's and 30's. Clifford Hill (1970) regards West Indian migrants as "economic refugees escaping from grinding poverty in their homelands," but West Indians are not merely concerned in relieving their impoverished situation. They are more concerned to improve their economic and social status on returning home. Those who migrate to Britain and North America were mainly employed at home - admittedly at a wage lower than they would earn in an industrial country - and had to make considerable sacrifices to migrate. Their expectations of considerable betterment in the metropolis are very high and their will to achieve strong. Not only would the acquirement of material goods and paper qualifications bring personal satisfaction, but they would guarantee the holder an improved status and respect in his country. A combination of myth and untrue stories, about the nature of North America and British societies, ill-prepared West Indian migrants for the host country. Most migrants therefore assumed that their goals could be achieved by hard work and stringent saving. They were often disappointed. Of the three main countries of migration, Britain, Canada and United States, migrants in Britain have found that they take longer than their North American peers to attain the economic position they originally envisaged. Britain offers relatively lower wages, lower standard of living and fewer opportunities than North America. Very often West Indian migrants have to alter their initial aspirations in order to cope with the reality of the new situation.

The 'closed' nature of the British homogenous society has prevented the West Indian migrants from achieving as easily as he imagined. Migrants assumed that because of their long historical association with Britain, the British subjects would welcome them openly. Instead, the British who traditionally saw the black man as a slave and servant, viewed the West Indian migrants as third class citizens who came to do the dirty jobs which they despised. Rather than play the role of third class citizens the West Indian migrants were competing with the British for jobs, homes
nd education. This competition produced the greater denial of socio-economic goods to the migrants.

North America, by contrast, the heterogenous, ethnic and cultural diversity, especially in American society, meant that another ethnic minority de very little impact upon the existing structure. Whenever the migrant moved into an area in which he was unwelcomed, the native-born residents moved. In Britain this was not usually the case. Most of the native-born were unable to avoid the 'dark strangers' by moving house. The combination of nearness and fierce competition for the limited social resources created an environment hostile to (West Indian) migrants. Migrants in North America did not experience the same degree of hostility in renting or purchasing accommodation. Most West Indian migrants, especially in New York were in competition with black Americans and not with the white population for jobs, housing and education. The possession of money was all that was needed. It has been noted that white Americans are more tolerant to West Indians than black Americans.

Iustration among West Indian migrants in Britain is augmented by the stories often told by friends or relatives, about friends or relatives who migrated to North America after their emigration to Britain and who, within a five year period have acquired a house, purchased a car, bought land at home,akes frequent visits to his country, sends home bigger remittances and generally enjoys a higher standard of living. Thomas-Hope (1977) has found that West Indian migrants with their highest level of dissatisfaction were the semi-skilled and skilled workers. In all samples men had a lower level of adjustment than females. (See Table V).
Table IV

Distribution of those poorly adjusted to their host environments to occupational group

<table>
<thead>
<tr>
<th></th>
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<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>London</td>
<td>19</td>
<td>44</td>
<td>32</td>
</tr>
<tr>
<td>New York</td>
<td>39</td>
<td>50</td>
<td>10</td>
</tr>
<tr>
<td>Toronto</td>
<td>28</td>
<td>44</td>
<td>24</td>
</tr>
</tbody>
</table>

Occupational Groups

(1) (Top professional managerial) and 5 (casual labourers & unemployed) are omitted because so few represented in the samples.

(2) Professional and specialised white collar workers.

(3) Blue collar and transport workers, general clerks and technicians.

(4) Unskilled workers.

Figures represented % of totals.

Level of adjustment by Sex.

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Satisfied</td>
<td>Dissatisfied</td>
</tr>
<tr>
<td>London</td>
<td>44</td>
<td>50</td>
</tr>
<tr>
<td>New York</td>
<td>76</td>
<td>16</td>
</tr>
<tr>
<td>Toronto</td>
<td>70</td>
<td>24</td>
</tr>
</tbody>
</table>

% of those 'unsure' omitted.

Thomas-Hope (1977) has further shown by comparisons between the adaptation of West Indian in Britain and North-America, that West Indian migrants in Britain have a higher degree of dissatisfaction and disillusionment.
Going to Britain has demanded greater modification - and often abandonment - of aspiration. The longer time spent to achieve these aspirations has produced a deep feeling of frustration. Those who have failed - often after more than one modification - experience a higher degree of personal inadequacy which can be self-destructive. Therefore, there is little wonder mental illness ensues. In Table 3, Bagley (1969) has shown the association between goal-striving and schizophrenia. Further research is needed to determine the association between unfulfilled goals, the degree of disillusionment and mental illness among West Indians not only in Britain and North America, but in their country of birth.

Another important factor in the aetiology of mental illness among West Indian migrants, is the feeling of isolation. This factor has received little attention from British researchers. Do the migrants have any definite ideas as to their destination when they get to Britain? Are they going as isolated individuals or are they joining family units, relatives or friends?

Most migrants irrespective of their occupations do have a definite address. In a survey conducted by Davison (1966) he found that almost 100% of female migrants know exactly where they are going. There is, however, one aspect of this finding which should be considered. A large number of young female migrants become student nurses, living in rural hospitals away from relatives and contact with a West Indian community. Such persons do experience strong feelings of isolation. A large proportion of the migrants during the period 1950s to 60s, were men, mainly accompanied by their wives and relatives. The degree to which they felt isolated needs to be researched.

In a paper recently presented to a conference on mental health in foreign workers, Verhaegen (1972) reported several investigations which revealed a sense of isolation among immigrants. The reason varied between homesickness, strange customs and diet and lack of religious support. However, the most important factor seems to be, unwelcoming and irresponsible behaviour on
immigrants. In contrast, Mezey (1960) found no evidence that isolation was a contributory factor in those who broke down with affective disorders. Malzberg (1967) and Murphy (1959) have shown that there is an inverse relationship between psychiatric admission rates and the size of immigrant groups. These findings have been recognised (Leading Article, 1967) and demonstrated for the immigrant population in New South Wales (Kraus, 1960). These observations may be useful in our comparative study of the Barbadian community in London and Reading. In Reading the Barbadian community is very cohesive, a microcosm of that in Barbados, while in London there is a marked absence of a community spirit, even in the Borough of Brent, which has the largest number of immigrant Barbadians in the United Kingdom (1970 Census, Section 14.)

In this review of the literature, most of the studies of mental illness and migration have been based on criteria from hospital admissions and psychiatric out-patient attendances. Studies of this nature pose several problems regarding their relevance. Should the researcher use first admissions or all admissions? Is the first admission the first time the individual has been ill? Furthermore, mental hospital admissions and to a lesser extent, psychiatric out-patient attendances tend to be a disproportionately weighted in favour of major psychiatric disturbances (psychoses), rather than a neurotic/personality disorder, which constitutes the major part of all psychiatric illness. What is needed are studies at the community and general practice level.

Conclusion

We have reviewed the literature, related migration to psychological disturbance and have observed that the following factors are causal in the relationship of migration to mental illness.

1. Social Isolation.
5. Social Selection.

From the review the following hypotheses emerged:

1. Individuals who migrate from one country to another have a higher rate of poor mental health than members of the host community.

2. Immigrants who experience strong feelings of loneliness, alienation, low self-esteem, difficulty in integrating— the negative impact of social isolation— experience poor mental health.

3. Immigrants who experience social and cultural disorientation, disruption in networks of social interaction and value conflicts, experience poor mental health.

4. Immigrants who experience difficulties in achieving their high goals and aspirations, suffer poor mental health.
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PART 3

RESEARCH FINDING ON U.K. BARBADIANS IN READING.
CHAPTER 11

RESEARCH FINDINGS ON U.K. BARBADIANS IN READING

METHODOLOGY.
The data was collected systematically through 'snow-ball' sampling. This technique and reasons for its use in this study are described below.

**Selection of Sample**

Random sampling is generally regarded as the most reliable and most widely used technique of obtaining sample populations. An enormous advance in sociological research ensued when the general theory of random sampling was developed and applied to social problems. However random sampling does not adequately cover the whole range of possibilities, it is unable to provide statistically useful samples in all situations. Random sampling is at its best when there is a known sampling frame, for example, an electoral register.

Careful consideration was given to finding a reliable sampling frame, from which West Indians could be identified by island group. To obtain a Barbadian sample from a known Barbadian population of over 2,000 individuals (see 1971 census figures) living in Reading, I employed a network/snow-ball sampling technique.

**Network/Snow-ball Sampling**

Network sampling is confined to small groups because larger networks are tractable. At present no systematic theory of network sampling exists; only a few analysts have attacked this problem - Goodman, 1961; Bloemena, 1964; Capobianco, 1970; and Frank 1971.

The snow-ball sampling employed in this research could be described as an $k$ stage $K$ name) snow-ball sampling procedure, which is defined as follows. A random sample of individuals in the sample is asked to name $K$ different individuals in the population, where $K$ is a specific integer, for example, each individual may be asked to name his "$K$ best friends,"or the "$K$ individuals
th whom he most frequently associates." (For the sake of simplicity we
assume throughout that an individual cannot include himself in his list of
individuals). The individuals who were not in the random sample but were
amed by those who were in it formed the first stage. Each of the individuals
the first stage is then asked to name $K$ different individuals. The question-
sked of the individuals in the random sample and of those in each stage is
the same and that $K$ is the same. The individuals who were not in the random
ample nor in the first stage, but were named by individuals in the first
tage form the second stage. Each of the individualss in the second stage
then asked to name $K$ different individuals. The individuals who were not
the random sample nor in the first or second stages but were named by
dividuals in the second stage form the third stage. This procedure is
ontinued until the required number of individuals for the $S$ stage has been
tained. The data obtained by using an $S$ stage $K$ name sampling procedure
an be utilised to make statistical inferences about various aspects of the
lationships present in the population.

**Obtaining the Reading Sample**

To obtain the Reading sample I contacted the Reading Community Relations
fficer (CRO), Mr. H. De Pass - who proved to be of invaluable assistance
providing information about the Barbadian population in Reading.

De Pass kept a list which contained the name and addresses of persons
visited his office officially. From this list, ten were randomly
elected - by consecutive numbers. This list contained over fifty Barbadians
that only ten persons were selected because it would provide an over representa­
tion of one type of person, namely those who visited the CRO’s office. The
Barbadians chosen from Mr. De Pass’ list were each asked two questions:
1) Could you tell me the name(s) of any two persons in this area (Reading)
on you most recently visited socially in the last month?
2) Could you tell me the name(s) of any two persons in this area (Reading)
who most recently visited you socially in the last month?

The replies to these questions often yielded four new respondents who formed the first stage. This procedure was continued as outlined in an $S$ stage $K$ name snowball sampling procedure, until 100 individuals were sampled.

Composition of the Sample

The sample was comprised of 100 Barbadians, 50 males and 50 females, 64 of the respondents were married, 26 unmarried, 3 widowed and 7 divorced or separated. All the respondents were born in Barbados and were first generation immigrants. There were a few respondents who came to England as children.

Most of the respondents (45 persons) came from St. Andrew, a parish in Barbados, 30 persons from St. Michael and 25 persons from other parishes.

Measurement of Variables

Three instruments were used in the study. These are, a revised version of the Holmes and Rahe Social Readjustment Rating Scale - adapted by Cochrane and Robertson 1971, the Middlesex Hospital Questionnaire (MHQ) - devised by Crisp, A.H. and Crown, S. (1970) and a Sociological Questionnaire devised by the researcher. The instruments are discussed further in chapters 8 & 9.

Measurement of Stress

The Holmes and Rahe Social Readjustment Rating Scale (SRRS) has been a significant stimulus in life events research (Holmes and Rahe, 1967). This instrument in both its original and modified form has been used in a variety of studies thus providing for comparability between studies. In this study, I used a modified version of the Holmes and Rahe (SSRS) - devised by Cochrane and Robertson (1971).
The revised (SRRS) contains 48 items (Questions) which are divided into 3 sections. Section I contains 31 items, which all respondents are asked to complete. Section II, 13 items for respondents who are married and Section III, 4 items for those who have never been married. Each event in the scale has a score indicating the relative magnitude of stress produced. Events range from 'new neighbours' - scaling 18 - to 'death of spouse' - scaling 86. 'Marriage' carries the mean score of 50.

Measurement of Psychological Disturbance

To measure illness symptomatology, the Middlesex Hospital Questionnaire (MHQ) was used. The questionnaire was devised by Crisp, A.H. and Crown, S. (1970) and has been shown to be reliable; (see Chapter 8 for a discussion of the development and reliability of the MHQ).

The instrument is comprised of 48 questions, which are divided into 6 symptom sub-scales, measuring Free Floating anxiety (FFA), Phobia (Phob.), Obsess-ionality (Obsess.), Somatic (Som.), Depression (Dep.) and Hysteria (Hys.). Each sub-scale contains 8 questions, scores in each question range from 0-2, with a maximum score of 16 in each sub-scale.

Measurement of Social and Demographic Variables

A sociological questionnaire was developed to measure the relationship between socio-demographic and cultural variables with stressful life events and psychological disturbance: the instrument contains 23 questions.

Informal Interviews

After the formal interviews using the three instruments, most of the respondents entered into informal discussion with the researcher. They spoke freely about immigration, England and the English people, prejudice, feelings of frustration, disappointment or pleasure with being in England.
These informal sessions provided a wealth of information which served to augment the data and give the researcher a better insight into the respondents' hidden thoughts.

Method of Analysis

The data was first analysed for means and standard deviations (See Table 1). Subsequently, correlation and regression analysis was performed by using the correlation ratio (ETA) and the Product Moment Correlation. These measures of association and reasons for their use in this study, are discussed below. ETA recorded stronger significant values than the product moment correlation, mainly because most of the distribution were not linear.

Correlation Ratio of ETA, and Product Moment Correlation

Product moment correlation is a measure of linear association. Many of the distributions of the sociological and economic data were clearly non-linear. In this extent, the conventional correlation coefficient will tend to underestimate the amount of association which exists between sets of data. Here, the array means fail to fall in a straight line; therefore, a better prediction is made by using a curve which 'fits' the means, by using the names themselves. A measure of association which adequately tests non-linearity is ETA, which is based on the analysis of variance, and requires that the dependent variable satisfies "parametric" assumptions.

ETA indicates the relative accuracy with which we can predict on the basis of the array means. It is a useful measure to the extent of correlation when regression is curvilinear. Further, ETA can also be used when the regression is linear, and therefore it is more generally applicable than the product moment correlation. It can be used to when a set of predictor variables are nominal or ordinal in character.

Standard deviations are given in brackets.

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<thead>
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<th>Sex</th>
<th>Scale</th>
<th>M</th>
<th>SD</th>
<th>t</th>
<th>d.f.</th>
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</table>

N = 50

* A comparison of NAO (CCII) sub-scales means scores in Baraband and U.K. groups
To be analytically rigorous, the data was tested by both the Correlation Ratio (ETA) and the Correlation based on linear assumptions.

In order to examine the relationship between stressful events and socio-demographic variables, the values of the (raw score) of the Stress Inventory as selected in preference to the scaled score (of the Stress Inventory) because the former score was found to be a better predictor of other variables in the analysis.

The significant values of the sociological questionnaire are located by using the ETA and Kendal's Tab B test of association. Further, patterns of correlations coefficients are examined to determine the degree of association between variables.

Further the relationship between psychological disturbance and stressful life events is analysed. An item analysis of the Stress Inventory is undertaken to identify the significance of each stress item and the difference between items for male and female respondents.

We will begin the analysis of the findings by examining 5 aspects of the migratory process.

1) The motivational factors which brought about migration.

2) The immigrants personal expectations, aspirations and preconceptions of gland.

3) The difficulties and stresses encountered in achieving personal ambitions.

4) The consequence of these difficulties on settlement intentions and finally

5) The effect of these experiences on social stability and mental health.
REFERENCE


CHAPTER 12

U.K. BARBADIANS: PRE-POST MIGRATION, ATTITUDES AND SOCIAL INTEGRATION

- PRE-MIGRATION INTENTIONS.
- DIFFICULTIES ASSOCIATED WITH MIGRATION.
- POST MIGRATION ATTITUDES.
- SOCIAL ISOLATION.
- SOCIAL STABILITY.
Pre-Immigration - Aspirations and Expectations about England and English People

Most migratory movements are motivated by the migrant's feeling of insecurity and inadequacy in his original social setting. The migrant feels frustration and inability to attain some level of aspiration. He is unable to gratify his expectations and fulfil the role desired. He cannot maintain a given level of physical existence to ensure his family's survival in the society. This may be due to over population, limited economic opportunities, political oppression, etc. Whatever the cause(s) it is the feelings of frustration and goal denial that motivates migration. For these reasons migrants tend to develop certain definite expectations about the new society and hope of resolving many of their frustrations.

In the case of Barbadian migrants, expectations were very high. The initial attraction to England was mainly limited to a single sphere (e.g. the attainment of certain economic and educational goals). With regard to other spheres, they by and large remain 'attached' to their original society and culture in many ways.

The migratory process always involve a narrowing of the sphere of social participation. This limitation is of a two fold nature. On the one hand there is some disruption and breakage in the social networks the individual had in the old society, roles he can no longer perform. On the other hand the individual encounters problems of adjustment and adaptation to the new society, along with those images of the old country, to which the immigrant is attached. As Eisenstadt (1954) points out,

"the immigrant may be said to live through the process of migration in an unstructured, incompletely defined field and cannot be sure how far his various aspirations can be realised. This like any non-structured and incompletely defined situation, give rise to some feeling of insecurity and anxiety."
This leads us to the following hypotheses:

(1) Prior knowledge about the host society acts as a moderating factor in reducing stressful life events and psychological disturbance during the initial period of settlement.

(2) High aspirations and expectations (goal-striving stress, - Parker and Kleiner, 1969) are conducive to poor mental health.

(3) Respondents who migrate because of reasons beyond their control, e.g. limited job opportunities, over population - have better mental health - experience less stress and psychological disturbance - than those who migrate for personal reasons e.g. emotional problems.

(4) Respondents who fail to realise their goals experience more stress and psychological disturbance than respondents who realised their goals.

(5) Respondents who felt negatively, (dissatisfied with or regretted) about migrating to England had poorer mental health than those who were satisfied about migrating.

Personal aspirations and expectations about England and English society, were constructed from seven questions, concerning the respondent's expected goals before migration, the relative ease or difficulty of achieving goals, and a post-migration assessment of his decision to migrate.

The questions are:

(1) What did you plan to do before you came to England?

(2) Did you follow your plan?

(3) If 'yes', was it relatively easy?

If 'yes' or 'no', what sort of difficulties did you meet in following your plan.
(4) Why did you come to England? (There is a list of 'negative' and 'positive' reasons).

(5) Before you left home (Barbados) what did you expect England and English people to be like?

(6) Now that you have been here for sometime, what do you think about England and the English people?

(7) Now that you have lived in England for sometime what do you think about your decision to come to England?

Findings

Stress and Psychological disturbance

Before leaving Barbados 51% had planned to work, 19 to study, 16 to work as well as study, and 14 had no idea of what they wanted to do. Of those who had a plan, 59 persons followed it, 17 attempted and failed, while the remainder made no attempt to follow their plan.

A significant relationship was found between reasons for migrating (ETA = .311) (ETA = .281 total M.H.Q) and expectations about England, as well as with stressful life events and psychological disturbance (ETA = .320). Those respondents who stated 'positive' reasons for migrating, e.g. "to join relatives, to find work and improve children's education," recorded less stress than those who migrated for 'negative' reasons, e.g. "to leave personal problems behind," and also had somewhat better mental health.

Further, a significant association was observed between respondents who hadn't realised their goals, (e.g. started studying but didn't complete the course) and stressful events. There was a direct linear relationship
between difficulties experienced in following one's plan and stressful events, \((\text{ETA} = .208) (r = .208)\). (See Table A & B)

Most of the respondents who started studying, failed, or didn't complete the course, were studying whilst working. They found working and studying rather stressful. These views were related to me by a respondent who said, "If I had finished that engineering course, I would be in a better job today, instead of the lousy job I have; I might have even open my own business."

Researcher: Why didn't you finish it?
Respondent: "Ah, it's a long story. Anyway, basically I just found it difficult to get home from work and attend classes. I used to go, but when I sit in the classroom I used to be so tired that half the time I fall asleep. Then there is winter. Man when it gets really cold, its difficult to go to a classroom and sit down. The first place I used to head for was home and the fire. Then I had to cook for myself. All of these things cause me to miss classes. In de end I couldn't take the exams. Since then I have lost interest, sometimes I feel really bad about it."

This was simply one of many disillusioned respondents, who came to England with high expectations, goal and ambitions which were realised.

Those respondents who had high expectations about England and the English people, e.g. "It's easy to earn lots of money," "I thought the people were friendly" and they had "no prejudice" recorded higher levels of poor-mental health than those respondents who had no idea. This finding confirms to some extent the Parker-Kleiner hypothesis that poor-mental health is associated with blaming oneself rather than a racist society for failure.

Despite the frustration many respondents experienced, sixty percent aid that they were 'satisfied' about their decision to come to England.
The other forty percent had mixed feelings, with the majority noting that 'life in England is tough' they felt that they hadn't made the best use of opportunities, and were therefore failures.

Sex Differences

Levels of stress associated with poor-mental health were measured by the raw score of the Stress Inventory (var. 87) and total M.H.Q., (var. 95).

Significant ETA associations were found between pre-migration plans, stress (.266) and psychological disturbance (.298) for male respondents. No relationship was found for females, indicating that male respondents who had firm pre-migration plans experienced more stress and psychological disturbance than female.

Male respondents who migrated because of 'negative' reasons (emotional problems) experienced more stress (.419) and psychological disturbance (.387) than females.

Male respondents who had high expectations about England and English people reported less stress (.393), but more psychological disturbance (.676).

The reverse was noted for females - more stress (.657) and less psychological disturbance (.393).

Second Generation and Goal-Striving Stress

The first generation immigrants held a level of aspirations which they strove hard to achieve. They experienced obstacles, e.g., social rejection and frustration in attaining their goals. They have come to tolerate a certain level of abuse, because they have accepted one basic fact, that is, their status as foreigners, with no rightful claim, (based on place of birth) to goods and services in England. However, their children - second
generation 'immigrants' automatically expect that they have equal rights, with those of the dominant group in the society, to goods and services. They assume that the situation should be less traumatic for them than it was for their parents.

Thomas and Znaniecki (1969) in a study of Polish Peasants in Europe and America showed that conflicts can be even more serious for the children than for the parents. When the child goes to school he becomes to a great extent acculturated, but in addition to school, he becomes influenced by his parents, who tend to relate their early experiences to him. He soon discovers that the same problems his parents experienced he encounters. Despite their place of birth, second generation 'immigrants' are unable to overcome the consequences of their colour.

Further, parents confronted with social rejection, react by idealising their lost (home) country, their efforts are directed towards maintaining in their offspring the values of the native country. The child finds himself torn between the conflicting cultures, that of the family (or the 'street,' if he lives in densely populated immigrant neighbourhood) and that of the school. Two things can happen, either the child acts as a mediator between his non-acculturated family and the new environment, or when he becomes aware of his important role, evade parent control and becomes a 'rebel.'

**Discussion**

Before immigrating most of the respondents had some plan or idea about what they wanted to do. Those who had planned to work reported less psychological disturbance and fewer stressful life events than those who came with intentions of studying, studying as well as working. Over 70% of those who had planned to study did not achieve their goals. This caused feelings of
frustration. It was also observed that this group was most unhappy with their present occupation and admitted feeling restless. Many expressed a desire to immigrate to Canada or the U.S.A. None were willing to return home.

There is a correlation at the 1% level, between those who wanted to re-immigrate and depression (.256). This finding is further supported by ETA relationship with depression (.300) and hysteria (.242) scales.

Those respondents who wanted to re-migrate were mainly men. They felt that England had let them down, and saw themselves as failures. They had expected England to be the land of opportunities, where people were friendly, it was easy to earn lots of money and that there were readily available opportunities to study.

The majority of the respondents came to England primarily to work and improve their standard of living. They expected England to be a place where there were more job opportunities than Barbados. They had no great expectations about England. However, over 50% of the respondents reported that they expected English people to be friendly. This expectation had its origin in the respondents earlier interaction with English people in Barbados. Sixty percent - 40 females and 20 males were 'satisfied' with their decision to immigrate to England. They preferred returning to Barbados than re-immigrating to Canada or the U.S.A. Female respondents were keener than males to return home.

Preconceptions of England - Values and Views

Most of the literature on West Indian preconceptions of England emphasises the cultural affinity felt by West Indians for the 'mother country' and the sense of disillusionment and rejection the immigrants experienced when they found that the English do not share this view of the West Indies
relationship to England, (Brown, 1970; Deakin, 1970; Lewis, 1969, 1971; Midgett, 1971; Rose, 1969; Tajfel and Dawson, 1965). These observations are indeed true, but what they fail to point/is, that West Indians coming to Britain have some knowledge of racism and discrimination.

At home West Indians experience discomfort about racial identity. this is partly due to the historic white bias of their societies. However the racial conflicts and discomforts experienced by West Indians at home does not entail the self-hate and feelings of inferiority that has been attributed to them in the writings of Lowenthal, 1972; Fanon, 1967. Sutton et al, (1975) found little evidence that Barbadians saw their disadvantaged position as due to inherent inferiority. Instead she noted that the black majority saw their position as due primarily to a disparity of opportunities; a denial of opportunities to achieve socially valued goods and position of esteem. The achievement of social acceptability was one of the main reasons why middle class Barbadians, who felt trapped, decided to emigrate.

Although the black population of the society felt that their inherent abilities were equal to those of the whites, they granted the whites social superiority, largely because the local whites were in positions of authority and therefore able to affect adversely their employment prospects. However, as Sutton pointed out, "race and colour were far from irrelevant in their social evaluations. In fact they were at the heart of Barbadian social stratification, which is built on an invidious grading of status distinctions described interchangeably in terms of either chromatic shade, or power of prestige."

The racial conflict experienced in Barbadian society is quite different from what immigrants experience in Britain, where racial identities ignore differences in shade and status.
Barbadian migrants did not generalise their experiences of invidious racism at home to England, or to all white people. They maintained an open mind about what they might encounter in England. They felt that being legal subjects of the British monarchy they would be welcomed and treated equally with indigenous population. Their belief in British fair-mindedness made Barbadians unprepared for the differences between what they read about England and the realities of twentieth century English culture. More important, they were totally unprepared for the contempt and indifference which many Britons felt for their colonial citizens.

Barbadians moving into the homogenous white society soon realised that however acculturated, law-abiding and 'English' they might be, their colour and colonial status set them apart from the English, and evoked different treatment from landlords and employers, (See for example Tajfel and Dawson, 1965).

As Gordon Lewis writes, Barbadians go to England with no developed sense of ethnic distinctness and only a submerged racial consciousness, and acquire in England a consciousness of being different, of being 'black people in a white world.' They gained much of their sense of ethnic difference as the full meaning of being black in a white society is driven home to them.

"As recently as the 1950's it was a cardinal article of faith among newcomers that they were coming 'home' to the 'mother country' and particularly so for the West Indian so much more culturally English than the Asian counterparts. The literature of disillusionment ..... is of recent growth, and to read it is to be made poignantly aware of the general figure of the West Indian, immeasurably saddened by the unexpected humiliations of his daily experience.... There can be little doubt that, as that reservoir of good will slowly evaporate, he becomes increasingly radicalised in his attitude to the total problem... More and more, to put it succinctly the immigrant sees himself less as a West Indian or a
Sikh in an English society, and more as a black man in a white society." (Gordon Lewis, 1969, 428).

Did these false preconceptions of England and English people create difficulties for Barbadian immigrants, during their initial period of residence?
What difficulties did they encounter through migration?

Conclusion

(1) No conclusive evidence was found to support the hypothesis that prior knowledge of the host society acted as a moderating factor in reducing poor-mental health during the initial period of immigration. The Barbadian immigrants found themselves in a rather fortunate position insofar that the recruiting agency provided them with accommodation. Being able to speak the same language, knowing something about England help most immigrants to communicate with and settle into the host society. However, this previous knowledge was not adequate in moderating stressful events and psychological disturbance.

(2) High aspirations and expectations (goal-striving) was found to be positively associated with poor-mental health.

(3) Respondents who migrated because of socio-economic reasons beyond their control (e.g., limited job opportunities) experienced less stress and psychological disturbance, than those who migrated because of personal reasons (e.g., emotional problems).
It is quite likely that those respondents who migrated because of socio-economic pressure, probably experienced emotional problems. These two aspects of the relationship between emotional/non-emotional problems and poor-mental health are interrelated.
Those respondents who didn’t realise their goals experience poorer-mental health than those who realised their goals. Of those who didn’t realise their goals, a large number tried and failed. Those who tried and failed expressed feelings of guilt. They blamed themselves for not trying hard enough.

I would hypothesise that such factors as, cultural ambivalence, feelings of social rejection, (in various forms of discrimination), frustration and disappointment at not being able to achieve aspirations are partly responsible for the high level of delinquency among young blacks.

As I have just shown most respondents had various aspirations and expectations which when unfulfilled resulted in varying degrees of poor-mental health. Their ideas about England were obtained through socialisation in an 'English sub-cultural society' - Barbados. In brief, respondents saw themselves as culturally identifiable with England and anticipated no major problem in adjusting to life in the 'mother country.' Such views created the socio-psychological milieu in which stress and psychological disturbance (poor-mental health) spawned.

The initial period of migration - the 'honeymoon period' - in which the immigrants were relatively protected from the social rigours of life in England, lasted for an average of three to five years. After this period the respondents began to realise that they weren’t going to achieve their goals as readily as they had thought. What difficulties respondents encountered in the migration process? What were the consequences of these difficulties for the respondents? The relationship between difficulties associated with migration and poor-mental health will be discussed in the following section.
Difficulties Associated with Migration

One of the theories of migration and mental health/illness contends that immigrants experience problems of adjustment, the most severe of which is 'cultural shock', the concept has never been properly defined. Landlin (1951) holds the view that immigrants experience shock because of intense feelings of personal inefficiency, normlessness, role instability, and role displacement. If the process of migration itself contributes to high levels of stress and psychological disturbance, we would expect to find evidence for the following hypothesis.

1. The more recently people have migrated the poorer their mental health.
2. Those experiencing more difficulties at the time of immigration will show poorer adjustment.

Maslauit (1954) suggested that immigrants are disturbed by living in an unstructured ill-defined field. Oberg (1959) on the other hand, pointed out that since value conflict causes immigrants to misinterpret cues of social interaction, daily life becomes a host of insurmountable problems. The cultural shock theory hypothesises that immigrants entering a society different from their native community will find it more difficult to adjust than will immigrants with a similar cultural background. This hypothesis implies that a change in culture has a disturbing effect on immigrants.

This brings us to another theory of migration, cultural change, which posits that acculturation varies directly with psychological stress. Proponents (Hallowell, 1955; Papajohn and Speigel, 1971) of the cultural change theory, contend that the adoption of the host values involves a disruption in the immigrant's native culture, which is likely to seriously challenge and probably devalue it. Derbyshire (1969) noted that Chicano youths tend to over-identify with their own culture.
under pressure to adopt the dominant American culture. Black Britons, (in England) refuse to adopt the dominant culture, to the extent that they speak West Indian creole and identify with such religio-political sects as the Rastafarians.

The cultural change theory, hypothesises that, the greater the acculturation the greater the psychological distress. This directly conflicts with the cultural shock hypothesis, which states that, as the immigrant becomes acculturised, his propensity toward mental illness is reduced.

In the following analysis the relative accuracy of these conflict hypotheses is examined by employing data on the difficulties associated with Barbadian migration to England.

(1) The more recently people have migrated the poorer their mental health.

(2) Those respondents experiencing more difficulties at the time of emigration will show poorer adjustment.

(3) Immigrants entering a society different from their native community will find it more difficult to adjust than will immigrants with a similar cultural background. (Culture shock hypothesis).

(4) The greater the acculturation the greater the psychological distress. (Cultural change hypothesis.)

(5) Experiences of racial hostility are positively related to poor-mental health.

Data relating to difficulties associated with migration was obtained from questions relating to difficulties in finding accommodation, racial hostility and from informal interviews with respondents.

The questions were:

(1) What kind of accommodation did you live in when you first arrived?

(2) Did you experience any difficulty in finding accommodation?
(3) If 'yes', what sort of difficulty?

(4) Do white/British people regard you as their equal socially?

(5) Have you experienced any difficulty because of your colour?
   
   (a) often.
   (b) Sometimes.
   (c) rarely.
   (d) never.

(6) Is the hostility,

   (a) verbal.
   (b) discrimination.
   (c) psychological.
   (d) other.
There was no significant association between difficulties associated with migration, stressful life events and psychological disturbance (poor mental health). The ETA test established a significant relationship between accommodation difficulties at time of migration and psychological disturbance (.260 with total M.H.Q.); Dep. (.269) and Hys. (.312). The nature of the difference showed that those respondents who lived alone in rooms tended to experience depression and/or hysteria.

No association was found between racial hostility and poor mental health.

Respondents did report having experience some racial hostility but this didn't seem to severely affect any of the respondents. As one respondent reminded me;

"If you mind these people they would drive you out of the country. We know they don't like us, so it's best to keep to ourselves. They'll smile with you and later talk your name. I used to have a lotta of dat a work. I suppose it affects some people more than others."
Sex Differences

Findings

No association was found between type of accommodation lived in on arrival and stress. A relationship was noted between type of accommodation lived in on arrival, difficulties in finding accommodation and psychological disturbance, for male respondents. Those respondents who on arrival lived in a room alone and those reporting difficulty in finding accommodation experienced psychological disturbance, (Correlation with total M.H.Q. .300 and .292 respectively). Female respondents who on arrival lived alone experienced as much psychological disturbance (.335) as males (.300).

Living alone was particularly upsetting for most respondents, who were accustomed to living in households in which there were many family members. Suddenly they were confronted with a strange new experience, living in cold, dark rooms, often with no friends nearby.

This data was further substantiated by comments made by respondents during informal interviews. Here I will report the comments of two respondents - male and female - who recalled the difficulties they encountered soon after arriving in England. I should add however, that these respondents did not come to England under the Government sponsored scheme.

During my informal interview one male respondent remarked:

"It was really rough. You can't imagine what it was like, leaving a warm country to come and live in a little room, hardly big enough to swing a cat. The place always seemed cold, dark and dismal; and then there was this smell, you know a mouldy smell. You wake up when it was dark, went to sleep when it was dark, you never seem to see the sun; I couldn't understand that. No one in the house said
Boy, I tell yuh those days were something else. Things got so tough that I had to send for my girlfriend."

Echoing these remarks was a female respondent who, reminding me that things had got a lot better, noted:

"When I first came here (England) I stayed with a friend for a while, then I started to look for a place of my own. It wasn't private, to grown women living in one small room. I had so many refusals, it wasn't true, I really felt downhearted. I eventually found a little room. The place was damp and light never seemed to get in it. Anyway I tried my best with it. I used to feel so lonely sometimes I would just lie there and cry my eyes out, and wish that I was home. The people in the house never spoke to yuh. Another thing, I could never get accustomed to sharing a bathroom and toilet with those people, they were really dirty. Sometimes it makes me sick to talk about it."

These comments typify some of the respondents experiences during the first year of residence in England.

Some of the respondents were partly responsible for some of the difficulties they encountered. They came to England with high aspirations and expectations of England and English people, which were not in keeping with the reality of English life. This made them somewhat more vulnerable to stress. Here they were confronted with disappointments in their life expectations. The harsh, painful realisation that 'England wasn't what they thought it would be', added to the unexpected force of racism was particularly disturbing for most respondents. Most of them experienced racial hostility of one kind or another and have remained 'sane', while others have had emotionally disturbed reactions, to the extent they harbour hate towards white people. One respondent recalling an incident he had with some while
workmates said, "I hate white people since then."

No association was found between experiences of racial hostility and poor mental health.

Male respondents reported more incidents of racial hostility than females; working females than housewives.

One of the male respondents reported having had a fight with a white man. Never they did report various racial incidents. One male respondent said,

"Racism comes in all form and sizes. When I first started to work in last job, they used to call me 'Sambo' and all kinds of names; and it isn't in fun. Then I noticed that the bloke that I was working with was taking extra long tea breaks or spending a long time in the loo. I ended doing my work and his. When I confronted him with this it caused a row, and soon I was experiencing all kinds of discrimination, even from the section ad. Eventually I left. Sometimes racial hostility is obvious and at otheres it is very subtle, it is a difficult subject. Most blacks in Reading have a touch of it, but we don't take it on, if we did we'll soon go mad."

Male respondents tended to report disputes between nursing sisters and aff nurses, and themselves. These disputes were often interpreted having a racial tone. A typical example was cited by a female respondent:

"There is no one who could tell me that sister Y and staff nurse X aren't prejudice, just look how they make up the rota, all their white friends get Friday, Saturday and Sunday off and the black workers usually t a late duty on Thursday, off Friday and Saturday and an early on Sunday. was so annoyed about it that I went to the nursing officer."
The difficulty in analysing racial hostility is, that unless incidents are recorded over time, it is difficult to know whether the respondent is being too sensitive, over-reacting, or whether the incident is a genuine case of racial hostility.

Burke (1930) studying the factor of race in a small group of Barbadians living in Reading, who either themselves, or a close relative had a mental breakdown, noted that racial incidents were the main cause of their illness. Burke's study, while interesting has many shortcomings, some of which are: the sample is too small, there was no supporting information from any of the care agencies and finally the researcher accepts fully the respondent statements that "racial incidents caused their breakdown" without a thorough analysis of relating factors.
Discussion

The majority of male respondents - 40 persons - came to England through sponsored immigration schemes, the other ten persons were sent for by relatives or friends.

Thirty female respondents who came to England were sent for by relatives, husbands or boyfriends. The other 20 females came through sponsored schemes, mainly nursing.

The difficulties experienced by those respondents who came to England through sponsored schemes were different for those who migrated through private sources.

Those males who were sponsored came to jobs and accommodation. They invariably shared accommodation with fellow black workers employed by the recruiting agency (e.g., British Rail Board or London Transport). This social situation provided some emotional protection and assisted them in getting over the initial settlement period. Those respondents who considered changing their jobs and accommodation encountered great difficulty in finding a suitable job and accommodation. Often they answered an advertisement only to find that the room or flat had just been "taken." On some occasions landladies and landlords were openly frank about their non-acceptance of black people. The situation was not much better when male respondents sought a job. Those who found alternative employment were given the lowest paid job. There was little that the respondent could do. Complaints of victimisation could result in dismissal or a stern reminder by the employed that "if you don't like it you could always leave." But what to, another dirty low paid job? The alternatives were many but poor.
For those male respondents who came to England, on an invitation from a relative or friend, finding a 'decent' job was a big problem. As one respondent pointed out:

"When I first came to England, things were bad. Nowadays you have the race relation act and all that to help people, but then, there was no such thing. I will always remember the difficult time I had in finding a 'decent' job. Every place I went they offered me a dirty job with not much money. After trying for many weeks I eventually found one which was not as bad as those I was offered before. But my real problem started when I decided to move from my sister's and try to find a room, man that was hell. I used to walk up and down. I spent hours looking for a room. I never know people to let a room so quickly. The advertisement would just come out, and by the time I go around, I was told that it was taken, that used to make me mad. It took me months to find a room. Lucky for me, I was still staying by my sister."

Female and male respondents who came to England on sponsored nursing schemes fared rather better than males who came to work for one of the service industries. Such respondents were provided with relatively good, clean lodgings. They had far fewer socio-economic problems. Admittedly the hospitals were usually in country districts, but the hospital administration tried as best it could to make life comfortable for its foreign nurses. It however could not remove feelings of loneliness and home sickness, most nurses experienced.

The nature/type of Barbadian immigration was such that most of them did not experience culture shock. Argellera (1971) in his study of West Africans and West Indians living in Lambeth, London, observed that West Indians suffered less from 'culture shock' - they broke down less early - than West Africans. He noted that only 25% of West Indians in his sample of psychiatric patients became mentally ill
Data for first admissions to Fairmile Hospital - serving the Reading area - which I obtained from the Oxford Linkage Analysis showed that few Barbadians/West Indians became mentally ill during the first 3 years of residence in England. Data from my study reveal that Barbadians experience relatively few problems on arriving in England. From the measure of 'social stability', it was noted that those respondents who were resident in Reading for a period 1 - 5 years experience more stressful events and psychological disturbance than those who were resident for a period 8 - 9 years.

These findings do not fully support the 'culture shock'/culture change' hypotheses, which states that:

(1) Those immigrants entering a society extremely different from their native community will find it more difficult to adjust than will immigrants with a similar cultural background.

(2) As immigrants became acculturised their propensity towards mental illness is reduced.

(3) The greater the acculturation the greater the psychological distress (cultural change hypothesis).

My caution is fully rejecting the 'cultural shock', 'cultural change' hypotheses, is due to the inconclusive nature of my findings. They point to a rather complex set of relations which contribute to varying levels of mental health and poor-mental health in the respondents.

Barbadian immigrants are reasonably familiar with English values, therefore English social structure is not extremely different from theirs.
This meant the immigrant experience few initial difficulties in adjusting to British society. However, after being in England for upwards of 5 years, immigrants began to realise that their values, ideas and expectations they had about England - learnt from upper class colonials - were invalid and incongruous with contemporary Britain. They experienced social rejection and racial discrimination from members of the host society. They experience alienation and goal frustration, many and varied obstacles and limitation in their pursuit for social betterment. These social and economic difficulties marked the end of the 'honey-moon' relationship immigrants had with England, and the beginning of a period of tribulation.

The more acculturated the immigrants became, the further removed they were from their native cultural identity; the less likely they were to adopt traditional/'folk' methods of coping with stressful events, the greater the possibility of psychological disturbance. However, there is a point at which long residence and a high degree of acculturation has a positive effect on mental health. This is best illustrated by Figure 1 which shows that there are two periods at which respondents are at greater risk of experiencing poor mental health. The first period - 6 - 8 years - occurs soon after realising the first 'goal failure'. The second period occurs between 11 - 12 years, when a second 'goal failure' may occur or the accumulative effect of stress, frustration and disappointment in one's life expectations precipitate psychological disturbance.
Relative index of poor mental health

Length of residence in years

1st 2nd 6 7 8 9 10 11 12 15 20+
After being resident for about 15 years and over most respondents become more socially stable and acculturated, deciding to remain permanently in England. Other respondents remained unsettled, dissatisfied with life in England and wanted to re-immigrate to North America. This group of respondents reported poor-mental health.

The difficulties most respondents encountered since arriving in England, had a significant effect upon their settlement intentions. Some respondents who arrived intending to stay permanently subsequently decided not to stay. Others who had no settlement intentions have decided to stay. The relationship between 'life experiences' and settlement intentions will be considered in the next section.
Conclusion

The hypotheses were tested and the following conclusions made.

(1) There was no relation between recent migration and poor-mental health. New arrivals experienced few problems during their initial period of settlement. Difficulties occurred after being resident for some years.

(2) Respondents encountered few problems at time of immigration, therefore the hypothesis, that respondents who experience difficulties at time of immigration will show poor adjustment remains unsupported. However, it is likely that some respondents who experience difficulties at time of immigration, could show poor adjustment later. My findings did not locate such respondents.

(3) Hypothesis No. 3 was partially supported by my findings. I found that immigrants who entered a society different from their native community are likely to experience stress and poor-mental health. This hypothesis is fully examined in the discussion that follows.

(4) My findings indicated that respondents who are 'moderately' acculturated are at greater risk of poor-mental health than those who are fully acculturated. There are several factors involved in the 'cultural change' hypothesis. These are further examined in the discussion.

(5) No evidence was found to support the hypothesis that racial hostility was positively associated with poor-mental health.
Pre-Post Immigration Settlement Intentions

The researcher was interested in finding out if there was a relationship between 'pre' and 'post-immigration' intentions to settle permanently in England, and levels of poor-mental health. What factors are implicated in the relationship?

Four questions from the sociological questionnaire in conjunction with information obtained from informal interviews were used.

The questions were:
(1) When you first came to England was it your intention to settle permanently?
(2) Have you decided to remain permanently?
(3) If 'yes,' why?
(4) If 'no' why?

The answers given in response to questions 3 and 4 were broken down into negative and positive reasons.

The following hypotheses are tested:
(1) Respondents who decided to settle permanently in England had better mental health than those who hadn't decided.

(2) Respondents who decided to settle permanently because of 'positive' reasons were likely to experience less stress and psychological disturbance (poor-mental health) than those who decided for 'negative' reasons.
Respondents who decided not to settle for 'negative' reasons were likely to have poorer mental health than those who decided not to settle for 'positive' reasons.
Findings

Nine of the respondents said that before immigrating they had planned to settle permanently in England. Fifty-six respondents (31 males and 25 females) made no plans, and 35 respondents (19 females and 16 males) never thought of it.

After being in England for an average of 11 years there was a change of attitudes about settling permanently. Fifty-six respondents (25 females and 21 males) decided to settle permanently, while 43 respondents (22 females and 21 males) were committed to returning home. Eleven respondents were undecided. What caused the respondents to decide on taking up permanent residence? Why was such a large number of respondents unwilling to settle permanently in England?

Those who decided to remain permanently were influenced by two factors:
(1) They had family ties and many friends in England, and
(2) They were currently enjoying a better and higher standard of living than they believe they would at home.

Respondents who decided not to settle permanently were influenced in their decision by two factors:
(1) They had family ties and relatives at home, and
(2) They were planning to work or start their own business at home.
Stress and Psychological Disturbance

There was no association between 'pre-immigration' intentions to remain permanently in England, stress and psychological disturbance. The ETA test indicated a relationship between 'post-immigration', plans to settle permanently, stress and psychological disturbance. Respondents who reported 'negative' reasons e.g. "limited job opportunities at home" experienced more stress (.218) and psychological disturbance (.301 with total M.H.Q) than those respondents who cited 'positive' reasons e.g. "have family and friends here."

Those respondents who decided not to remain permanently in England because of 'negative' reasons, e.g. "English people too unfriendly," "too much discrimination" reported more stress (.225) and psychological disturbance (.216 with total M.H.Q) than those who reported 'positive' reasons, e.g. "have family and friends at home."
Sex Differences

No association was found between 'pre-post immigration settlement intention of respondents, stress and psychological disturbance (poor mental health). Female respondents who decided not to remain permanently in England, reported no stress but a high degree of psychological disturbance (.363 with total M.H.Q).

Further, female respondents who decided to remain in England for "negative" reasons "because we can't do any better" reported much more stress (.526) and psychological disturbance (.464 with total M.H.Q) (poor mental health) than those who cited 'positive' reasons and "family commitments." Those female respondents who decided not to stay for 'negative' reasons "don't like it here, people too unfriendly" reported more stress (.426) and psychological disturbance (.294 with total M.H.Q) than those who gave 'positive' reasons

The nature of the difference indicated that those female respondents who decided to stay or not to stay, because of 'positive' reasons, "currently enjoying a better standard of living," "have family and friends here" experience less stress than those who reported "negative" reasons, "don't like it here."
Discussion

The majority of the respondents, (91 persons) said that they had not planned to settle permanently in England. They had hoped to stay in England for an average of 5 years, during which time they would acquire their goals and return home. However, this was not to be. After being in England for 5 years, most respondents hadn't realised their goals and had to stay for a longer period. The longer they stayed, the more necessary it became for them to settle. For example, relatives came to live in England, parents were brought over to help care for the children while parents worked. Such factors encouraged respondents to be house-owners and to put down roots.

For many respondents their complete family, include extended kin, were living in England and they saw no reason to return to Barbados. As a male respondent pointed out:

"I really can't complain, because I have done fairly well since I have been here. I had no intentions of settling permanently in England, I just wanted to make some quick money, return home and buy myself a property, but I got married, started a family and was forced to buy a house. In the end I got committed to this country. My wife sent for her mother to help look after the children while we work, and in a few years her sisters and two of my brothers came over. I have a few uncles and aunts in Barbados, but most of my relatives are either here or in Canada, so it wouldn't make much point me going back, unless I got a job which offered accommodation for my family."

The enjoyment of an improved, or higher standard of living in England was another deciding factor in respondents' decision to settle permanently in England.
Some respondents were resolute in their decision not to stay in England irrespective of their social situation. Such views were held by a female respondent who had her immediate family and near relatives living in Reading. She insisted,

"England is not the place to bring up children and I don't want mine brought up here. Children here don't have the freedom like the children in Barbados. The teachers are so prejudice, the children just don't seem to learn anything. To tell you the truth, I don't like it here. If I had my way I would pack my bags and leave tomorrow, but I have to wait on my husband. Every year he has the same story, we're going to leave next year, and we still here. I am getting absolutely fed up."

Most of the Barbadians immigrants in Reading are employed by British Rail, the local postal and transport services, the many industrial factories in and around Berkshire and the National Health Service, as nurses, auxiliaries, cleaners and the like. Jobs in these services do not prepare an immigrant for successful re-entry into the Barbadian labour market. There are no trains in Barbados, the postal, transport and health services could not possibly absorb the surplus labour, so what kind of jobs could largely unskilled immigrants obtain if they return home? It's a serious question which most immigrants have to consider before planning to return home.

Those who were returning home to find a job, frequently expressed dissatisfaction with life in England. They were apprehensive about their decision to re-settle. They weren't sure that returning home would be a wise decision, it might probably create more problems for them. Respondents who had families were more apprehensive than single persons.
Overall, respondents who reported 'negative' 'pre-post immigration' reasons for settling or not settling permanently in England recorded significantly high score on the symptom sub-scales FFA (.306) and Hys. (.286).

Only respondents who were returning after studying, recorded low scores on the anxiety scale. It would appear that this group of immigrants felt at ease about returning home. They were aware that good job prospects awaited them.

Most of the respondents who decided not to settle permanently in England seemed restless and 'socially unstable.' They changed jobs frequently and expressed a higher degree of dissatisfaction with current occupation than the 'permanent settlers.' Unemployed respondents, numbered significantly among those who decided to re-immigrate to North America - Canada or United States of America.
Conclusion

The hypotheses were tested and the following conclusions drawn.

(1) Respondents' decision to settle permanently in England was based on several factors. Respondents who decided to settle permanently for 'positive' reasons had better mental health than those who decided to settle for 'negative' reasons.

Some of the factors which influenced respondents' decisions were:

(a) the presence or absence of family members residing in Reading.
(b) the degree of social, racial, and economic difficulties they experienced while living in Reading.
(c) job availability at home (Barbados) and
(d) finally the degree of difficulty they anticipated in re-settling.

(2) Respondents who reported 'positive' reasons for not staying/settling in England recorded less stress and psychological disturbance (poor-mental health) than those who reported 'negative' reasons.

(3) Female respondents who decided not to settle permanently, reported significantly more (poor-mental health) than males. This was a rather surprising finding, and could possibly be due to the demands of being working wives, without the traditional social support of parents and extended kin. Mothers expressed much concern about bringing-up their children in an English society. They feared that black children have little or no chance of succeeding in this society.

It was noted that respondents who decided not to settle permanently in England, could be identified by certain characteristics; such as frequent job changes, dissatisfaction with present occupation, unemployment, and a feeling of social isolation.
The theory of social isolation postulates that migration involves not only physical separation from the homeland, but separation from one's orienting set of mutual obligations and networks of social interaction, thereby causing the most emotionally disturbing experiences associated with immigration. The migrant must sever both personal and social ties and enter a new social network whose size becomes a barrier to social betterment. Migrants often experience strong feelings of loneliness, alienation (Hanalin, 1951) and desocialisation (Jaco, 1970) low self-image/esteem and an inability to cultivate or sustain social relationships (Weinberge, 1966). Jaco, (1954) outlined the negative impact of social isolation in Austin, Texas, where he found that residents of an area with the highest rates of schizophrenia also suffered a large degree of social isolation, as measured by indices such as knowledge of neighbours, number of friends and membership in lodges and fraternal organisations. Lowenthal, (1964) found that social isolation per se, was neither decisive nor significant in the onset of mental illness among an aged group. Weinberg (1966) later integrated both views by suggesting that situational isolation precipitates mental illness and that one's subjective interpretation of isolation may predispose him to mental illness. Thus the theory of social isolation posits the central hypothesis:

That a severe limitation of contact and communication with the larger society causes the immigrant great stress in the performance of social roles that he plays and might directly or indirectly contribute to the onset of mental illness.
This lead us to hypothesise that:

(1) Respondents who had limited contact and communication with the wider society/community, will experience a high degree of stress and psychological disturbance (poor-mental health).

(2) Respondents who infrequently or never contact near relatives experience a higher level of poor-mental health than those who are regular contact with near relatives.

(3) Respondents whose near relatives live in the Reading area, will feel less isolated and have better mental health, than those whose near relatives live outside of Reading.

(4) Respondents who visited friends often experience fewer stressful events, less isolation than those who rarely or never visit friends.

A measure of social isolation was constructed from answers to nine questions concerning contact with near relatives, friends, neighbours and community organisations.

The questions were:

(1). Do you have any friends on your street?

(2). How friendly are you with your neighbours;

(3). Could you tell me the name(s) of any two persons in this area who most recently, you visited socially in the last month?

(5). What kind of relationship do you have with these persons?

(6). Do you attend any local sporting or social club?

(7). Do many of your near relatives live in this area? (Reading)

(8). Who are they?

(9). How often do you contact each other?
Findings

Stress and Psychological Disturbance

A relationship was found between stressful life events, near relatives and visiting close friends. The nature of the difference, was, those respondents who didn't have near relatives living in Reading reported more stress (.297) and general psychological disturbance (.230) than those whose near relatives and extended kin lived nearby. Respondents who rarely or never visited their close friend(s) for 'social visits' reported more stress (.345) and psychological disturbance (.215) than those who often visited close friends.

A small association was observed between general psychological disturbance (.207) and non-attendance at local sporting and social clubs. Those respondents who didn't attend social or sporting clubs were at greater risk of experiencing psychological stress than those who attend such clubs, social/sporting clubs were the main avenues through which social intercourse and activities were realised.

The remainder of the variables in the social isolation index showed no significant association with poor-mental health.
Sex Differences

Male respondents visited their relatives more often than female respondents. Thirty seven male and 43 female respondents visited their relatives weekly. No association was found between stress and male and female frequency of contact with near relatives. However, frequency of contact is associated with total M.H.Q. (.300) and a relationship is found for male and female respondents. Male respondents who visited their relatives frequent experience the least psychological disturbance (.488).

Further ETA analysis revealed a strong association significant at the .001% level between infrequency of females visiting friends, and stress (.556). Females who rarely contacted friends had poorer mental health than those who contacted friends regularly.

Close contact with near relatives and friends is an important index of social isolation. An individual's near relatives and close friends are usually regarded as his primary network, through which social support is obtained. Disruption or absence of these networks is likely to impair the individual's ability to cope with life changes.

Male respondents were in regular contact with their friends more often than female respondents. This was due partly to a large number of male respondents whose close friend(s) worked at and for the same company. Relatively few men visited their friends at home. Men tended to engage in social activities outside of the home, while for women home visits were common.
Overview

Social isolation was more strongly correlated with psychological disturbance than with stressful life changes. It would appear that the absence of the respondents' near relatives, kin and close friends are less likely to affect life stress than psychological disturbance as such.

Individuals who are socially isolated tend to experience loneliness and feel depressed. This was shown by the relatively high association returned on the depression sub-scale (0.315).

Here stress and psychological disturbance is viewed in tandem, both having a varying effect on each other in determining the level of poor-mental health. It is likely that individuals who are socially isolated are likely to experience an increase in stress due to life changes, which in turn leads to varying levels of psychological disturbance. The absence of social support networks, in the form of family and friends, possibly impairs the individual's coping (physical and psychological) abilities. The relationship between social isolation, stress and psychological disturbance is probably an interactive one, and patterns of cause are difficult to isolate.
Unmarried respondents experienced more social isolation than married respondents. Most of the respondents had at least one friend living in the same street. Although respondents were reasonably friendly with their neighbours they rarely exchanged house visits.

For most female respondents at least one of their close friends was non-West Indian, while the close friends of most males were Barbadians or other West Indians.

One possible reason for females' choice of non-West Indian friends relates to the security they felt in discussing personal matters. A few respondents who had non-West Indian friends said,

"Some West Indians like to gossip too much. This community is small, so you got to be careful who you talk to if you don't want to hear it the next day. Here everybody knows everybody so its no wonder."

Male respondents did not display the same degree of distrust with fellow Barbadians or West Indians; the reverse was the case. Most male respondents preferred to associate with fellow West Indians, to attend the West Indian social and sports club than any of the local 'white' clubs in Reading.

Few female respondents were members of the West Indian Club. They visited the club only on special social occasions e.g. Barbados Independence dance - and were usually accompanied by a male; the older generation Barbadians still consider it improper for a woman to attend clubs when unescorted.
There are several factors which contribute to the relative absence of social isolation among the respondents.

(1) The presence of a cohesive Barbadian community and West Indian culture, supported and maintained by other West Indians.

(2) Most of the respondents have their near relatives and extended kin living in Reading, and:

(3) Over 60% of all respondents came from two parishes in Barbados—44% from St Andrews and 20% from St Michael. In the former parish, St Andrews, all the respondents came from two small districts—Walkers and Bellplaine; this meant that respondents often knew each other or each others relatives before emigrating. These sociodemographic variables were factors in the absence of social isolation.

Findings related to parish of former residence

A non-linear relationship was observed between the last place of residence (parish) and stressful life events. ETA (.304); and in addition with psychological disturbance symptom scales: FFA (.246), Fhob. (.353), Obsess. (.394), Som. (.403), Dep. (.227), and Hys. (.266). See Table 1.

Those respondents who were from parishes which were generally unrepresented, (Sy Lucy and St John) in the Reading sample, reported a high level of poor-mental health, than those who were from St Andrew and St Michael.
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Conclusion

The following conclusions were drawn from the findings.

(1) Barbadian respondents had limited contact and communication with members of the wider 'white' community. This was observed from their low/non-membership of 'white' social and sporting clubs and other community organisations in Reading.

(2) Respondents appeared to be more fully integrated into a Barbadian/West Indian 'sub-cultural' community, and mainly attended 'black' clubs and churches.

(3) Most respondents lived near other family members and were in regular contact with them. (This could to some extent be a function of "snowball" sampling, very isolated Barbadians being missed).

(4) Those respondents who didn't have near relatives living in Reading, and those who visited near relatives and close friends infrequently, experienced more stressful events and greater psychological disturbance than respondents whose near relatives lived in Reading and who visited friends regularly.

(5) The central hypothesis in the social isolation theory was not proven, namely, that 'a severe limitation of contact and communication with the larger society might directly or indirectly contribute to the onset of mental illness.'

For the respondents, contact and communication with members from their cultural background seemed paramount. They interacted less with white members of the wider community. Their integration into a West Indian sub-culture, cushioned them against the adverse effects of stressful life events; they felt less isolated.
It was noted that respondents who lived in predominantly white neighbour­
bourhoods, expressed feelings of isolation. One respondent who lived in such a neighbourhood, remarked:

"Living out here is nice and clean, but feels too far. I miss my friends and relatives. When we were living in Wilson Road, we used to see our relatives and friends often, but now they rarely visit and once I get in I hardly go out again. Even though I have my family living here I sometimes feel lonely."

Researcher: What about your friends up here?
Respondent: "I don't have any friends up here. We speak and so on but that's all. White people live a different sort of life to black people."

Conversely respondents who lived in mainly black neighbourhoods expressed a feeling of security and commonality. In the words of one respondent, "There is nothing better than being among your own people, its a good feeling, yuh feel safe. Here (referring to the neigh­bourhood) everybody knows each other - and we get on good. We try to help each other out."

From this observation I have concluded that respondents who live in neighbourhoods in which there is a high density of Barbadian or West Indians are less likely to social isolation than respondents who live in a predominantly white neighbourhood.
From informal interviews we have observed that some respondents experience varying degrees of social isolation, ranging from temporary separation from parents and relatives, due to family disputes, to permanent separation, due to death of parents.

Those respondents who were isolated had poor or no social contact with relatives and friends. Further, as a result of inadequacies in their social relationships both within and outside the family, certain individuals felt that they did not really belong to their peer-groups: that is, they became alienated from their peers. Under severe enough conditions alienation may lead to a withdrawal from social interaction. In any case, isolation does not seem to be the crucial experience in predisposing the individuals to poor-mental health and possibly illness.

In terms of process, social isolation is to be viewed as a sign that the individuals interpersonal difficulties have become so great that he is no longer capable of functioning in interpersonal relationships. The question of how he got that way is not a question of social isolation per se. It is rather a series of problems, starting with the question of what are the conditions that produce alienation and continuing with the process by which subsequent interpersonal experiences transform this base of interpersonal difficulty into interpersonal failure. Faris (1934) has suggested:

"Any form of isolation that cuts the person off from intimate social relations (disrupts his social bonds/network) for any extended period of time may possibly lead to mental disorder." This is a serious possibility for subjects in my own study.
Social Stability

The question of social instability as an index of poor-mental health has been thought at times to be particularly relevant for serious mental health, such as psychosis and personality disorder. The idea has been proposed that those persons who migrate are predisposed to psychological disturbance (Odegaard, 1936). This view was refuted by Malzberg (1955) who argued for a more complex relationship between migration and poor-mental health.

Tritze, Lemukan and Cooper (1972) add a new dimension to the problem when they showed that higher rates of psychopathy were found among those who moved frequently as compared to those who reside for a long period in the same community. The investigator also noted that the ratio was higher for intra-city migrants from other communities.

In the light of these findings the following hypotheses will be examined.

1. The longer a respondent is resident in a particular area (Reading) the less likely he is to be poorly integrated with the community, and to experience poor-mental health.

2. Respondents who exercise a high degree of occupational stability, experience less stress and psychological disturbance than those respondents who were occupationally unstable.
Social stability was determined by an index constructed from answers to 7 questions. The questions were concerned with residential and occupational stability.

(1) How long have you lived in Reading?

(2) How long have you lived in England?

(3) Are you thinking about moving from here?

(4) If 'yes' why?

(5) Are you employed?

(6) How long have you been in your present occupation?

(7) How satisfied are you with your job?
Findings

A significant association was found between length of residence and mental health. The nature of the difference indicated that those respondents who were resident in Reading/England for an average of 12 years reported more stressful events (.400) and more general psychological disturbance (.466, total M.H.Q.) than those who were resident for an average of 8 years. Recent arrivals (1 - 4 years) reported fewer stressful events and less psychological disturbance. This finding contradicts the 'alien psychosis'/'culture shock' hypothesis, which states that the most vulnerable period for most immigrants is during the three years of residence.

No relationship was noted between occupational stability, stress and psychological disturbance. An association was observed between job satisfaction and psychological disturbance (.293 total M.H.Q.). Those respondents who were dissatisfied with their job/occupation experienced more psychological disturbance than those who were satisfied.

No association was noted between the other variables e.g. 'thinking about moving' and poor-mental health.
Discussion

Our findings have shown that there is an association between length of residence and poor-mental health. Respondents who were resident in Reading/England for an average of 8 years experience less stress and psychological disturbance than those who were resident for an average of 12 years.

This finding conflicts with Rwgellara's (1969) comparative study on mental illness among West Indians and West Africans. He revealed that 28% of the West Indians - in his psychiatric sample - broke down within 2 years of arrival in the U.K. and 38% with 3 years of arrival. Admittedly, Rwgellara's study was based on a known "ill" population, with no breakdown for country of birth; therefore we are unable to make direct comparisons. However, there seems to be a relationship between mental illness and length of residence; this relationship is not as simple as it appears.

There seems to be two periods at which respondents are at great risk of experiencing high levels of poor-mental health. The first, when they realise that they weren't going to achieve their goals within the planned period 1-6 years, and secondly, when persistent failure in achieving goals led to/produces frustration and anxiety. The respondent(s) feel(s) remorseful and guilty about his failure to prove himself. In the words of one respondent, "who wants to be a failure, you tell me?"

The first 'planned period' is reached around 5-6 years and the second 12-13 years. it would seem that the 'second period' is crucial and more important tha the 'first period.' The immigrant/respondent is likely to get over his initial disappointment by rationalising the situation, for example, accepting that his 'planned period' was
unrealistically too short, or by simply extending the time period for another 6 or 7 years - a second period. Failure to achieve personal goals within this extended period creates considerable disappointment and disillusionment and can lead to severe psychological disturbance. These feelings of disappointment and disillusionment can be best illustrated by citing the comments of two respondents, a male and female, who experienced failures in their attempt to achieve personal goals. These failures left both respondents 'broken' and undecided about their future.

Throughout the interview, the first respondent held his head down and spoke in a low sullen tone. He said, "I have been in the country for nearly 18 years and have nothing to show for it. I thought that I would have been back in Barbados by now, but I am still stuck in this God-forsaken country."

**Researcher:** What happened?

**Respondent:** "Ah well, for one thing I shouldn't have worked for London Transport as long as I did. I was working and studying and kept getting poor grades. Anyway I managed to pass my ONC (Ordinary National Certificate). I wanted to do my HNC, but I failed it a couple of times and finally packed it in. I decided to change to accounts, but it has been a terrible disappointment. So far I passed Part I but I just can't pass the rest. This is the fifth time I have failed them and I feel absolutely fed up with the blasted thing."

**Researcher:** You shouldn't feel too bad, at least you have an ONC.

**Respondent:** "What the hell can I do with an ONC? It's almost outdated, every year guys leave Cave Hill with first degrees and cannot get a job. What chance do I have?"
Researcher: What are you going to do?

Respondent: "I feel so depressed I don't really know. I got a sister in Canada and some aunts and uncles in the States, I might go there and see if my luck changes, but at the moment I really don't know."

The other respondent, a female, came to England to study nursing. After taking the GNC - General Nursing Council - test, entered nursing school as a student nurse. Repeated failure of the final exam, meant that she had to settle for a Pupil Nurse status and an SEN (State Enrolled Nurse) certificate. This was a tremendous blow to her pride and a set back for further studies in nursing. However, after having had two children Mrs X decided to recommence nurse training, as a psychiatric nurse. Recent failure in this venture was very disappointing for Mrs X, who once again failed to achieve her ambition- to be a fully qualified nurse.

Contemplating her failure and future Mrs X remarked, "It really hurt me when I failed the exam. The hurtful thing is, that the questions weren't difficult and I was sure that I had passed. I am not ashamed to tell you; when I received the letter, I just cried and cried. I couldn't believe it, after all the hard work I had put in. It sure put me off nursing."

Researcher: Why not try something else?

Respondent: "No, nursing is the only thing that interest me. I'll just forget the whole thing. I feel absolutely sick. There were some girls in the class, thick as shit, yet they managed to pass. There must be someone up there (pointing to the sky) who don't like me. What's the point of trying? One of my sisters had trouble getting her exams here, went to New York and today is a RN (Registered Nurse). If I didn't have a family I would gladly leave this country"
for good."

These remarks can be further supported by my personal knowledge of several acquaintances and friends, who tread a similar path to disappointment and failure. They experienced intense frustration and anxiety about their future. Three of them finally succumbed to the stress produced and became mentally disturbed. Others escape from personal shame by re-emigrating, not to Barbados— but to North America, Canada or United States of America. They hope that "things will change for the better."

Respondents who experienced such failures, numbered significantly among those respondents who decided not to settle permanently in England.

The best level of mental health was observed in respondents who were resident in Reading for an average of 22 years. These respondents, whether they previously experienced failures in personal goals— seemed resigned to their present social position and level of personal achievement. The respondents in this group were 50 years and over, and had families, most of them decided to settle permanently in England.
Sex Differences

When the data is analysed by sex, a different pattern emerges. ETA analysis revealed that male respondents who were resident for an average of more than 11 years, experienced a high level of stress (563) and general psychological disturbance (428).

This finding is consistent with statements made by male respondents, regarding feelings of frustration after being in England for a relatively long time.

Most of the male respondents (40 individuals) lived in London, mainly around Paddington, before moving to Reading. They moved from London because they wished to be near relatives and friends and because housing conditions were better in Reading. On arriving in Reading they received considerable social, psychological and some financial support from their relatives and friends.

Conversely, female respondents experienced more stressful events (.548) and psychological disturbance (.718) during their first year of residence. They subsequently settled down and were better at adjusting to life in Britain than their male counterparts.

Most of the female respondents (36 individuals) came to Reading from Barbados into the protected environment of their parents or close relatives. Females tended to be over protected from what their relatives described as 'the dangers of living in a foreign country.'
Some of the female respondents remarking on their early experience in Reading recalled many occasions when they were not allowed out unless accompanied by an adult member of the family.

An association was found between number of years in present job, job satisfaction, stressful life events and psychological disturbance. Male respondents who were in occupations for more than 10 years reported high stress (.505). No association was noted for females. Further, males who said that they were dissatisfied with their jobs, experience much stress (.943) and psychological disturbance (.405) was less for females than males.

These findings are fairly consistent for both sexes, the females showing slightly better occupational stability and lower psychological disturbance (better mental health) than men. The longer women worked in their present occupations the more stable they tend to become. This difference is probably due to the following reasons:

1. The majority of men were in occupations they did not like - manual repetitive factory jobs - but remained in them because the alternatives were worse, they were wary of changes and above all hoped to get promotion by staying on. This was frequently denied them. The longer they remained in their jobs without achieving any meaningful betterment, the more frustrated, stressed and psychologically distressed they became. Some of the male respondents recalled occasions when they trained junior staff who subsequently became boss. Such incidents were especially painful for the respondents because they felt helpless, unable to change the system, which they see as racist.
(2) Women on the other hand generally leave the job market to have babies and usually return after weaning them; these exits and entries tend to cushion some respondents against stress and frustration associated with employment.

Conclusion

Occupational stability (length of residence in the same job) was found to be associated with poor mental health. Respondents who remained in the same occupation for over 10 years, reported better mental health than those who changed jobs relatively often. However, a proportion - 25% - of those who were in the same occupation for over 10 years and over expressed dissatisfaction with their jobs and made no attempt to leave. This was probably due to scarcity of jobs in the area and the reluctance on the respondent's part to disrupt the social network they had formed at work.
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CHAPTER 13

STATUS FACTORS

- HIGH ASPIRATIONS/SOCIAL STABILITY.

- EDUCATION.

- EMPLOYMENT.
Social mobility, education and job satisfaction were found to be significantly associated with poor mental health. The relationship between social mobility and poor mental health is complicated by conflicting findings which report mental illness among both upwardly and downwardly mobile individuals (Graham 1957; Eaton and Larsy 1978; Hollingshead and Redlich 1958 and Laughton 1958). There is further, considerable difficulty in using intra-societal studies of social mobility in an analysis of migration and poor mental health. I therefore find it prudent to report my findings, which indicate a significant association between respondents' aspirations and poor mental health, without discussing social mobility.

Findings

Respondents who had high aspirations were found to experience more stress \((r = .693)\) (See Table I) and psychological disturbance, ETA, FFA (.429), phob. (.905), obsess. (.680), som. (.849), dep. (.597) and hys. (.374) (See Table III) than those with low aspirations.

Sex Differences

Men were noted to have higher aspirations and subsequently poorer mental health than women, this was strongly correlated at the .001\(^\text{st}\) level and above on four of the symptom sub-scales: phob. \((r = .659)\), obsess. \((r = .519)\), som. \((r = .626)\) and dep. \((r = .470)\) (See Table V). Female respondents reported a significant score at one symptom level, obsess. \((r = -.278)\).
**TABLE I**

**HIGH ASPIRATIONS/SOCIAL MOBILITY AND STRESS LEVEL**

Significant level * of correlation coefficient of all respondents (n=100).

Correlation of variables of sociological questionnaire with raw score (var. 87) of the S.R.E.

<table>
<thead>
<tr>
<th>Var. of the sociological questionnaire</th>
<th>S.R.E. var. 87</th>
</tr>
</thead>
<tbody>
<tr>
<td>73</td>
<td>.498</td>
</tr>
<tr>
<td>74</td>
<td>.693</td>
</tr>
<tr>
<td>77</td>
<td>.316</td>
</tr>
</tbody>
</table>

* Significant levels.

\[ 5\% = .195 \]
\[ 1\% = .255 \]
\[ 0.01\% = .325 \]
### TABLE III

**U.K. Barbadians - High Aspirations and Symptom Level**

Comparison of psychological disturbance (vars. 89-95 of the MHQ) with socio-demographic variables in 100 Barbadians of both sexes in the U.K.

Values of ETA recorded.*

<table>
<thead>
<tr>
<th>Socio-demographic</th>
<th>Sub-scales of the MHQ 89-95.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>FFA.</td>
</tr>
<tr>
<td>73</td>
<td>.376</td>
</tr>
<tr>
<td>74</td>
<td>.326</td>
</tr>
<tr>
<td>75</td>
<td>.429</td>
</tr>
</tbody>
</table>

Significant levels.

5% = .195
1% = .255
001% = .325
Significant level * of correlation of male respondents ($N = 50$). Correlation of sociological questionnaire with sub-scales of the M.H.Q. (vars. 89-95). ETA values recorded.

### Vars. from sociological Questionnaire

<table>
<thead>
<tr>
<th>Sub-scores of M.H.Q. variables 89-95.</th>
<th>FFA.</th>
<th>PHOB.</th>
<th>OBSES.</th>
<th>SOM.</th>
<th>DEP.</th>
<th>HYS.</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>89</td>
<td>90</td>
<td>91</td>
<td>92</td>
<td>93</td>
<td>94</td>
<td>95</td>
</tr>
<tr>
<td>73</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>74</td>
<td>0.381</td>
<td>0.915</td>
<td>0.670</td>
<td>0.896</td>
<td>0.652</td>
<td>-</td>
<td>0.293</td>
</tr>
<tr>
<td>77</td>
<td>0.433</td>
<td>0.583</td>
<td>0.465</td>
<td>0.564</td>
<td>0.491</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

*Significant levels.

$5\% = 0.275$

$1\% = 0.355$

$0.01\% = 0.455$

Key to socio-demographic variables.

73 .......... pre-post migration (social mobility).

74 .......... post migration (social mobility).

77 .......... Intergenerational.
Stress for respondents with high aspirations centred on the difficulties experienced on gaining promotion in their job and finding employment which was less degrading and which offered promotion prospects. Most of the respondents noted that they did not experience any great difficulty in finding a job, but the jobs that were readily available to them were either just as bad, or worse than the one they had. Jobs they wanted were usually filled by white workers.

An insight into some of the difficulties and stresses upwardly mobile blacks encounter was outlined by a male respondent, who was a post office supervisor. He said, "When I first came to Britain, I worked for British Rail at Paddington Station. I did that for a few years to get on my feet, because it was never my intention to spend the rest of my life on trains. I also got fed-up living in London, because the place was dirty and I could not get a reasonably price house for the family, and in the end I moved to Reading. When I moved I decided to change my job, so I joined the post office. In those days trying to get promotion was like hoping to get milk from a stone. I sat all the exams and I passed them. I kept putting my name down for a higher post whenever one became available, but nothing happened. This went on for years. Sometimes I even train men, who became supervisors before me. Man I felt so frustrated that on many occasions I had planned to chuck the damned job in. My wife used to keep encouraging me to stick it out; eventually I made it, but it wasn't easy. Now there are two black supervisors."

Education may play a palliative role in protecting the individual against the shock of life crisis by virtue of the options it open to him.

The educated are comparatively more literate and therefore in a better position to be aware and to evaluate available alternatives for coping. They are also more likely to associate with others of comparable education status, with the corresponding advantage of an increase in opportunities for solutions to problems necessary in coping with life events. There is also a greater probability of the educated having within their network of friends and associates professionally competent individuals who can advise them and /or play other ameliorative roles.

In this section the following hypotheses will be tested.

(1) The process of acquiring higher education is positively related to poor-mental health.

(2) Respondents who acquire further education at home experience poorer-mental health than those who acquire further education in England.

(3) Respondents who had no certificates of special training reported less stress and psychological disturbance than those who did.

(4) Respondents who left school between the age of 10 - 15 years, and who hadn't achieved further education are likely to feel guilty and remorseful about their educational failure and hence experience more psychological disturbance than stress.
Educational achievement was gauged with an index constructed from answers to questions concerning school leaving age, acquisition of further education and certificates of special training. The questions were:

(1) At what age did you leave school?

(2) Did you acquire further education (in England)?

(3) Did you acquire further education while at home (Barbados)?
   (a) through night school (evening classes).
   (b) correspondence courses.
   (c) full or part-time college.
   (d) university.
   (e) never.

(4) Do you have any certificates of special training?

(5) If 'yes' what are they?
Most of the respondents left school between 15 - 18 years. Very few of them acquired further education. Those who did, did so primarily through evening classes.

Since being in England few of the respondents - only twenty-four persons - acquired further education, (through full/part-time college or university) or certificates of special training.

Respondents who have certificates of special training or higher qualification were in the 25 - 33 age range. I have discovered from conversations with the respondents, that most of them made some attempt to attend evening/night classes but either changed their mind or found it too demanding to work and attend classes. The cold weather was cited as one of the main reasons for not completing courses.

**Stress and Psychological Disturbance**

There was a small negative correlation between having acquired further education and stressful events. Those who had acquired further education experienced more stress than those who hadn't \((r = -.222 \text{ See Table IV})\). ETA indicated a strong relationship between further education - 'acquired education' (.872), (.304 with total M.H.Q.) 'acquiring education' (.874) (.306 with total M.H.Q.) - stress and psychological disturbance, (See Tables VIII and X.)

The acquisition of certificates of special training was strongly associated with stressful events. Both the correlation \((r = .363)\) and the ETA score (.873) were significant at the .001% level.

Educational achievement was strongly related to the symptom scales of the M.H.Q.: Phob. (.906) \((r = .430)^*\), Obsess. (.668) \((r = .355)^*\), Som. (.864) \((r = .482)^*\) and Dep. (.598) \((r = .373)^*\). See Tables IX and XI.*
Comparison of Psychological Disturbance (Sub-scales of the M.H.Q. Vars. 89-94) with socio-demographic variables in 100 Barbadians of both sex in the U.K.

Values of ETA with recorded *

<table>
<thead>
<tr>
<th>Socio-Dem.</th>
<th>FFA</th>
<th>PHOB</th>
<th>OBSESS.</th>
<th>SOM</th>
<th>DEP</th>
<th>HYS</th>
<th>TOTAL MHQ.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vars.</td>
<td>89</td>
<td>90</td>
<td>91</td>
<td>92</td>
<td>93</td>
<td>94</td>
<td>95</td>
</tr>
<tr>
<td>65</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>.201</td>
<td>.262</td>
</tr>
<tr>
<td>66</td>
<td>.263</td>
<td>.906</td>
<td>.668</td>
<td>.864</td>
<td>.598</td>
<td>-</td>
<td>.304</td>
</tr>
<tr>
<td>67</td>
<td>.275</td>
<td>.902</td>
<td>-</td>
<td>.849</td>
<td>.602</td>
<td>.244</td>
<td>.306</td>
</tr>
<tr>
<td>68</td>
<td>.236</td>
<td>.900</td>
<td>-</td>
<td>.850</td>
<td>.585</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Key to socio-demographic variables.

65 - School leaving age.
66 - Acquired further education (England).
67 - Acquired further education (Barbados).
68 - Certificates.

* Significant levels.

$5\% = 0.195$

$1\% = 0.252$

$0.001\% = 0.325$
Significant levels of Correlation Coefficient of all respondents, (N=100). Correlation of variables from the Sociological Questionnaire with sub-scales of the MHQ variables 89-94.

<table>
<thead>
<tr>
<th>Sociological Variables</th>
<th>Sub-scales of MHQ Variables 89-94</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>FFA-89</td>
</tr>
<tr>
<td>8</td>
<td>-</td>
</tr>
<tr>
<td>11</td>
<td>-</td>
</tr>
<tr>
<td>24</td>
<td>-</td>
</tr>
<tr>
<td>26</td>
<td>-</td>
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<tr>
<td>31</td>
<td>-</td>
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<tr>
<td>33</td>
<td>-</td>
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<tr>
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<td>-</td>
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<td>36</td>
<td>-</td>
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<td>37</td>
<td>-</td>
</tr>
<tr>
<td>42</td>
<td>-</td>
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<tr>
<td>43</td>
<td>-</td>
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<tr>
<td>51</td>
<td>-</td>
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<td>55</td>
<td>-</td>
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<td>68</td>
<td>-</td>
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<tr>
<td>73</td>
<td>-</td>
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<td>74</td>
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<td>76</td>
<td>-</td>
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<td>77</td>
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<td>-</td>
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<td>-</td>
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<td>82</td>
<td>.210</td>
</tr>
<tr>
<td>83</td>
<td>-</td>
</tr>
<tr>
<td>86</td>
<td>.296</td>
</tr>
<tr>
<td>45</td>
<td>.200</td>
</tr>
</tbody>
</table>

Significant: $r = .195$, $p < .05$

Levels:
- $r = .255$, $p < .01$
- $r = .325$, $p < .001$
Sex Differences

There was no relationship between school leaving age and poor mental health for male and female respondents. While overall, male respondents experienced more psychological disturbance than female, female respondents who left school age 10-15 years reported psychological disturbance; no association was found for males.

Discussion

Males who had high educational aspirations, reported higher levels of stress and psychological disturbance (poorer mental health) than females. Males tend to be more educationally and occupationally mobile. There are several factors which amount for this difference. In most Western societies males are encouraged (at home and school) more than females to be high achievers. Through early socialisation females tend to be co-opted by parents, especially mothers, into household tasks. Further, young women after leaving school or college are likely to become pregnant, get married or engaged in other activities which curtail their educational achievement. Finally, men are expected to perform dominant roles in society, to be in positions of power and to be leaders.

With the rise of the feminist movement, the role of women vis-a-vis men, has been seriously challenged, and more women are becoming high achievers, for example, managers, directors, prime ministers and the like. It is therefore likely that we may observe a significant shift in the relationship between stress and upward mobility in females.

Variation in the level of psychological disturbance between male and female respondents is partly due to the difficulties male respondents encounter during the process of educational mobility and to the high level of social stigma attached to men who are seen as failures. This was a frequently reported cause of stress among, mainly, male respondents.
Commenting on the frustration encountered since living in England, a male respondent added;

"Yuh know when I first came here I had high goals, I don't know what happen to them. I always wanted to be an electrical engineer. When I got myself sorted out I registered to do engineering with the evening classes. I was attending regularly, when I lost my job. Sometimes I used to leave work early so that I could get to the classes. One of the 'busy-bodies' informed the supervisor and I got the sack. My mind was occupied in finding a job, in the meanwhile I was missing out in the various lessons. I did return but I was too far behind to catch up. One thing and another distracted me. Since then I have a family to support and I haven't had time to get back to studying. I had a Wolsely Hall correspondence course but I just couldn't keep up with returning the lessons. It's really frustrating, because if I had that qualification I would be home (Barbados) today, holding down a good job, instead of being stuck here. At the moment I couldn't go home and expect to do bus conducting. To begin with there aren't any vacancies, and secondly, I would feel ashamed to do that job after being in England for all these years. What would the people think?"

Here we see that the respondent's failure to achieve his 'life goal' is accompanied by strong feelings of guilt and low self esteem.
Conclusion

(1) Those respondents who acquired or were acquiring higher/further education reported a higher level of poor-mental health than those who weren't acquiring higher education.

(2) Respondents who acquired higher education at home (Barbados), reported a higher level of poor-mental health than those who acquired further education in England. Coming to England with a high educational background was instrumental in determining the level of aspirations respondents possessed. Respondents who had a high education expected England to provide them with numerous and varied educational opportunities, which it did. What they hadn't considered was the difficulty in acquiring their goals. It was the frustration experienced and the non-acquisition of goals - in my cases - which heightened the level of poor-mental health among 'educational aspirant.'

(3) Respondents with 'no certificates of special training' recorded lower levels of poor-mental health than those who had certificates.

(4) Leaving school between age 10 - 15 years, meant that a limited level of educational achievement had been acquired. In later life those respondents who hadn't achieved/obtained a 'school leaving certificate,' felt guilty about their failure and as one respondent said, "find it very hard to start studying again." Furthermore, they felt "bad" about being seen as a failure by their children. Very often they transfer their own goal ambitions to the children, and see them as possible ways of relieving their guilt feelings.
Education plays a very important role in Barbados. It symbolises success and prestige. A person with advanced education, (higher certificates, diplomas and degrees) and a highly regarded, well-paid occupation, commands respect regardless of his/her skin colour. On the whole a "good education" guarantees one a white-collar job, with relatively high status and comfortable life style. Secondly, a "good education" is not only very important in terms of one's personal achievement, but is a source of improvement for the family, and its 'standing' in the locality. Parents own aspirations and social betterment are dependent (upon how they turn out) - upon their children's success - this applies mainly to lower class parents.

As it was only the 'fortunate few' who received a secondary education and reach university standard, people began to look elsewhere. They looked to England. They looked to England, as the 'mother country' to provide the opportunities Barbados denied them. The prospect of educational and job opportunities was one of the most powerful 'pull' factors in the migration process.

First generation immigrants were pleasantly surprised by the wide range of educational opportunities: free education from primary school to university, numerous colleges, polytechnics and other institutions of higher learning providing a wide range of courses.

Many of them eager to obtain further education seized these opportunities and acquired degrees and diplomas in the hope of improving their social position. Disappointingly they soon discovered that the acquisition of paper qualifications did not give them an improved social status, guarantee a better job, nor respect from the host society as would have been the case in Barbados. In England, educational achievement is not a symbol of prestige and success.
Whatever their occupation and/or education Barbadians and other West Indians -
tend to be defined as black by English people and therefore cannot obtain
the respect and prestige that they can in Barbados. Admittedly, one can
point to a few Barbadians who have successfully obtained some respect from
their professional peers, but certainly not from a wider social grouping.
This undoubtedly lessens the symbolic importance education has for
Barbadian immigrants.

Respectability Vs Reputation - Value Adjustment

In discussing the importance of education in Barbadian (West Indian) society,
I indicated that the acquisition of paper qualifications guaranteed one a
"decent well-paid job" and led to upward mobility, the achiever becomes
respectable.

This leads to a discussion of two very important values - 'respectability'
and 'reputation' - found in Barbadian (West Indian) society. Peter Wilson
(1973) in his book, "Crab Antic" discovered both respectability and
reputation and the relationships between them in great detail, here I will
only summarise what they entail and briefly indicate the implications.

Respectability

For Peter Wilson, "respectability" is defined through the use and perfection
of the language and speech of the metropolitan culture. Although not
mandatory for respectability, a fair skin and caucasoid facial features are
considered highly desirable and preferable. Where the aspiring person is
not so blessed, then he must maintain a standard of dress, conduct and a
life style that are identified with the life of white expatriates or with
the metropolis."

A higher education opens the way to the attainment of a respectable
occupation, such as a lawyer, doctor, civil servant or teacher - these being
considered exemplary of respectability.
There was considerable pressure on the poorer classes to become respectable, to gain a 'good education' a 'decent' job and a life style befitting a respectable person. Respectability by definition is exclusive for the few. The majority of the under-privilege realised that they could not achieve this goal if they remain in Barbados. Encouraged by the British to emigrate to England, they hoped to acquire material wealth, educational qualifications, return home and become respectable.

Many stories have been told - and I can recount from my personal knowledge - about Barbadians and other West Indians, who have studied in England. Those who qualify and remain in England have made no appreciable social and economic improvement. On the other hand, those who qualify and return home have achieved considerable social and economic betterment and are now respected citizens. The reasons for this disturbing experience to most Barbadians, is due to the changing structure and values of British society.

Reputation

Reputation is a counter-culture to respectability. Reputation emphasise egalitarianism and opposes class hierarchy. In reputation, it's learning and wisdom that are valued, whereas respectability recognises education. A man's reputation rest on the extent of his wisdom, but if he wants to become respectable, he needs a certificate.

Changing Values of English Society

Since the second world war there have been major changes in England. The reconstruction of an industrial economy meant more and better employment prospects for the lower classes. The acquisition of material wealth led to an improved standard of living for the less well off. Those things which were once the preserve of the middle classes could now be purchased by the members of the lower classes. Social values were changing, respectability
became a less dominant value. A man's position in society gradually became associated with what he had, rather than who he was, although 'who he was' undoubtedly influenced 'what he had.'

Today in the twentieth century in England, respectability is no longer as sought after as it was in Victorian England. Today, reputation can guarantee a place among the elite in society. An individual is renowned for what he has achieved rather than solely for who he is, or who his father was. This situation is a reversal of what occurs in the Caribbean - for many Barbadians living in England, this created confusion.

They immigrated to achieve something they couldn't achieve at home, i.e. respectability. Further they felt that if they couldn't achieve it in Barbados, then surely they could and should achieve it in England, the 'Mother Country.' However they later discovered that respectability, so important at home, is not accorded to them,

(a) because of their blackness,

(b) respectability is no longer important, it has been usurped by reputation, and

(c) the criterion for respectability in Barbadian society is not the same in English society.

Peter Wilson has noted that "respectability" denotes a way of life and a standard of living, which though feasible through Caribbean societies it is is not authentic to it. Its origin is alien and its value misplaced.
It could be argued that prejudice against blacks indirectly contributes to the relatively low emphasis on education among Barbadian immigrants. It is not only that blacks in Britain along with working class whites encounter blockages to educational and occupational advancement. It is also that status distinctions based on education and occupation are in Barbados, unlike England, superceded by the overwhelming importance of colour. For many Barbadians who came to England with the express desire of getting further education and improving their social position, the harsh realities of English society has caused them to feel frustrated and disappointed. Only those immigrants who obtained higher qualifications (e.g. lawyers, etc.) and returned home have managed to obtain the prestige and respect lacking in England.

However, although education is not a major cultural theme, immigrants do value education highly and desire their children to do well. Foner, (1979) reporting on findings of Rutter et al (1975), noted that Rutter and his colleagues found a high degree of involvement among the 54 West Indian parents interviewed; many had taken their children to the library in the last three months or had bought them books. Nonetheless other factors seem to prevent the West Indian child from being high achievers at school. Rutter and his colleagues (1975: 119) write: "West Indian children were more likely than were indigenous children to go to schools with high rates of pupil turn over, absenteeism, and a high proportion of 'free meals' children, factors associated with less satisfactory educational progress."

Migrants often are not able to help their children with school work, cannot understand their children's assignments and teaching devices used in English schools. Parents cannot always afford to provide a home environment conducive to academic success. Teachers may also
e prejudiced against black children - they may have low expectations of them.

Foner (1979) noted the observations of two of her respondents, who pointedly remarked, "black children are kept down here. Few black kids go to university teachers do not encourage black children, no matter how 'brainy' they are."

The problems of preconceptions and expectations today is centred on second generation blacks who encounter different difficulties from their parents. Young blacks (British) do not consider the availability of free education to be advantageous, and therefore are not motivated to make most of the available opportunities. Secondly, having left school academically qualified they will confront blockages to occupational advancement in English society, and are likely to regard the efforts made to acquire certificates as useless, because it doesn't provide them with the occupational opportunities that both they and their parents had hoped for. As Foner noted, young blacks "cannot like their parents express their frustrations by hoping to return home; they are home."

So there exists in the second generation of blacks in England, disappointments, frustrated ambitions and expectations. The institutionalised nature of racism ensures that this situation will be perpetuated.
Employment and job satisfaction may provide a supportive milieu during crises. Continuous employment provides important resources - economic potential - necessary to purchase relatively high quality services, including legal and medical, which can do much to reduce the impact of crises.

Much of the poor mental health in lower class blacks may be stress-related, and persist as a function of the chronicity of stressors in the circumstances of lower class life. Gove (1973) found that for a large number of working class men the stress of unemployment often persisted for a year or more, passing through stages of anticipated loss of job, job loss, failure to find work and finally unemployment.

Unemployment may be special significance in inducing stress, is suggested. Levin (1978) found marked reductions in feelings of self-esteem, accompanied by estrangement from family and friends and cognitive distortions of temporal perception. Wilcock and Frankie (1963) made a similar observation in their study of the effects of permanent lay-offs and long-term unemployment of psychological adjustment. They found that loss of self-esteem and deterioration of interpersonal relations, have their roots in circumstances created by financial insecurity, accompanying job loss.

Kasl (1974) concluded from a review of early studies of unemployment and mental health, that loss of self-esteem is the most consistently reported finding resulting from the combine effects of self blame for employment and the hardship caused by financial insecurity.
These diverse comments on the significance of work for the psychological well-being of individuals strongly attest to the role of employment-related stress in the development of psychological impairment.

The following hypotheses will be examined.

(1) Unemployment is negatively related to poor-mental health.

(2) Unemployed men experience greater stress and psychological disturbance than unemployed women.

(3) Housewives in part-time employment experience less stress and psychological disturbance than unemployed housewives.

(4) Dissatisfaction with one's occupation is negatively related to poor-mental health.

**Findings - All Respondents**

**Stress and Psychological Disturbance**

No association was found between employment/unemployment and poor-mental health. ETA recorded scores which pointed to a significant relationship between respondents who were in part-time employment and poor-mental health. Those respondents who were in part-time employment reported more stress (.332) and psychological disturbance (.213 total M.H.Q.); on the symptom scales FFA (.287), Phob. (.379), Obsess. (.260), Som. (.321), Dep. (.258) and Hys. (.232), than those who were in full-time employment.

Respondents who said they were dissatisfied with their jobs experience more stress (.315) and psychological disturbance on the symptom scales, Phob. (.262), Obsess. (.271), Som. (.318) and Dep. (.233) than those who were satisfied.
Sex Differences

Stress and Psychological Disturbance

Males who were seeking employment and those in part-time employment reported more stress (.378) and psychological disturbance (.382 total M.H.Q.) than females. Females were less dissatisfied with their jobs than men. Those males who were dissatisfied reported more stress (.476) and psychological disturbance (.302 total M.H.Q.) than females.

Discussion

Most female respondents who were unemployed expressed their dissatisfaction with being at home. As one respondents remarked,

"I get really fed-up being at home. Everyday it is the same thing, no change. I really wish I had a part-time job to break the monotony. I used to work at the hospital (Battle Hospital) when I first moved here, but since I had the children I haven't been out to work. The other problem is, that my husband doesn’t want me to work, he thinks I should stay at home and look after them. I like to have my own money, so that I don't have to ask him, I hate asking him for money.

A funny thing happened the other day. My mother came and I was complaining to her. Do you know what she told me? I should be glad I don't have to work hard like other women. She doesn't seem to understand that women in these days like to work for their own money, anyway, things are so expensive, two people need to work."

Males who were unemployed were more distressed and experience poorer mental health than women. A 35 years old fitter exclaimed,

"Man, I have been unemployed for the past 9 months, and I feel bloody awful. What can I do. The people at the labour exchange can't find me a job, so what hope is there."
Researcher: Why don't you seek some other type of job, until you can get a skilled job?

Respondent: "Huh, you joking. You want me to do some dirty, dusty job for a few pounds? No sir. Why you think they still have these jobs on their books? Because no one wants to do them, so why should I. Mind you, I understand what you mean, don't get me wrong, because sometimes I feel so depressed that I don't want to see outside. It's not nice to see most of your friends working, looking after their families and you joining a dole queue; yuh can't even buy a drink. The hurtful thing is, whenever people see you, they always ask: are you working yet or something like that. The other day I had to tell one of them to..... off. I betcha if I was a woman they wouldn't pester me so much."

Researcher: Why?

Respondent: "People kinda expect a man to work, you know what I mean, and look after his family. A woman is different. She doesn't have to work. She only works to help out, or if she wants to, but a man is suppose to work."

Most of the respondents who were employed expressed dissatisfaction with their jobs. More males than females were discontented. It would seem that the majority of males were in occupations they didn't like, but remained in them because of the difficulty in finding better occupations. Furthermore many of them hoped for promotion, while others had become accustomed to the job and were therefore reluctant to change. Such views were succinctly put by a middle age male respondent who said,

"I'll tell you something, there is a lotta people who do jobs they don't like, I know for a fact. I have been working with....... for nearly 9 years, it may be more, but I don't like the job. It's not the type of job I would like to do, but what's the alternative. Go and work at ......... or for more money at ............... but worse conditions? Look if I had packed
up this job in the first two years I might have been better off. I wouldn't be stuck in it now. When you are a married man with a family you can't change jobs so easily, you have gotta find one first before leaving the one you've got. You see when you have been working in a job for some time you get used to the people, and everything, so it's hard to leave it even though you don't like it. I suppose if I hated bad enough I would have left. In my case, I have had a few pay rises since I have been there, but those bastards wouldn't promote me, they are saving it for some white guy. Anyway what the hell, I'll leave it one of these days."

Here the respondent highlights an important point. That is, while most respondents dislike their jobs, they are forced in accepting the situation because of various personal and domestic factors. Most importantly they don't dislike their jobs to the extent that they want to quit. This seems to suggest that their feelings of dissatisfaction is related to some ideal type of job they have aspired towards. Here males have higher aspirations than females and are therefore likely to experience more stress and psychological disturbance than females.

Conclusion

(1) No association was found between employment/unemployment and poor-mental health. However married male respondents who were unemployed, reported more stress and psychological disturbance (poorer-mental health) than married or single females. Being unemployed created considerable distress for male respondents at several levels.

(a) Their role as the 'bread-winner' for the family was curtailed. this made them feel remorseful, guilty and helpless. In situations where wives worked, while husbands were unemployed, the situation was made worse. The husbands were expected to perform certain domestic tasks which they rarely or never did when they were employed. For example, tidying the house.

(b) Unemployment frequently led to additional tension in the house and strained relations between spouses. Wives didn't like to see husbands
'lazying around' at home, felt they should be out looking for a job. Mrs Payne emphasised this point:

"there is one thing I hate to see, is a big man sitting around doing nothing. My husband and I used to row nearly everyday. Just imagine I come home from working hard all day, and he sitting down in front of the tele'. That used to make me mad. The house in the same way as I leave it. He expects me and Sybil (her teenage daughter) to come home and clean up after him, and he at home all day doing nothing. He wouldn't even pick the rice or peel the potatoes. All he used to say was "he feel depressed" depressed my eye, what he want is a job."

(c) They were unable to socialise with former workmates and friends because they didn't have money. These factors caused them to experience low self-esteem and further increased feelings of emotional distress.

(2) Most of the respondents were dissatisfied with their job; more males than females. Inspite of their dissatisfaction, few respondents were very anxious to leave their present employment. They were apprehensive about the alternatives and more importantly didn't dislike their job to the extent that they would leave. Several personal and domestic factors intervened.

(a) Married respondents with families were less likely to quit their jobs than single respondents.

(b) In most cases there were few job options available - those that were, were in many cases worse than the one they had.

(c) The longer respondents remained in a job the less likely they were to leave. They had become accustomed to the social atmosphere, had made friends and adopted 'a way of life' peculiar to the job.
(3) No association was noted between poor-mental health and housewives/housewives in part-time jobs. However it was observed that respondents who were in part-time employment reported more stressful life events and psychological disturbance than those who were in full-time employment.
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CHAPTER 14

DOMESTIC FACTORS

- SEX.
- MARITAL STATUS.
- HOUSEHOLD ACCOMMODATION.
- RELIGION.
Sex and Mental Illness - A Review of the Literature

Constance Nathanson (1975) who has written one of the more thoughtful papers on the subject states that:

"One of the most consistent observations in health survey research is that women report symptoms of physical and mental illness and utilise physician and hospital services for the conditions at higher rates than men. At the same time in Western Europe and North America, women's expectation of life at birth has exceeded men's since the 18th century or before, and the gap between the sexes, both in expectation of life at birth and in age-adjusted death rates have continued to increase. The apparent contradiction between women's biological advantage and their unfavourable morbidity experienced has received surprisingly little attention from sociologists. Explanations have been offered for specific findings, but there has been no systematic attempt to account for the range of differences between the sexes in reported illness and in the utilisation of health services." (p. 52)

A great deal has been written about sex roles and their meanings for the mentally ill. (Gove, 1972; Gove and Tudor, 1973; Pearlin, 1975; Radloff, 1975; Weissman and Klerman, 1977).

It has been argued that the experience of women in a male oriented, male dominated society, exposes them to greater stress than men. Further, Gove and Greaken, (1977) argue that it is exposure to stress, with fewer attendant defences than men, which accounts for the preponderance of women among the mentally ill.

Biological arguments about female constitutional frailty (Weissman and Klerman, 1977) and socio-cultural arguments (Kaplan, 1977) and ineffective coping (Pearlin and Schooler, 1978) suggest that stress may
have a more severe impact on women than on men.

The literature on sex differences and health suffers from over-simplification. Since almost every survey of health and health care undertaken includes the sex variable, the literature provides a vast reservoir of data on this issue available for secondary analysis.

A literature review looks at some of the methodological and conceptual issues that must be considered, in an examination of sex differences in health, as proposed by D. Mechanic, (1976). Further, alternative hypotheses that might contribute towards achieving a better understanding of such differences are considered.

Conceptual and Methodological Problems

Measurement of Illness

Mechanic notes that most discussions of sex differences makes no distinction descriptively or analytically between different levels of measurement of illness or illness behaviour. Three relevant distinctions are:

1) differences between reports and behaviour.

2) differences between patient-dependant utilisation and physician dependant utilisation, and

3) differences between illness, disability and limitation of mobility.
Sex differences in rates of utilisation of some services cannot be easily interpreted. Such differences may also be a product of varying social accessibility of services relative to the way in which men and women conceptualise and express their problems. Physicians are far more tolerant to neurosis (a female pattern) than they are of alcoholism or drug addiction (male patterns).

Physical, Psychological and Behavioural Symptoms

Men and women express distress differently, yet most surveys of illness and distress pay little attention to types of acting-out behaviour typical of male response patterns, (Philips, and Segal, 1969).

Although more illness generally are reported for women than for men, there are many categories of illness where male prevalence is considerably higher than female prevalence. In an epidemiological survey dealing with psychological distress among college students, Mechanic et al, (1976) Newmann (1975) found that while women reported an excess of both psychological symptoms, men reported more difficulties with alcohol.

A review of existing morbidity reports (National Centre for Health Statistics, 1974, 1975) suggests that sex differences are not simply due to a tendency of women to report all symptoms more readily.

It has been hypothesised that women have more mental illness than men, due to the stressful roles of women. Conceivably the hypothesis is correct, but there is little convincing data. Dohrenwend (1965) in an excellent review paper made the following conclusions.

(1) There are no consistent sex differences in rates of functional psychoses in female (34 studies) or one of the 2 major sub-types, schizophrenia (26 studies), in particular; rates of the other sub-types,
manic-depressive psychosis are generally higher among women (18 out of 24 studies).

(2) Rates of neurosis are consistently higher for women regardless of time and place (28 out of 32 studies).

(3) By contrast, rates of personality disorder are consistently higher for men regardless of time and place (22 out of 26 studies).

These results cannot be easily explained by role theories arguing that at some time and place one or the other sex is under greater stress and hence, more prone to psychiatric disorder in general. Instead, the findings suggest that "we should discard undifferentiated, unidimensional concepts of psychiatric disorder and with those false questions about whether women or men are more prone to mental illness." The important question for further research is: What is there in the endowments and experiences of men and women that pushes them in different deviant directions?

**Hypotheses Concerning Sex Differences**

The problem of sex differences can be pursued usefully through empirical analysis. Some of the alternative hypotheses which might assist in a better understanding of sex differences are:

(1) Women may perceive more symptoms than men because they have more interest in health and more health knowledge. Alternatively women may not perceive any more symptoms than men, but they may be willing to report symptoms to an interviewer.

(2) Since women have higher levels of distress, they are more likely to use medical services. Alternatively the relative convenience and accessibility of services for men and women.
(3) Women's role obligations are more consistent with being sick and seeking care.

Hypothesis 1 - Perception and Knowledge.
This is consistent with socialisation patterns which allow women to complain more readily and to appear less stoical. These differences in response to symptoms are apparent in young children and they increase as the children become older (Mechanic, 1964).

Benn (1965) has presented a theoretical social psychological analysis based on the idea that external circumstances and behaviour help people to interpret their internal feelings. Women may be more ready to respond to unorganised symptoms and distress by limiting their activities; taking some bed rest or using some other measure. Men may be more likely to deny vague, unorganised symptoms. There is evidence that persons are more likely to report symptoms if they did something about them (Mechanic, 1965). To the extent that women take more actions or use more medications, they should be more likely to conceptualise the situation as one involving illness. There is substantial evidence that women use much more medication than men, particularly psychoactive drugs. (Linn and Davis, 1971; Dunnell and Cartwright, 1972 and Cooperstock, 1971).

Another important determinant of women response to symptoms is the cultural ethos of the society or the way in which members of the society respond to distressing symptoms. In some societies women endure considerable pain (far greater than men). While the men seek attention for the slightest ailment, the women often continue their daily task, seemingly untroubled by the distressing symptoms they experience.
Hypothesis 2.
Since women have higher levels of distress, they are more likely to use medical services.

Distress itself cannot explain the total sex effect. One possible explanation is that women are more dependent and more likely to seek interpersonal solutions to feelings of distress. As boys get older they learn to be stoical and uncomplaining, (a frequent complaining boy, is regarded as a sissie; a highly derogative term) while girls are taught to seek solace from others. In a study of children's response to illness, Mechanic (1964), found that among fourth grade children, there were no sex differences in the willingness to tell others when they fell unwell. Among eight graders while 75% of the girls were still ready to confide only 59% of the boys had similar inclinations.

Data from the National Ambulatory Centre was consistent with the hypotheses of greater readiness to use services among women (Health -United States, 1975).

However, it is not clear from existing studies whether the higher rate of utilisation among women represents a universal response or whether it is specific only to certain types of services and help-seeking patterns.

Greenley and Mechanic (1976) in a study of university students, found that women were significantly more likely to use psychiatric counseling and general medical services and no more likely than men to use often formal personnel, such as dormitory counselors. These data suggest that while the sex differences are substantial relative to medically related and psychologically related agencies, sex differences are not necessarily operative for all possible affiliative or helping relationships.
In a national survey of mental health problems and help-seeking, Gunn and Veroff and Feld (1960), reported no consistent overall relationship between sex and source of help, except for use of physicians.

Hypothesis 3
Women's sick role and seeking care.

Women's usual role obligations are more consistent with being sick and seeking care.

Nathanson (1975) in a well written article, discussing the implication of this hypothesis noted that,

"Women with a large number of role obligations will be unlikely to adopt the sick role. This proposition is supported by two sets of findings; that mothers with pre-school children show low levels of illness behaviour, and that employed women report less illness than housewives. Rivikin also found that married women reported fewer illnesses than women who were single, widowed or divorced, and interprets her findings as resulting from married women's more demanding roles."

This hypothesis is a subtle one and difficult to test without considerable data on the circumstances surrounding family life.

Further, Nathanson (1975) has reported that women consistently report more disability days than men for acute illness and longer duration of restricted activity and bed disability. In general however, the above hypothesis is plausible and is worthy of more careful investigation.

From this review two central hypotheses emerged, which will be tested by my data. These are:

(1) Female respondents experience more stressful life events than men.
Female respondents experience a higher level of poor-mental health than men.

Findings

Women reported more and different stressful events than men - a total of 189 stressful events for women against 152 events for men. Events which female respondents considered to be particularly stressful were: "quarrels with my neighbour," "increase in the number of arguments with spouse and other family members," "trouble or behavioural problems with own children and a decrease in personal income." See Table I:

Male respondents often reported, "a substantial income increase, death of a family member" and "change in the hours or conditions of present job," as the most frequent life events.

Stress and Psychological Disturbance

Sex was strongly related to stressful life events ($r = .929$ ETA (.876) and to psychological disturbance (.929 with total M.H.Q.); and by symptom scales Phob. (.904), Obsess. (.530), Som. (.843) and Dep. (.572). This association indicated that female respondents experienced more stressful life events than male respondents, and this was reflected in their somewhat poorer-mental health.
### Table I - U.K. Barbadians - Females

<table>
<thead>
<tr>
<th>Events</th>
<th>No. of Respondents</th>
<th>Original Weight (Holmes and Rahe)</th>
</tr>
</thead>
<tbody>
<tr>
<td>For Married</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quarrel with neighbours.</td>
<td>14</td>
<td>26</td>
</tr>
<tr>
<td>Income decreased substantially by 25%</td>
<td>15</td>
<td>62</td>
</tr>
<tr>
<td>Death of a family member.</td>
<td>7</td>
<td>69</td>
</tr>
<tr>
<td>Death of a close friend.</td>
<td>10</td>
<td>55</td>
</tr>
<tr>
<td>Increase in the number of arguments</td>
<td>10</td>
<td>55</td>
</tr>
<tr>
<td>with spouse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immediate family member seriously ill</td>
<td>13</td>
<td>59</td>
</tr>
<tr>
<td>Trouble or behavioural problem with own children.</td>
<td>9</td>
<td>49</td>
</tr>
<tr>
<td>or Unmarried</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase in number of arguments with other family members.</td>
<td>8</td>
<td>43</td>
</tr>
<tr>
<td>Break-up with steady boyfriend or girlfriend.</td>
<td>6</td>
<td>51</td>
</tr>
</tbody>
</table>
Conclusions

My findings have shown that female respondents report more and rather different stressful life events than men. Further, those events reported by females were more likely to lead to a higher level of poor-mental health for female, than those events reported by males. Reasons for difference in levels of poor-mental health, are many and varied and have been exhaustively reviewed above. However, it does appear that an important factor implicated in the high levels of poor-mental health among women, is of a socio-cultural nature.

While I have noted that most respondents have relatives and friends in Reading, I have also detected the extent and 'wealth' of the social networks which exist. This observation was made by interacting with Barbadians and listening to their comments on life in England. These observations were distilled by a female respondent who replied:

"I have most of my relatives here, so I am luckier than some. This country can be a very lonely place. Everybody mind their own business. Sometimes people you work with pass you on the street and don't say a word!"

Researcher: Are your relatives very helpful to you?

Respondent: "Yes and no. Some of them try harder than others. They come and visit me when I am sick and stay for a few days to help with the children. But they don't stay long, because they have their own family to look after, in the end I still have to get up and manage as best I can.

You see England change a lot of people. Plenty families breakup since they came here, Everybody is looking after themselves, they don't have time for others. It's terrible, but this is not the way we used to live at home (Barbados). The problem with some of my relatives, is, not that they don't want to help, but they cannot afford to spare the time, they have become hard-hearted."
Disruptions in Social Networks

The respondents are living in a society which, seemingly similar, is vastly different to the one of their birth. These different values, norms and patterns of socialisation affect the individual and group in different ways.

The main sufferers of this socio-cultural upheaval have been females. There are fewer relatives nearby to assist in childcare and other support roles. Assistance is more limited than in Barbados, and there is greater likelihood of strained relations developing between spouses. This is likely because there has been a change in conjugal roles and patterns of social support. In Barbados conjugal roles are segregated with close-knit (high interconnectedness) social networks. Since immigrating, conjugal roles have been altered to varying degrees. Segregated conjugal roles, have been partially replaced by joint conjugal roles and loose-knit networks. Bott (1957) states that such couples must rely more on each other for emotional support and satisfaction, than couples with close-knit networks. A study which strongly confirmed the relationship between close-knit, same sex networks and conjugal role segregation has been conducted by Turner (1967). Moving from Barbados to England has severed or disrupted important sources of support from friends and kin. The lack of such support forces couples to rely primarily on each other for emotional support for the first time, and they may find it very difficult to adjust to this new demand on their relationship. In times of emotional stress women are more likely than men to seek help from private or institutional sources, thereby exposing themselves to social definition. Men on the other hand prefer to show their masculinity by trying to handle their troubles without external assistance.

It seems clear that the implications of these different causal factors in the male/female-illness model warrants further study. What's the role of
marital status in this model? Do married women have a lower level of poor-mental health than unmarried men? In the next section the data is adjusted for marital status and age.
Marital Status

It has been consistently demonstrated in the epidemiological literature that the married have better mental health and experience fewer stressful life events than do the unmarried (Bachrach, 1975). This general hypothesis will be tested by the following hypotheses.

(1) Married respondents report a higher level of poor mental health than unmarried.

(2) Female respondents report a higher level of poor mental health than male respondents.

Findings

Of the 100 respondents in the study, 65 were married, 25 single, 7 divorced and 3 widowed (See Table II).

Table II

<table>
<thead>
<tr>
<th>Status</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>32</td>
<td>33</td>
</tr>
<tr>
<td>Single</td>
<td>14</td>
<td>11</td>
</tr>
<tr>
<td>Divorced</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Widowed</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>50</td>
<td>50</td>
</tr>
</tbody>
</table>

Stress and Psychological Disturbance

An association was found between marital status, stressful life events (.251) and psychological disturbance (.299 total MHQ), symptom scales FFA (.251), hob. (.208), dep. (.255) and hys. (.221). The nature of the difference
Indicated that married respondents experience more stress and psychological disturbance (poor mental health) than unmarried respondents.

A number of reasons for this difference has been hypothesised. Firstly, the married are better protected psychologically by virtue of the strong motivational attachments that develop between them and their spouses and children. Secondly, the role demand of married women make them more susceptible to mental disorder than the unmarried (Gove, 1972; and Tudor, 1973). My findings from the Reading study throw some doubt on the applicability of these hypotheses with Barbadians. Ten of the thirty-three married females experienced a marked increase in the number of arguments with their spouse, 14 reported 'quarrels with neighbours' and 9 reported 'behavioural problems with own children.' These events were regarded by the respondents as stressful. Some of the reasons for these stressful events will be discussed later.

Sex Differences

When the data was adjusted for sex, a stronger relationship was noted between male respondents marital status and poor mental health. The difference was that male respondents (married/unmarried) reported a higher level of stress (.341) and psychological disturbance (.299 total MHE) - poor mental health - than female respondents. This observation confirms previous findings by Davis (1962, 1969), Gurin, Veroff and Feld (1960) and several other researchers.

In an 1969 article, Philips and Segal noted that the studies of mental illness by Davis (1962); Gurin, Veroff and Feld (1960); Langner and Michael (1963); Righton et al (1963) and Philips (1966) which were based on self-reported symptoms, found higher rates of psychiatric disturbance among women. Building on the suggestion of Gurin et al (1960, pp 209-10), Philips and Segal (1969) argue that these results do not reflect real sex differences in frequency of
disturbance differences, but only the greater reluctance of men to admit to certain unpleasant feelings and sensations. Further they argue that men are more reluctant because it is culturally more appropriate and acceptable for women to be expressive about their difficulties (Philips and Segal, 1969, p. 59). Although their article is replete with data tangentially related to their argument, they have no data bearing directly on this main premise.

A similar argument is proposed by Cooperstock (1971), in an article devoted to explaining the results of two studies which showed that psychotherapeutic drugs are much more likely to be prescribed for women than for men. In essence, her argument is that "contemporary Western women are permitted greater freedom than men in expressing feelings, and that she feels free to bring her perceived emotional problems to the attention of a physician." (Cooperstock 1971, pp. 240-41). However, like Philips and Segal, Cooperstock has no evidence that bears on her theoretical explanation.

Such studies as I have shown vary with contrasts in the concepts and methods used at different times and in different places by various investigators. However, they have consistently reported relationships between various social variables and various types of disorder across methodological differences. It would seem, that an important question, in this debate, which needs to be answered by further research is, "what is there in the endowments and experiences of men and women that pushes them in these different deviant directions?" (Dohrenwend, B.P. 1969, p. 1453).
Sex Differences and Life Events

Women

Using the weighted scores as a measure of the quality of stress respondents experience, it was observed that male and unmarried female respondents reported fewer and different stressful life events than married female respondents (See Table I & II).

Four of the stressful events married respondents reported were (1) 'quarrel with neighbours,' (2) 'death of a close friend', (3) 'increase in the number of arguments with spouse', and (4) 'immediate family member seriously ill.' These events involved disruption - (of a temporary or permanent nature) in social networks. Both of the stressful events reported by unmarried respondents, similarly involved disruptions in respondent's social networks, in the case of the unmarried, an intimate relationship. Studies by Brown et al (1975); Roy (1978); Lowenthal and Haven (1978); and Henderson et al (1978) have all shown that disruptions in social networks and lack of close affectional bonds considerably increase the likelihood of psychological impairment.

It has been shown by researchers (Leighton, 1959 and Myers et al, 1975) that a low level of neighbourhood interaction/integration is causally related to psychological disturbance. A useful measure of neighbourhood integration, is the level and nature of the relationship between neighbours. My data reveals that 28% of married female respondents, had a quarrel with their neighbours, none of the unmarried respondents reported this event.

Insipite of the relatively high level of 'unfriendly behaviour' between female respondents and their neighbours most married females were well integrated in the neighbourhood and to a lesser extent the wider community.
Table III - U.K. Barbadians - Male

Most frequently reported events

<table>
<thead>
<tr>
<th>Events</th>
<th>Male Respondents</th>
<th>Original Weight (Holmes &amp; Rahe)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in hours or conditions of present job.</td>
<td>9</td>
<td>31</td>
</tr>
<tr>
<td>Income increased substantially by 25%</td>
<td>38</td>
<td>35</td>
</tr>
<tr>
<td>Death of an immediate family member</td>
<td>10</td>
<td>69</td>
</tr>
<tr>
<td>Death of a close friend</td>
<td>8</td>
<td>55</td>
</tr>
</tbody>
</table>

Male respondents reported "income increased by 25%" and "death of a family member and/or close friend" as the most stressful life events, (See Table III.). Seventy-six percent of male respondents reported having acquired a 25% increase in their incomes. For some respondents this "created more problems than it solved," insofar that having more money led to an increase of debts through hire purchase. As one respondent pointed out:

"When I got that rise it created more problems than it solved. Things in the house that were working alright, my wife suddenly thought was old, and need replacing. She doesn't seem to realise that it leads to more debts. Now I seem to be working to pay off debts."

The other stressful events reported by males involved disruption in their social networks, to a lesser or greater degree. These events were: 'change in hours or conditions of present job,' 'death of an immediate family member,' and death of a close friend." As I have shown in the discussion on social
support, disruption in social networks/bonds has important consequences for the level of social support individuals receive (Henderson, 1977). It seems probable to assume that individuals who have lost a close affectional bond (Brown, 1979) through death, are likely to experience a reduction in the level of social support received and a subsequent rise in the level of stress.

Marital Status, Age and Sex.

An analysis of marital status by age provides some useful additional information. Most of the respondents could be divided into three age groups 21-39 (56 persons), 40-49 (31 persons) and 50+ (13 persons). (See Table IV below).

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>21-29</td>
<td>14</td>
<td>18</td>
</tr>
<tr>
<td>30-39</td>
<td>11</td>
<td>13</td>
</tr>
<tr>
<td>40-45</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td>46-49</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>50-59</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>60-69</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>70+</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Married Women

For the purpose of analysis, married women were divided into two age groups, the under and over 40's. Women age 40 and over reported more and different stressful life events than the under 40s. The over 40s reported events which centred around spouse and children, e.g. 'arguments with spouse', behavioural problems with children', serious illness or death of family member'.
The under 40s, mainly between age 29-39 years reported events which centred around 'change in financial status, income decrease, pregnancy, marriage and mortgage repayments'.

All the female respondents over 40 years had children, most of whom were at school or soon leaving school. The behavioural problems with their children were mainly concerned with discipline. Parents attempted to rear their children according to a traditional Barbadian (West Indian) model. This presented several problems for child - parent relations. In some instances, teenagers left home and/or later became involved in petty crimes; I visited several teenage-second generation - Barbadians in assessment centres.

Behavioural problems with children tended to create a tense atmosphere in the home, which tended to spill over into arguments between spouses. Parents who were unable to discipline their children, who subsequently became involved in petty crimes and other delinquent acts regarded themselves as failures. As one respondent remarked:

"I try to give the boy everything, yet he still turn out bad. What more can I do? The first thing people say is, that he wasn't brought up right, but they don't know how hard I try."

Young married female respondents age 21-29 years experienced events which were concerned with their new status. Most of the young married females had babies or young children, who need constant attention. This new role tended to create tension and anxiety about their own ability to cope.

Marriage and the subsequent arrival of babies meant that, in most cases, the respondents had to give up their jobs and become dependent on the sole earnings of their husbands. This in some cases resulted in financial strain, with mortgage and other payments. Further, domestic demands, restricted the number of social activities respondents could engage in. Expressing her frustration, a respondent noted:
"It's nice to have a family, but sometimes the children can be a damned nuisance. I hardly have anytime for myself. It seems to be one long cycle; bottle, nappies and bed. I haven't visited some of my friends for months. It's difficult to travel with children. It's not so bad for Errol, because he goes to the club with his friends, while I am stuck in the house with the children. Sometimes I feel as though I could scream."

Several studies have found high levels of emotional disturbance in mothers of young children, irrespective of marital status. (Brown et al, 1975; Richman, N. 1974, 1976; Moss and Flewis, 1977 and Hooper et al 1972). Gavon, (1966) emphasises the relatively isolated existence experienced by such mothers and the absence of opportunities for relaxation or outside stimulation. Under these circumstances, strong supportive relationships with spouse or key network members would be crucial.

Unmarried Women

There were no unmarried women over 40 years. The unmarried women were mainly in age group 21 - 29. Most of them (8 individuals age 24 - 30) had young children, and lived in council accommodation. The stressful events they experience centred around, lack of material resources, unemployment, a high level of dissatisfaction with or absence of boyfriend and present standard of living.

During the period of my research - 6 weeks - in Reading, I got to know this group of unmarried mothers quite well, and without exception, they all had the same problems, or the same problems predominated. They all had one or more children for one man or more men, who established 'visiting relationships', on some occasions the men stayed for a few months. They had limited financial and material resources. They were all unemployed and vacillated between feeling depressed and 'normal'. Their main source of social activity/outlet was the Friday or Saturday night party.
Despite their social situation, they seem to support each other admirably, and when one of them was feeling 'down/depressed' the other(s) cooked, collected the children from school and even slept in the 'distressed respondent's' lat. A great deal of sharing existed between these young women. On occasions they disagreed, but it was usually temporary, and lasted for a day or two.

An important feature of social support which occurred was the sharing of childcare. All 8 respondents were involved in the discipline of each other's children in a highly unstructured/informal manner. Further all the respondents were in close contact with their mothers, even if their mothers were overseas.

The other three unmarried females, age 21-25 years, reported events which were concerned with 'an increase in the number of arguments with parents and siblings and with other family members,' and 'breakup with steady boyfriend.' They appeared to be less stressed than the older age group of unmarried others. This might have been due to the absence of motherhood and the problems surrounding it.

In sum, unmarried females reported fewer and less intense stressful life events than married women. This finding is contrary to the generally held concept that married women have lower levels of emotional disturbance than unmarried women. The reasons given are, that the married are better protected psychologically by virtue of the strong emotional attachments that develop between them and their spouses and children; they feel 'secure and loved.' While this general thesis might be true, my findings from the Reading study throw doubt on its relevance.

Most of the married respondents reported events which resulted in disruption or severance of their social (support) networks. I would hypothesise that it is the difference in the degree of disruption in social networks, by married/married that determines the varying degree of poor mental health.
Married Men

Most of the married men were over 30 years. They reported events which were fairly similar to those reported by married females.

Young married respondents reported events which were concerned with 'taking out mortgage', 'gain of new family', 'promotion and change of responsibilities at work'. The older married, aged over 40 (years) reported events which revolved around 'income increase/decrease', 'death of a close friend', 'illness of friend or family member' and an 'increase in the number of arguments with spouse.'

The younger married men were 'highly mobile', eager to achieve/acquire a high paid job. They tended to be more involved in family life than the older married men. Their level of domestic involvement exposed them to more stress. A one young male respondent said:

"I like helping Margaret because I think it's tough being home all day with the kids. The problem is that it sometimes leaves me knackered. Sometimes when I come home from work, I am so tired, I don't really want to be bothered with them."

Generally the young married appeared to experience slightly poor mental health than older married men, the difference was not significant.

Unmarried Men

The unmarried men in the sample were mainly under 30 years. Unmarried males between 21 - 29 years reported 'unemployment', 'break up with girlfriend' and 'arguments with family members' as the most frequent stressful events. The older unmarried males - over 30 years - reported 'unemployment', 'change in conditions of work', 'friend or family member ill' as the most frequent life events.

There was a marginal difference in terms of poor mental health experienced by
young and old unmarried respondents. The young unmarried, experienced stress of less intensity than the older respondents. Unmarried males, like females, reported fewer stressful events of a less disabling nature. Stress for this group centred around disputes and 'break up' with intimate companion, unemployment and frustrated goal striving.

In summary we have observed that married men experience more stress than unmarried men. Some of the reasons for this are:

(1) Greater pressure on married men to be gainfully employed.
(2) Family responsibilities.
(3) The payment of bills e.g. mortgage.

Discussion

The West Indian family has undergone some noticeable changes since immigrating to Britain. The roles of women in the West Indian family has been altered in some of the following ways.

(1) Women have become financially and increasingly more independent of their husbands.
(2) They expect a greater degree of involvement, responsibility and responsiveness from their husbands, both at an emotional, social and domestic level.
(3) They are more aware of advances in 'household technology' and request such aids to be purchased jointly.

However it is at the domestic and social level that most problems occur. The socio-cultural differences of English and West Indian society have created problems in most West Indians home, domestic disputes - child - parent, between spouses - have been the most frequent. The children - especially those born in Britain - demonstrate their unwillingness to adhere to the strict discipline of their parents. They prefer the more liberal stance
adopted by the parents of their English counterparts. Obviously these disputes lead to strained relations between parents and children. Often the husband is blamed for not being at home to support his wife in disciplining the children. Accusations made by both spouses are the same and at different times. These stresses and tensions increase.

On informal interviews with female respondents I observed that disputes between spouses were usually more stressful for women than men. Women spend more of their time at home than men do, and usually have fewer avenues through which they can defuse their tensions. Men on the other hand, traditionally spend more time out of the home and are often able to release their pent up feelings, through various social activities, for example, visiting the pub, the West Indian social club, betting shops etc. On visits to the West Indian club in Reading, I overheard men having 'bitching sessions', discussing how 'miserable de woman is' - that is, their wife or girlfriend.

The central point here is, that while the role of most immigrant women vis-a-vis men has changed appreciably, that of men has remained relatively unchanged. Most men adhere to traditional attitudes. For them their role is to maintain the economic stability of the household, apart from that there is little involvement in domestic activities. It is this dysfunction of roles that has caused the greatest suffering and disruption in the West Indian family and has considerably increased arguments between spouse and children.
In the light of my findings I am unable to support the hypothesis that married women experience less stress than unmarried women, because of their strong emotional involvement with spouse and children. I have found that more than half of the married women experienced more stressful relationships with their spouses and children than unmarried women do with their boyfriends and/or children.

Conclusion

In the light of hypotheses tested and my findings I conclude that:

1) Married respondents experience more stress and psychological disturbance (poor mental health) than unmarried respondents.
   - Married women in all age groups reported a higher level of poor mental health than unmarried women.
   - Married men in all age groups reported a higher level of poor mental health than unmarried men. It was noted that married men in the 'young' age group under 35 years were highly mobile and reported life events which centred around 'goal striving' stress. Married men in the over 36 years age group, reported stress which centred around disruptions in their social bonds, e.g. increased arguments with spouse and children and death of close friends.

2) Female respondents in all age groups reported a higher level of poor mental health than males.
In every industrialised and industrialising country in the world, there is an acute shortage of urban dwellings and a substantial proportion of the world's population is living in severely sub-standard housing: slums that have survived the uncontrolled building of the nineteenth century or shacks that reflect the uncontrolled urbanisation of the twentieth century. In spite of overcrowding and the physical decay of buildings, it is often difficult to demonstrate that bad housing is directly responsible for bad physical and mental health; although both are usually associated with bad housing, this is because both of these are generally secondary effects of poverty (Schorr 1964).

There is clear evidence that inadequate space standards can disorganise family life. The current expert consensus in European countries is that the lower limit for mental health is 170 square feet of floor area per person (Muril, 1962). These represents standards for new construction; many European families have a current space standard of less than 80 square feet of floor area per person, while it is certain that families are to be found in Barbados and other Caribbean countries with less than 20 square feet of floor area per person.

There is also evidence that an equally important criterion is the number of rooms in the dwelling. A careful survey by Loring (1956), using paired groups of "well adapted" and "disorganised" families showed that significant differences were associated with number of rooms available, floor area, and general surroundings, but not with other supposedly significant factors such as possession of a bath or the physical condition of the dwelling.
(1) The more children respondents had, the more likely the respondents were of experiencing poor-mental health.

(2) Respondents whose housing conditions hadn't changed since arriving in Britain experience poorer-mental health than those whose housing conditions had changed.

(3) Respondents who were members of a household with a family size of more than 6 persons, 2 bedrooms, 2 double beds, 1 single bed and an average bed density of more than 2, were more likely to report/experience poorer-mental health than those with a smaller family size, 3 bedrooms, 2 double and 2 single beds.

(4) Respondents who said that their homes were crowded reported poorer-mental health than those who didn't consider their homes to be crowded.

In order to measure household accommodation and composition, an index was devised from questions taken from the sociological questionnaire. The questions are:

(1) How have your housing circumstances changed?
   
   (a) bought a house
   (b) bought a flat
   (c) rent council accommodation
   (d) rent privately, a flat/room
   (e) hasn't changed
   (f) other
(2) how many people live in your house/flat?
   (a) number of adults 16+
   (b) number of children 5-15
   (c) number of infants 1-4

(3) How many bedrooms do you have in your house/flat?

(4) How many single beds do you have in your house/flat?

(5) How many double beds do you have in your house/flat?

(6) Do you consider your present home to be crowded?

Findings

Sixty seven respondents who once lived alone or shared accommodation with relatives are now owner-occupiers. Most of the houses have three bedrooms and an average of 6 persons per household.

Most families had an average of 4 children, above the national average of less than three children. However, it must be remembered that it is usual for West Indians to have large families.

Number of Children

Stress and Psychological Disturbance

The number of children respondents had was correlated with stress $(r = .223)$ and psychological disturbance, as measured by the symptom sub-scales: Phob. $(r = .203)$, Obsess. $(r = .261)$, and Som. $(r = .276)$.

A strong curvilinear association was located from the ETA test, pointing to a relationship between number of children and stress $(.875)$, and
psychological disturbance (.340 total M.H.Q), FFA (.409) Phob. (.908), Obsess. (.570), Som. (.864), Dep. (.632) and Hys. (.347), indicating that in general the more children respondents have the more likely respondents were to experience stress and psychological disturbance (poor-mental health). However, those with no children at all had poorer-mental health, while those with many children, now aged over 16, had better mental health.

Poor-mental health was likely to result from social and economic pressure. Some of the factors included here are:

(1) The more children respondents had, more money was needed to support them. This extra expenditure, put pressure on parent(s) who had either to work harder or find another or additional employment which paid more.

(2) Caring for a large family often result in greater emotional strain for parents.

(3) The more children respondents had, the more necessary it became to provide them with bigger accommodation and more bed space.

**Household Accommodation and Composition**

**Stress and Psychological Disturbance**

Changing housing circumstances was strongly associated with stressful life events (r = .279) ETA (.339) and psychological disturbance; symptom sub-scales Phob. (r = .203) ETA (.376), Obsess. (.291), Som. (.276) and Hys. (.320) (r = .242). Those respondents whose housing circumstances hadn't changed (i.e. they still live in the same type of accommodation, as when they first arrived) reported more stress and psychological disturbance than those respondents whose housing circum-

*See Tables V and VI*
Household accommodation and composition - and psychological disturbance in U.K. Barbadians

Comparison of psychological disturbance (sub-scales of M.H.Q. vars. 89-94) with socio-demographic vars. - 100 Barbadians of both sexes in the U.K.

* - ETA values recorded.

<table>
<thead>
<tr>
<th>Socio-dem. variables</th>
<th>Sub-scales of the M.H.Q.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>FFA.</td>
</tr>
<tr>
<td>Vars.</td>
<td>89</td>
</tr>
<tr>
<td>31</td>
<td>-</td>
</tr>
<tr>
<td>33</td>
<td>.232</td>
</tr>
<tr>
<td>36</td>
<td>-</td>
</tr>
<tr>
<td>37</td>
<td>-</td>
</tr>
<tr>
<td>38</td>
<td>.301</td>
</tr>
</tbody>
</table>

Significant levels.

5% = .195
1% = .255
0.01% = .325

Key to socio-demographic variables.

31 .......... changed housing circumstances.
33 .......... No. of family members 5-15 years.
36 .......... No. of single beds.
37 .......... No. of double beds.
38 .......... No. of persons per bed (bed density).
TABLE VI

Household accommodation and composition

Significant level of correlation coefficient of all respondents ($N = 100$).

Correlation of vars. from the socio-demographic with sub-scales of the M.H.Q. (vars. 88-94).

<table>
<thead>
<tr>
<th>Socio-dem. variables</th>
<th>FFA</th>
<th>PHOB.</th>
<th>OBSESS.</th>
<th>SOM.</th>
<th>DEP.</th>
<th>HYS.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td>-</td>
<td>.203</td>
<td>-</td>
<td>-</td>
<td>.242</td>
</tr>
<tr>
<td>33</td>
<td></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>6</td>
<td></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>.281</td>
</tr>
<tr>
<td>7</td>
<td></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-.211</td>
</tr>
</tbody>
</table>

Significant levels.

- $5\% = .195$
- $1\% = .255$
- $0.01\% = .325$

Key to socio-demographic variables.

1 ................. changed housing circumstances.
3 ................. No. of family members 5-15 years.
6 ................. No. of single beds.
7 ................. No. of double beds.
A relationship was observed between age characteristics, household composition and household tenure groups. Respondents from 6 person households with 3 family members 16+ (over 16 years), 2 age 5-15 and 1 age 1-4, with 6 bedrooms, 2 double and 2 single beds and an average bed density of 2 persons reported less stress and psychological disturbance than respondents with a larger family size and fewer bed space.

Homes which were overcrowded were strongly associated with poor-mental health. Respondents who said that their homes were crowded reported more stress (r = .344) and psychological disturbance (r = .393 total M.H.Q) than those respondents who said their homes weren't crowded, See Table VII.

Conclusion

My findings demonstrated a strong relationship between change in housing circumstances, since arriving in England and poor-mental health. Respondents whose housing situation remained unchanged reported poor-mental health. Those respondents whose housing situation remained unchanged were mainly males.

During the interviews, members of this group noted that they had no need to alter their housing conditions as they were unmarried. They saw no reason why they should put themselves in debt by obtaining a mortgage. Further, most single persons experience great difficulty in getting a mortgage from Building Societies. As one respondent pointed out:

"I suppose it looks bad for me to be still living in a room, but I like it. Just think of all the hassle I would have to go through in purchasing a flat or a house. Man dem debts would send me mad. I don't know how some people manage it. This room suits my purposes, anyway
TABLE VII

Household accommodation and composition - and stressful life events in U.K.

Barbadians (N = 100) *ETA recorded*.

<table>
<thead>
<tr>
<th>Socio-demographic variables</th>
<th>Raw score of S.R.E.</th>
</tr>
</thead>
<tbody>
<tr>
<td>31</td>
<td>.239</td>
</tr>
<tr>
<td>33</td>
<td>.214</td>
</tr>
<tr>
<td>36</td>
<td>.306</td>
</tr>
<tr>
<td>37</td>
<td>.222</td>
</tr>
<tr>
<td>38</td>
<td>.344</td>
</tr>
</tbody>
</table>

Significant levels.

\[
5\% = .195 \\
1\% = .255 \\
0.01\% = .325
\]

Key to socio-demographic variables.

31 ............changed housing circumstances.
33 ............No. of family members 5-15 years.
36 ............No. of single beds.
37 ............No. of double beds.
38 ............No. of persons per bed (bed density).
I hardly spend anytime here. I am usually at my girlfriend or by my mother. I suppose if I was married I would have to get a house. Sometimes I think if I had bought a house long ago it would have been worth quite a lot today."

Age characteristics of family members, family size and bed space were strongly associated with poor-mental health. Respondents who were members of 6 person households with 3 family members over 16 years, 2 age 5-15, 1 age 1-4, with 3 bedrooms, 2 double and 2 single beds and an average bed density of 2 persons reported a low level of poor-mental health.

A large family with many young children and limited accommodation put financial and emotional pressure on parents, thereby heightening the level of stress they experience. The degree to which stress leads to psychological disturbance, depends to some extent on the housing situation/conditions and the level of social support respondents receive. For some families, especially one parent families, social support was received through institutional departments (e.g. Social Services) and family contact (e.g. parents and siblings). There were relatively few respondents who admitted receiving institutional assistance. This was either they didn't need it or were ashamed to admit that they were in receipt of it. When asked, during the informal interview, about their source of assistance, in times of 'hardship' and 'need' respondents replied, "my family."

As Burke (1980) has shown, Barbadians in Reading, are reluctant to use the Social Services, even when family members are psychiatrically disturbed. They prefer to send them to Barbados. Respondents disliked being questioned in detail, about personal matters. Further, they distrusted the objectives and utility of the services. A male
respondent describing his dislike and distrust of the Social Services added:

"They ask you too many blasted questions, just to give you a few pounds. They don't need all of that information. I am sure they collect it for somebody else. Not only that, but you have to go back so many times, wait for hours ahh non hours, before you can see anybody. It's a bloody waste of time. Furthermore, the service is lousy. It's far too impersonal to be any good."

Traditionally Barbadians have big families. It is very common to find a family of seven, (five children and two parents) in Barbados. Respondents in Reading had larger families, (a six member family was fairly common) than the U.K. national average.

Those respondents who admitted that their homes were crowded recorded a higher level of poor-mental health than those who said their's weren't crowded. Few respondents admitted living in crowded homes. This was either because their living conditions were adequate, or they were ashamed to admit that their houses were crowded. The latter attitude, of shame, was observed from my study in Barbados.

In Barbados children are traditionally regarded as a blessing from God. Although this belief is dying, some people still view children as 'God-given;' to love and care for affectionately - there is always a place/accommodation in the home for a child. Having many children is not usually associated with negligence of any sort. However, when a parent admits that his house/home is crowded it infers that he is not looking after his children/family properly; he has more than he can take care of. It is difficult for a respondent, whether he is in Barbados or Reading, to admit to this.
Religiousity

Few people would disagree that religion is still an important institution in our society. The present debate centres around what role it should and does play in the everyday lives of people.

There is a paucity of research on the relationship between religion, stress and/or psychological disturbance. Therefore I had to rely on old studies.

There are 3 types of data available on the role of religion and personal adjustment. S. Dominger (1954) studied 68 psychotic cases in a Kentucky Psychiatric Hospital, and found that 10.3% of the cases had tried to find an answer to their problem in religion, and his failure to do so was the cause of his breakdown.

Oates (1955) found among future Baptist missionaries in the South of America many cases of emotional frustration and of conflict with parents. The students were shielded from psychosis by their religious way of life. The same author on the basis of 76 clinical observations in Louisville, suggested that religion had a twofold effect, both negative ("the obsession with sin, the importance of taboos against drinking, dancing and sexual relations creating a state of anxiety in some patients") and positive ("prayer has a soothing effect, reassures the mind, comforts the patients and relieves anxiety").

Eaton and Weil's study of the Hutterite colonies in Canada and the U.S.A., revealed that religion went a long way in explaining the paradoxical character of their morbidity when compared with the U.S.A. in general: the almost total absence of organic psychosis, since alcohol, drugs and sexual indulgences are forbidden; the very small number of schizophrenics, high rate of manic depressive and the rarity of several forms of neurosis.
Eaton and Weil (1955) show that the pious atmosphere, the prayers and brotherly love permeating the settlement eliminated doubt and anxiety and created a feeling of security.

From these studies it is safe to conclude that religion itself is less important than the individual's response to it—whether he accepts it, rebels against it or fails in his quest for the divine.

Finally the religious way of life seems to be more important as a therapeutic aid, than as an explanatory factor in mental disorder.

The following hypotheses will be tested.

(1) Religious affiliation has no relationship with poor-mental health.

(2) Frequency of church attendance is positively associated with poor-mental health.

(3) The disruption in church attendance caused by migration is negatively associated with poor-mental health.

(4) Religion plays a therapeutic role in relieving emotional distress.

(5) Church attendance provides a greater measure of social support for females than males.

Religiousity was assessed by answers to four questions concerning religious affiliation, and frequency of church attendance while in Barbados and currently in England.
The questions are:

(1) What is your religion?

(2) How often did you attend church at home?

(3) How often do you attend church (England)?

(4) Do you attend church during the week?

Findings

All Respondents

Forty-seven respondents, 25 females and 22 males reported their religious affiliation as Church of England, while 17 respondents, 5 females and 12 males reported that they had no religion. The other 26 respondents were distributed between the Roman Catholic and Protestant Churches.

Stress

No relationship was observed between religious affiliation and stressful events.

Immigration has considerably altered the church-going habits of most respondents. Sixty-three respondents, 45 females and 28 males reported that when they were at home (Barbados) they attended church frequently (weekly). Since immigrating, 15 respondents, 9 females and 6 males reported frequent church attendance. Thirty-five respondents, 13 females and 22 males never attended church. Only 12 respondents attended church weekly (See Table VIII).

No association was found between frequency of church attendance and stressful life events.
<table>
<thead>
<tr>
<th></th>
<th>In England</th>
<th>At Home</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>M</td>
</tr>
<tr>
<td>Frequently</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>Occasionally</td>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td>Rarely</td>
<td>6</td>
<td>14</td>
</tr>
<tr>
<td>Never</td>
<td>13</td>
<td>28</td>
</tr>
</tbody>
</table>

**Table V**

**U.K. Barbadians - Frequency of Church Attendance**
An association was found between psychological disturbance and religiosity. The ETA test revealed this relationship on all the measures of religiosity: religious affiliation (r = .283 total M.H.Q.) and symptom scales, Obsess (r = .327), Dep. (r = .252), Hys. (r = .334) and Dep. (r = .203), and frequency of church attendance (r = .238 & .327 total M.H.Q.) symptom scales, Obsess (r = .258), Dep. (r = .250) and Hys. (r = .240) (See Table IX). Frequency of church attendance was relatively correlated with psychological disturbance (r = -.292 total M.H.Q.) This indicated that those respondents who attended church rarely or never were likely to experience poorer-mental health than those who attended frequently.

The relationship between religious affiliation and psychological disturbance is less clearly indicated. However, it seems to suggest that those respondents who are affiliated to Anglican and Catholic Churches, were at less risk of psychological disturbance than those who were members of the Protestant Churches (Baptist, Methodist). This finding will be further examined in the discussion that follows.
Religion and (psychological disturbance) symptom level - U.K. Barbadians

Comparison of psychological disturbance (vars. 98-94 of the M.H.Q.) with socio-demographic variable of 100 Barbadians of both sexes in the U.K. Values of ETA recorded *.

<table>
<thead>
<tr>
<th>Socio-dem. variables</th>
<th>Vars. 89</th>
<th>90</th>
<th>91</th>
<th>92</th>
<th>93</th>
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</tr>
</thead>
<tbody>
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<td>-</td>
<td>-</td>
<td>.327</td>
<td>-</td>
<td>.252</td>
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<td>-</td>
<td>.258</td>
<td>-</td>
<td>.250</td>
<td>.240</td>
</tr>
</tbody>
</table>

* Significant levels.

- 5% = .195
- 1% = .255
- 001% = .325

Key to socio-demographic variables.

24 .......... religion affiliation.
26 .......... frequency of church attendance (in Barbados) prior to emigration.
Sex Differences

Stress and Psychological Disturbance

There was no association between stress and religiosity in male respondents. However, an association was noted between psychological disturbance and frequency of church attendance in England, for male respondents (0.388 total MHQ). Those males who didn't attend church were at greater risk of psychological disturbance than those who did.

Females who were members of established churches (Baptist, Methodist) reported higher levels of stress (0.331) and psychological disturbance (0.385) total MHQ) than those who were members of Anglican and Roman Catholic churches.

No relationship was found between poor mental health and mid-week church attendance for male / female respondents.

The direction of relationship between religious affiliation, frequency of church attendance and psychological disturbance, seem to indicate that those respondents who were non-conformist (Pentecost, Seven Day Adventist) and attended church frequently were at greater risk of psychological disturbance than those who were from Anglican/Catholic churches and who rarely attended church. This finding was surprising, because the researcher thought that frequency of church attendance would be positively related to low levels of poor mental health.
Discussion

Barbadians come from a predominantly English cultural background in which most of their major social institutions are based upon English ideal types. Probably the most outstanding example of this is religion. All the major branches of the Western church are firmly established in Barbados, and their patterns of worship as well as their beliefs and practices are very largely identical with those in similar churches in this country. Thus it would seem reasonable to expect that churches could provide an entrance into wider society or a reference group with which the incoming migrant could readily identify himself and find unconditional acceptance. Such, however, has not been the case.

Hill (1963) has shown that an average of 69% of the total population in the British Caribbean attend regularly one or another of the six major branches of the Christian Church - the Roman Catholic, Church of England, the Baptist, Congregational, Methodist and Presbyterian Churches. A survey of attendance of West Indian at the same churches in the whole of Greater London area revealed that only 4% of the immigrants are regular in church attendance. My findings for Barbadians reveal that over 60% of respondents attended church frequently while at home (in Barbados). Since arriving in England only 15% attend church frequently. Clearly, some major variables are responsible for these changes in church going habits.
Functional Aspects of the Church

During my discussion with respondents they spoke about what church-going meant to them at home (Barbadés) and what it means now. Respondents cited the absence of 'black' churches, spiritual 'coldness' of English churches and the hypocrisy of white members as reasons for poor church attendance among blacks.

Church-going in Barbados, provided an avenue through which respondents could release and relieve themselves of 'life's' burdens. It was a salve for their wounded spirits, a cooling balm, which refreshed and gave them psychological strength to face the hardships of life. It also provided a social function. At church they made new friends, met old friends, exchanged information about each other and planned future meetings. These functions were aptly described by a female respondent while reminiscing and comparing church-going practices in Barbados and England. She said:

"You know when I think back on how I used to go to church in Barbados, it really grieve me. At home, we (refers to everyone she knew) used to look forward to Sundays. It was such a nice time. We used to put on our best clothes on that day. I used to listen to such nice sermons, they used to bring water to my eyes, and make your troubles seem so slight. I always remember that passage of scripture (at this time she began a long recitation). After church we used to exchange news and other things, it used to be a blessed day. These days church-going isn't the same. There is not that spirit, that atmosphere anymore, it doesn't really encourage you to go. I go because I was brought up in a Christian home and these things always stay with you till you dead."
Rex and Moore (1967) in their study, noted five positive functions churches in the Sparkbook community perform.

1. They provide comfort and security to the old and bewildered.
2. They serve as welfare agencies which operate between the various Statutory services offered in the Welfare State.
3. Some sects provide a suitable context for tension release among the more deprived sections of the immigrant population and give meaning to their deprivation.
4. They encourage thrift and personal virtue. They provide an ethnic and a set of values which enable people to compensate for their disprivilege, and,
5. They make it possible for social and cultural groupings to assert their identity, replacing the kin and friends who have not come to England.

Unfortunately Rex and Moore's five positive functions are not always found among immigrant churches.

**Disaffection**

Most 'immigrant churches' are millennial-type religious movements. When they fail to redress the social grievances of their members and the condition of deprivation, other and more violent forms of millenialism may emerge.

Some blacks, in general, who had espoused a Christian religion, now define Christianity as white racist. They have turned instead, to follow Islam and Rastafarianism, which they see as less racially discriminating. As an African religion it is not associated with European political oppression, where Christianity in Africa and elsewhere had been introduced during colonial occupation, and used to induce psychological as well as
social accommodation of an oppressed status. To forge a new identity 6 of the male respondents had joined new groups, such as the Rastas.

Many West Indians in Britain, while not adopting Islam or Rastafarianism find it psychologically easier to identify with African heritage by simply foregoing Christainity. Admittedly these new identities tend to be superficial for most blacks, primarily because the identities lack socio-historical connection with their early socialisation in the Caribbean. This search for a new and/or different identity is peculiar to most young second generation West Indians.

Conclusions

(1) A relationship was found between religious affiliation and poor-mental health, as measured by the psychological questionnaire, indicating that those respondents who were members of mainstream Protestant Churches were at greater risk of suffering from poor-mental health than those who were Anglican or Catholic, or members of fundamentalist sects.

(2) Frequency of church attendance was negatively related to poor-mental health. Respondents who rarely or never attend church were at greater risk of poor-mental health than those who attended frequently. Those who attended church often seem to recieve spiritual upliftment and relief (albeit temporary) from their burdens.

(3) My findings did not reveal an association between non-church attendance and poor-mental health. However, from my discussions with respondents it does seem that a few of them felt guilty about not attending church. Ward (1970) has shown that the 'religious outcome' of a migrant who was an active churchgoer at home depends on his initial interaction with English/immigrant churches.
It would seem that religion performs a therapeutic role for many respondents. Creating an integrative community (Durkheim, 1952) through which respondents share each other burdens. This function, although still present in many immigrant churches, is not as meaningful as it was in Barbados.

I have noted that more females than males attend church, both in Barbados and in Reading (England). Why does this occur?

I would hypothesise that the answer lies in the socio-sex roles of the respondents. Females are socialised into being more psychologically introverted than men. They spend more time at home and engage in more 'indoor' social activities - house visits - than men. Church attendance provides women with a socially accepted communal forum through which they can share their problems, seek help and guidance from God. Men on the other hand, are likely to engage in 'out-door' activities, for example, visiting pubs and engaging in sporting activities. This form of social interaction aids in the release of their pent-up feelings.
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<th>Author(s)</th>
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<tr>
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CHAPTER 15

THE ROLE OF SOCIAL NETWORKS. SOCIAL SUPPORT: A REVIEW OF THE LITERATURE

- THE FAMILY.
- NEIGHBOURHOOD INTERACTION.
- COMMUNITY INTERACTION.
THE ROLE OF SOCIAL NETWORK/SOCIAL SUPPORT - A REVIEW OF THE LITERATURE

SOCIAL NETWORK

A major weakness of most stress related research has been its emphasis on social support as an independent variable. Here I propose to follow the direction of Mueller (1980) and discuss social support as an important variable within the wider context of social networks. I have decided on this line of analysis because I find it instructive and a useful analytical model within which to locate my findings. The social network concept provides the basis for an integrating framework in which the view of the contribution of the social environment to poor mental health. Evidence linking network variables to psychiatric disorder is reviewed in the following areas.

(1) network structure, (2) supportiveness of network relationships, (3) recent change or disruption of the network.

The term "networks of social relations" or "social networks" used to understand the social behaviour of the persons involved is a rather recent development (Mitchell, 1969). Among the first studies to employ networks as an analytical tool were those of Barnes (1954) and Bott (1957). Since these early studies, network analyses have been applied to a variety of social phenomena. For example, adaptation of migrants (Mayer, 1962, 1961) and the utilisation of health services (Mc Kinlay 1972; Kadushin, 1969).

For the purpose of this discussion, social networks will refer to the interpersonal linkages among a set of individuals. An individual's network may
be divided into 3 orders or levels. Here I will focus on the first order - primary network. The primary network, consists of kin (immediate family and relatives) and to a greater or lesser extent friends (e.g. neighbours, workmates). The primary network represents the major ties or social bonds, individuals have with others. As Henderson (1977) points, the primary networks contains the main effective attachments of the individual, and it is from hem that his psychosocial supplies are derived (e.g. social support).

Social Networks And The Community

Numerous ecological studies have found evidence that psychiatric disorder is concentrated highly in more socially disorganised areas of a community, and less prevalent in residentially stable subcommunities (Faris and Dunham, 1939; Hyde and Kingsley, 1944; Klee et al, 1967; Levy and Rowitz, 1973; Loom, 1975). Socially disorganised areas are characterised by high influx and outflux of people, changes in racial and ethnic composition, high proportion of people living alone, and less stable and cohesive family structure. Leighton et al. (1963) in their study of treated/untreated psychiatric disorder in rural Nova Scotia, suggests that "weak and fragmented network of communication" (Leighton, 1965, p 26) were implicated in those communities from which the mental illness was highest.

Another important factor in determining prevalence of mental disorder in communities, is the social characteristics of the neighbourhood, for example, the presence of subgroups and whether there is a high degree of congruence/incongruences among subgroups. For example several studies have shown that blacks living in predominantly white neighbourhood have higher social deviance rates than blacks living in mostly black areas; and conversely whites living in primarily black neighbourhoods have substantially higher rates than whites in comparable white areas (Faris and Dunham, 1939; Levy and Rowitz, 1973; Quinney, 1971). Mints and Schwartz (1964) showed from a number of
communities in the Boston area varied with the proportion of Italians living in those communities. More specifically communities with higher proportions of Italians tended to have a lower rate of Italians admitted for severe psychiatric disorder than did communities with a lower proportion of Italians, regardless of the socio-economic level of the community. Similar findings were reported by Murphy (1959) in his study of minority groups in Singapore. Wechsler and Pugh (1967) also found that rates of psychiatric hospitalisation were higher in social groups, that were under-represented in the community. I would hypothesise that the relatively low rate of psychiatric hospitalisation among Barbadians living in Reading may be accounted for by the predominance of a large subgroup of the Barbadians (1,295 persons) in the community.

In sum there is considerable evidence that lack of congruence with one's neighbours and community is linked with higher rates of psychopathology. Findings from a variety of studies investigating the relationship of social factors to psychiatric disorder are compatible with a network interpretation. Below I will briefly review those studies which deal with the relationship between network and structure and psychiatric disorder.

Network Structure And Psychiatric Disorder

The primary network usually consists of 25-40 people, of which 6-10 are intimately known individuals. Within the network, possible linkages occur. These linkages often form several clusters with 6 or 7 highly interconnected individuals in each cluster (Hammer et al, 1973). The degree of interconnectedness of network ties seems to be directly related to the duration of ties (Hammer and Schaffer, 1975).

Network Patterns Of The Mentally Ill

Pattison et al (1975) examined the primary social networks of a normative urban sample of 200 subjects and smaller samples of neuritic and psychotic subjects. He found that networks in the normative sample followed the
pattern described. Primary networks of neurotics were smaller in size (about 10-12 persons). Henderson (1978) compared the primary networks of neurotic patients with matched controls and reported results consistent with Patti'son et al (1975).

The psychotic group in Patti'son's (1975) study had very small primary networks (4 or 5 persons), it consisted mainly of family members. These networks were tended to be highly interconnected and more nonreciprocal than neurotics.

In short, persons with psychiatric disorders appear to have personal networks that are smaller in size than non-psychiatrically ill persons. Results with regard to the density or interconnectedness of networks are less clear. Our next concern is with the quality of networks or relationships, in other words, their supportiveness.

**Network Support (Social Support) And Psychiatric Disorder**

The relationship of social support to health is currently receiving considerable attention. Several studies have suggested that social support may be protective against the noxious effect of stress on the individual. (Cassel, 1976; Dean and Lin, 1977; Rabkin and Struening, 1976).

Before discussing the evidence for a link between the level of social support and psychiatric impairment, several studies, whose findings suggest that social support may reduce problems/complications for persons subjected to stress, will be reviewed.

**Role Of Social Support**

Lin and Ensel (1979) notes that "social support may be defined as support accessible to an individual through social ties to other individuals, groups
The general assumption is that the greater the social support an individual receives, in the form of close relationships with family members, kin, friends, acquaintances, co-workers and the larger community the less likely the individual will experience illness.

There is mounting evidence that the presence or absence of social supports entails certain epidemiological risks and benefits. Much research suggests that social supports have a direct effect on health. Holmes (1958) for example, demonstrated that the incidence of tuberculosis in Seattle was highest for people who, because of their 'social marginality', lacked significant intimate social contacts. Miller and Ingham (1976) found that men lacking a social support network had far more symptoms of tiredness than those women having an active social support network.

Recent authors, (Cassel, J. 1974; Cobb, S. 1976; Kaplan, B.H. et al 1977) have argued that the influence of social support on health can best be understood by considering their role in modifying the deleterious effects of stress, either by reducing the stress itself or by strengthening the individual's coping abilities.

Holmes and Rahe (1967) considered any life change which requires readjustment to be 'stressful' whether it is positive or negative (marriage, job promotion, etc, as well as death of a family member or job/school examination failure, etc). Social supports were found to reduce psychological distress following job loss and bereavement, (Burch, 1972; Parkes, 1972; Gore, 1973) and help protect against depression in the face of considerable life change (Brown et al, 1975).

The individual's ability to cope and tolerate stress depends not only on social supports but on his biological constitution and early life experience. Much of the literature on stress and social support has failed to consider the interplay between stress and social support in explaining illness aetiology.
Recent research by Nucholls et al (1972) have examined the interplay between stress and social support. The investigators found that the absence of social support was associated with increase complications in pregnancy and delivery only when accompanied by high stress, lack of support did not in itself increase risk. Thus under a wide range of stressful conditions, and for a diversity of health problems, the presence of social support appears to have a protective/mediating effect.

Confiding Relationships - A Form Of Social Support

A number of studies have identified the presence of a confiding relationship (i.e. a relationship in which a person can talk about the things that are troubling him/her with the other person) is critical.

Brown et al (1975) in a survey of psychiatric disturbance (primarily depression) among a random sample of urban women (N = 220) observed, that the presence of a confidant (husband or boyfriend) provided women significantly with greater protection from severe affective disorder, when confronted with adverse events, than when such confidants were absent.

Roy (1978) in a matched controlled study of 84 depressed women, found that significantly more depressed women had non-confiding relationships with their husbands than controls. A study among the elderly by Lowenthal and Haven (1968) suggested that the presence of a confidant served as a buffer against social losses in role status. Those experiencing such loses, who had a confidant tended to be less depressed. Miller and Ingham (1976) also showed that women who did not have a confidant had more severe symptoms (i.e. tiredness, anxiety and depression) than those who did. Finally, research by Henderson et al (1978) in a general population sample, indicated
a relative lack of close affectional ties among those with neurotic symptoms. It should be noted that none of those studies is able to adequately address the issue of direction-of-effect in the social support - psychiatric disorder relationship.

Other Studies

Several other community studies have reported associations between measures of social support and psychiatric symptoms. Hamburg, B. (1974) and Hamburg D. et al (1967) have argued an alternative hypothesis, namely that social support mediate the impact of stress by strengthening the individual's coping efforts. Andrews et al (1978) studied the effects of stressful life events, coping style and social support on psychiatric impairment. The finding indicated that the availability of support from relatives, friends and neighbours in times of crisis was associated with a lower rate of psychiatric impairment. This association did not take the form of a moderating effect on the relationship between life event stress and impairment but rather that of an independent relationship between social support and psychiatric impairment. Results from a community study by Myers et al (1975) in New Haven suggest that level of social integration (contains elements that could be regarded as indicators of social support) may have a moderating effect on life events. Finally Leim and Leim (1976) from a study of college students (N = 172) indicated that the higher the proportion of persons in one's personal network providing encouragement and emotional support the lower the likelihood of reported feelings of depression. This relationship was independent of level of life event stress.

There is considerable evidence which indicates a link between lack of social support and psychiatric impairment; especially in cases of depressive symptoms. However from the available studies there seems to be a debate as to whether
the effect of social support on psychiatric status are limited to moderating the impact of the life event stress, or whether social support has an effect independent of the presence of stressful life events. Here, I follow Mueller's (1980) direction when he points out, that the measures of stressful life events and social support are highly inter-related. That is, many, (if not all) of the events in stress questionnaires/inventories involve changes in the respondents's personal (primary) networks that affect the availability of social support. For example, the 'death of a spouse' or 'close friend', may mean the loss of an intimate confidant. Therefore the more appropriate question we should be asking is; What are the consequences of a particular event or set of events for an individual's social support network? rather than, are existing support relationships effective in moderating the impact of stress?

There is a need for more systematic studies of the support psychopathology relationship employing more refined measures of social support and psychiatric status. Mueller (1980) suggests a number of dimensions for consideration. (1) the source of support (e.g. spouse, relative, friend, workmate professional) (2) the type of support given (e.g. emotional, informational, monetary, running errands, baby-sitting or carrying out other tasks). (3) the intensity of the relationship (e.g. confiding versus non-confiding relationships).

The Lack Of Social Support By Network Members

I have argued in the discussion that social support performs a mediating role in the stress - illness relationship. Now, I shall briefly review studies which noted that the lack of social support is related to increase risk of psychological impairment. There are few studies available that have dealt directly with the effects of social support on the course of
psychiatric disorders. Klerman (1978) has observed that when supportive relationships are withdrawn from depressed individuals, feelings of helplessness and worthlessness are reinforced. Vaughn and Leff (1976) studied factors related to symptomatic relapse in 30 neurotic depressed patients and found that the rate of relapse was related to the level of criticism of the patients by key relatives living with the patients (e.g., spouse, parents). The investigators suggest that lack of social support on the part of key network members may increase the risk of relapse in recovered depressives.

Several other studies have suggested that the course of depression may be affected by the supportiveness of family or marital relationships (Bullock et al., 1972; Feldman, 1976; and Weissman and Paykel, 1974). In short, it appears likely that the supportiveness of close network relationships exerts an influence on the course of psychological impairment.

There are few theoretical explanations as to why social support should be negatively related to illness. Langlie (1977) posited two hypotheses which help to explain the role of social support and its association with illness.

1) "Social groups differ in the norms regarding preventive health behaviour and in their ability to exert pressure to conform to these norms."

2) "Interaction patterns may provide information of practical utility, such as how to prevent disease."

These hypotheses lead one to assume that social support may act as a preceding factor reducing the likelihood of the onset of illness, by preventing certain events from becoming pathological — or it may serve as a 'buffer' reducing, modifying, or eliminating the effect of stressful life events.
Peralin and Schooler (1973) pointed out that if social support is seen as serving a coping function, then there are three ways in which coping behaviour can be exercised.

(1) "by eliminating or modifying conditions giving rise to problems."

(2) "by perceptually controlling the meaning of the experience in a manner that neutralises its problematic function, and

(3) "by keeping the emotional consequences of problems within manageable bounds."

However, what seems to me to be of major importance is, why individuals do not uniformly become ill after exposure to stressors or similar magnitudes? Why is it that among those exposed to a common stress, some defend successfully with the minimum effort, while others mount heroic defences? The answer seems to lie in the different capacities of individuals: biological, psychological and the individuals’ interaction with members of their social network.

Rabkin and Struening (1976) included other factors in a revised etiological model in which:

"illness onset is generally associated with a number of potential factors, including the presence of stressful environmental conditions, perception by the individual that such conditions are stressful, the relative ability to cope with or adapt to these conditions, genetic predisposition to a disease and the presence of a disease agent." (p 1014).

Focusing on one of the factors cited by Rabkin and Struening (1976), McFarlane et al (1980) reporting on a longitudinal study conducted in Ontario, Canada, observed that the main factor determining the adverse effect of stressful events is an individual's perception of not being in control. This "appears to fortify
the impact of undesirable events, and the absence of either control or anticipation appears to strengthen the disruptive influence of desirable events." (p. 131).

With due regard to the various factors implicated in the etiological model (Rabkin and Struening, 1976), at present, the most attractive theory about the nature of the phenomenon involve pathways through facilitation of coping and adaptation (Cobb, 1976).

Adaptive capacities at the psychological and social level centre around ego, strength, problem-solving ability, flexibility and social skills. At the interpersonal level, the adaptive capacity of the individual is raised by positive primary relationships and one's network of social supports. These levels of adaptive capacity provide the individual with a body of coping resources.

I would hypothesise that the persons with a strong array of coping resources are less likely to have noxious circumstances/stressful events/changes override their defences and lead to a pathological end - states of a somatic or psychological/psychiatric form. The multi-disciplinary schema of Caudill (1958) reminds us of the many levels at which experiences take place simultaneously and successfully. The four main factors/levels in this multivariate paradigm, biological psychological, interpersonal and socio-cultural, interact in complex way to determine human health and well being.

From this discussion it would seem that the extent to which recent life events adversely affect health is dependent on how well they are coped with; implicated here is the level and type of social support received. I therefore hypothesise that:

(1) The positive relationship between recent stressful events and illness will be modified by personal coping resources. Effective personal resources will weaken the relationship, whereas ineffective personal coping will
strengthen it.

(2) The positive relationship between recent stressful events and illness will be modified by the contribution made to the coping process by support from the social network. The stronger such support, the weaker will be the relationship. (McFarlane et al, 1980).

Further,

(3) Social support possibly acts as a preceding factor in reducing the likelihood of the onset of illness, in providing normative pressure against the likelihood of certain events occurring; or

(4) Social support serves as a "buffer" against the adverse effects of life changes by providing the information needed to reduce or eliminate drastic psychological or physical consequences of life changes; and

(5) Social support may moderate the level of psychological symptoms not just as the time of stress but always, (Miller and Ingham, 1976).

How do these concepts and hypotheses assist in explaining/analysing Barbadians' interaction with stressful life events? How do they cope? What mediating factors are involved? Do such factors protect, "buffer" them against racism in this society?

There is a multiplicity of factors which can effect life events at different stages in their development. At one extreme they could effectively nullify the event thus rendering it harmless. At the other extreme they could have no effect on life events, thus allowing them to become pathological. Most of my respondents are located between these two extremes.
ne of the mediating factors which can effect life events, is social support. 

Although researchers disagree about the nature and quality of social support, there is general agreement that social support - embodied in social networks - lays an important part in the life events - stress - illness model.

I have singled out three areas of the respondents' social interaction to locate social support. These are:

1. The family
2. The Neighbourhood
3. The community.
In the past fifteen years, there has been a rapidly growing research literature dealing with the role of the family group, as a source of practical assistance to its members, during periods of acute need. Sussman and Bruchinal (1962) have written a comprehensive review of empirical studies. They showed that most families studied, irrespective of class, reported giving aid to relatives and receiving aid from them. Assistance included continuing and intermittent financial aid on social occasions, (e.g. birthdays, etc) or help with hospital or funeral expenses. It included care of children performing household task and psychological support during times of crisis.

A particular significance of these contributions of resources and services, is, that during times of crisis an individual is too pre-occupied with his current predicament to think about the demands of ordinary everyday task. Either the household runs down or he must exert special effort to maintain it - and this is at the expense of energy and attention needed to deal with his predicament.

Direct discussion of the family as a source of support during periods of employment crisis is provided by several investigators. Caran (1959) describes the supportive response of family and relatives to the unemployed family member as involving both a mobilisation of financial aid and emotional support. Kornarorsky (1940) found that the attitude of one's spouse towards the unemployed partner and prior strength of the marriage bond were critical in determining the quality of adjustment to economic deprivation and job loss to many people during the great depression.
Further evidence of the important role of family support has been supplied by Gore's study of unemployed men (1978) showed that strain in the form of elevated cholesterol levels, increased depression and more frequent illness was considerably reduced among those with good marital relations, ties to the extended family and to peer groups.

Brown et al (1972) focuses exclusively on current family life and reported that a family's negative emotional response appears to interact with working patients, increasing the likelihood of a relapse. These findings suggest that stress related to work is particularly debilitating when the family environment is rejecting and engulfing.

Miller and Ingham (1976) extending the debate, suggested that partial protection from the development of psychological symptoms is provided by social support. They suggest that social support moderates the level of psychological symptoms not just at the time of stress but always. Here, social support may be provided by having at least some acquaintances. Brown et al (1975) suggested that only an intimate relationship could give virtually complete protection from a depressive illness following a major life stress.

Silberfield, (1978) in a study, testing Brown's hypotheses, that symptom levels are moderated by the presence of social supports, noted that psychiatric and family practice out-patients were found to differ markedly in the social networks they participated in. Psychiatric patients showed themselves to be relatively impoverished. The psychiatric group tended to have more 'close' relationship with friends rather than relatives. It is likely that friends do not provide the degree of support that relatives do, where those relationships are close.
t is possible to explain this data by considering that there is a general
association between the presence of more psychological symptoms and a tendency
to have less extensive social networks from which to draw upon for support.
Aplan (1976) notes four important functions the family performs in assisting
its members to cope with stress.

1) The family group augments the efforts made by the individual on the basis
of his ego - capacities to master these emotions.
2) The family can add to a member's ego - derived capacity to tolerate such
frustrations by expressing solidarity and by offering love, affection and
comfort.
3) Families can help individuals accomplish their "worry-work" and "group-
work" - by offering guidance on the basis of past experience of family
members, but also by counteracting despair and feelings of helplessness
through their continuing presence and expression of love, and through
maintaining hope in an eventual triumph.
4) The family may provide (the individual) with a permanent replacement for
the objects of roles lost in the outer world or with a replacement source of
alternative emotional satisfaction.

These observations lead us to propose the following hypotheses:
1) Family support has a positive relation with poor mental health.
2) Frequent contact with family members (near relatives) is positively
related to poor mental health.
3) Respondent's whose family and close relatives do not live in Reading
experience more stress and psychological disturbance than those respondents
whose family and near relatives live in Reading.
4) A family's negative emotional response to a family member increases the
level of stress and psychological disturbance he experiences.
An index of family contact was constructed from answers to 5 questions from the sociological questionnaire. The questions were concerned with the number of near relatives in the neighbourhood and the frequency of contact with relatives.

Questions:

1. Do many of your near relatives live in this ward/Reading?

2. Who are they?

3. If 'yes' (to question 1a)
   
   Do you contact each other,
   
   Once a week.
   Once a month.
   Only on special occasions (e.g. Xmas, birthdays).
   Never.

4. Do you have any friends on your street?

5. How friendly are you with your neighbours?
   
   Do you say good-morning.
   Chat over the fence.
   Exchange house visits.
   Don't speak.

Information obtained from conversations with the respondents is used to further illustrate, the nature of contact between relatives, the level and type of social support obtained.

Forty-three of the female, and 45 of the male respondents had near relatives in the area. Contact between the respondents and their near relatives was frequent. Twenty-eight of the females and 37 of the male respondents visited their near relatives weekly. (See Tables I and II)
Family 'contact', used here, refers to visiting. This form of contact considerably underrepresented the level of interaction between respondents and relatives. Most of the respondents reported - during conversation - that they see one of their relatives almost daily, either while travelling to and from work or during visits to the shopping plaza.

This level of contact implies that family members and relatives are usually in a good position to identify emotional changes - brought on by stressful events - in the respondent. Further, to offer assistance in coping with the problem. For most respondents, knowing that there is someone around, to whom they can turn to in time of stress, is most beneficial.

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<td>17</td>
<td>Brother/sister</td>
</tr>
<tr>
<td>2</td>
<td>Grandchildren</td>
</tr>
<tr>
<td>5</td>
<td>No relative in area</td>
</tr>
</tbody>
</table>

* Cousins living with their parents.
* Brothers and sisters living with parents.
TABLE II  U.K. BARBADIANS

NO. VISITING ALL NEAR RELATIVES - FREQUENCY OF CONTACT

<table>
<thead>
<tr>
<th>SEX</th>
<th>WEEKLY</th>
<th>MONTHLY</th>
<th>SPECIAL OCCASION</th>
<th>NEVER</th>
<th>E.G. XMAS</th>
</tr>
</thead>
<tbody>
<tr>
<td>F</td>
<td>30</td>
<td>10</td>
<td>8</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>37</td>
<td>10</td>
<td>3</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

Findings

Stress and Psychological Disturbance

There was no relationship between the number of near relatives living in Reading and poor mental health. The ETA test pointed to a significant association between type of near relatives (parents, sisters and brothers), proximity of residence, life stress (,297), general psychological disturbance (,347) and symptom sub-scales FFA (,278), phob. (,370), obsess. (,278), Som. (,426), dep. (,351) and hys. (,412).

The nature of the difference revealed that those respondents whose near relatives (parents and siblings) lived outside Reading were at greater risk of experiencing poor mental health, than those whose near relatives lived in Reading.

Two important aspects of the relationship between near relatives and poor mental health can be identified.

(1) The nearness of the blood relation (e.g. parents, siblings) was important.

Respondents whose near relatives were mainly uncles and aunts were more likely to report poor mental health than those whose near relatives were parents or siblings.
Proximity of near relatives was only positively associated with poor mental health when near relatives lived in Reading. The important point here is, that family social support was more positively forthcoming when the respondents parents and/or siblings lived in Reading.

Controlling for 'frequency of family contact,' with psychological disturbance (MHQ) the dependent variable, and stress (SRE) the independent variable, there was a significantly strong positive correlation (above .001%) between stressful life events and infrequent or no family contact. A further association was reported for psychological disturbance (.215 total MHQ). This suggests that those respondents who rarely or never contacted their near relatives were more likely to experience poor mental health than those respondents who were in frequent contact with near relatives.

Most respondents considered contact with family members to be important. As one respondent reminded me:

"Having my relatives around makes me feel a lot better. I know that if I have problems there is always someone I can talk to or ask for help, not a stranger, but someone who is part of you. It must be very lonely being in England without any relatives around. To tell you the truth I would feel quite lost."

Another added, "When I first came to Reading I didn't know many people. I had a few friends who I met in London, but they used to spend a lot of time at their relatives, as a result I saw less of them. One day I had a rough time at work with my foreman, who was prejudice. When I got home I felt sick and fed up like hell. There was no one I could really talk to. I had a few friends, but I didn't want to burden them with my problems. If I had any relatives around I would have gone to them, but I had to bear it. This is
A Respondent's Experience Of Family Support

Here I report part of a conversation I had with one of the female respondents. This conversation centred around topics about the difference between Barbadian and English society, the problems black people encounter, how many of them become ill and finally, what the respondent does when she has a serious problem.

In response to the question, what's the main difference between Barbadian and English society, the respondent replied:

"The main difference is the people. Barbados is a place where everybody knows everybody. Often, who you don't know, know you or a relative of yours. Where I lived in St. Andrew, the village isn't too big so I know everybody. Here people are different. Everybody here mind their business or are too busy. Anyway, it's not too bad in Reading, because there are many Bajans here. Further more most of them come from Walkers and Bellplane (these are electoral wards in St. Andrew), so we have a lot in common. I have been living in Reading for the past 15 years so I know most of the Bajans here. We get on alright together. Reading is different from London, because here they are not many of us, so we stick together. In London it's everyman for himself, they really don't care about you."
What do you do when you have a serious problem?

"If I have any problems I discuss them with my husband. The problem is that sometimes we don't get a chance to talk properly, because he works nights and I work days. We work like that, so that there is always someone home to look after the children, keep them out of trouble. Sometimes they go over to their aunt or uncle, but we can't burden them, they have their own children. It's good to have your family living nearby, in case you are sick or in trouble you can get someone to come in and help you and look after the children.

My sisters are good to me. I usually discuss any problems I have with them. I have a brother living off the London Road, but the sort of things I discuss with my sister I couldn't tell him, after all he is a man. Sometimes I discuss things with Mrs. White - she is my best friend. Outside of these few people, I don't discuss my business with anyone else."

The situation discussed here, is fairly typical of some of the conversations I have had with respondents. The respondents have a good family relationship, and in particular, with one family member with whom he/she discusses problems. The family and relatives are supportive both before and during crisis periods. Caring for the children while the family member is at work, offering financial and psychological support during periods of acute stress.

The family group also helps to monitor fatigue when a member is experiencing a crisis. At such times the family may play an important role by offering the individual advice which may prevent a worsening of his physical and mental condition.
'Family contact', as a measure of social support was found to be an important variable in the stress illness model. Those respondents who lived nearby and were in frequent contact with near relatives experienced less stress and psychological disturbance than those respondents whose near relatives lived outside Reading and whom they infrequently contacted.

When 'family contact' was controlled, a strong positive relationship at the .001% level was found between stressful life events, psychological disturbance (poor mental health) and no family contact.

Family contact was found to be an important variable in reducing the level of poor mental health, when the respondents' near relatives - parents, siblings and children - were living in Reading.

Further it was observed that family support had a significant effect on poor mental health, only when there was frequency of contact between respondents and relatives. Where infrequent contact occurred, near relatives were unable to monitor respondent's stressful life changes. This meant that when family members were contacted for 'support', the stress had either become more severe and/or near relatives were relatively unprepared to offer immediate assistance. This was forcibly illustrated by one respondent who recounting his experience said:

"I have quite a few relatives living in Reading you know, but I hardly see them. Occasionally we meet in town or while travelling and we have a chat, mind you there is no hard feelings between us, I just prefer to keep to myself. A few months ago I got laid off (was made unemployed) so things weren't going too good. I expected some back-pay but that didn't come through, at the same time a whole heap of bills start coming in. I tried to battle it out, but boy, the pressure start to get me down. I decided to
I went to him he didn't have any money, because he had just spent some in fixing up his house. He said he was sorry; anyway I eventually got some off another brother. Probably if I used to keep in contact with them things wouldn't have got that bad, but I don't like going at them, I prefer to stay by myself."

Conclusion

Family support was found to have a positive relationship with poor mental health when 'family contact' was frequent. Further, the level of family support was observed to be influenced by the nearness of relatives. Respondents whose parents, siblings or children lived in Reading were more likely to receive a higher level of family support than those respondents whose uncles and aunts, lived in Reading or parents and siblings lived outside Reading. Expressing this view, a female respondent remarked,

"Sometimes I wish I was living in London, or some other big city, but I suppose Reading has its advantages. I have my family here, and we get on quite well. If I got any problems my mum helps me sort them out or I could discuss it with my sister."

Researcher: "Would you discuss your problems with your aunt or niece?"
Respondent: "Not really."
Researcher: "Why?"
Respondent: "Because I don't think she would understand, and help me as much as my mum would. No. I prefer to discuss it with someone in my immediate family."

Bell (1967) noted that 80% of respondents said they can count on aid from relatives if they are sick for a month or more. Further they ranked parents, siblings and children as most important, with other kin second, friends, co-workers and neighbours third.
No relationship was found between lack of family support and an increase in stress and psychological disturbance (poor mental health). Based on available findings in several areas of family research, we have seen that there is substantial support for the view that the degree of stress associated with the experience of life events, economic and non-economic depends in part on the individual's familial support. An assessment of the support characteristics of an individual's primary family group should enable researchers to account more fully for a person's level of psychological functioning.

The family also represents an intermediate level of social analysis with demonstrable relationships to both more micro and macro social variables.

The family represents one of three important areas of social support which is implicated in the stress - illness model. A second area from which social support can be derived is the neighbourhood.
neighbourhood is ordinarily viewed as a smaller version of the local community. The latter has been conceived of in two distinct ways; first, it has been defined as simply a locality and the people living in it, second, it has been seen as a social fact, a type of group. Both notions have their roots in folk theory. It is common in most cultures to think of spatial collections as units of some importance, and the belief that spatial propinquity leads to social interaction and the development of shared values and action patterns is also widespread.

Thus the local community is often discussed as a concrete social unit. To it is imputed meaningful social bonds, the generation of social value and psychological support for the individual. In short the local community is seen as a primary group.

The work of Leighton (1959) and others (Dunham, 1965; Levy, and Rowitz, 1973; Vers et al, 1975) suggests that the extent of social integration within the larger social environments has implications for psychological functioning. Leighton in particular makes a conceptual distinction between an individual's support and the supportive or non-supportive "climate of a neighbourhood."

Outside of the family, extended kin and peer group, the individual's interaction with his neighbours and others in his immediate spatial locality is an important determinant of his social behaviour. Myers et al (1975) have shown that poor integration into the neighbourhood is negatively associated with stressful life events and illness. The implication here is, that social integration into the neighbourhood may play a mediating role in the stressor illness model.
here, I will examine how respondents interact with other individuals in the
neighbourhood, and how the interaction acts as, or provides social support
for respondents during stressful periods.
The following hypotheses will be tested:

1. A high level of neighbourhood integration/interaction is negatively
related to poor mental health.

2. A high level of neighbourhood interaction acts as a form of social support
reducing the level of stress and psychological disturbance (poor mental
health) respondents experience.

The level of neighbourhood interaction was determined by answers to six
questions which were concerned with number of years resident in the
neighbourhood, type of social relationship with neighbours, number of
friends who live in the neighbourhood, type of social relationship with
neighbours, visit to and visit from closest friends.

1. For how long have you lived in this neighbourhood?
2. How friendly are you with your neighbours?
   - Do you say good-morning?
   - Chat over the fence?
   - Exchange house visits?
   - Don’t speak.
3. Do you have any friends in this street?
4. Have you visited your close friend in the last month?
5. Has your closest friend visited you in the last month?
6. What colour/race are your two closest friend?

Findings

Stress and Psychological Disturbance

No association was noted between neighbourhood interaction and stress.
However, there was a linear relationship between neighbourhood interaction
and psychological disturbance. Those respondents who had few or no friends
living in the neighbourhood ($r = -0.222$ ETA (.230 total MHQ) symptom scales dep. (.231) and hys. (.248), who weren't friendly with other neighbours (.285 total MHQ) and who rarely visited friends (.215 total MHQ) symptom scales, obsess. (.220) and dep. (.249) experienced poor mental health. Such respondents demonstrated poor integration in the neighbourhood.

**Discussion**

Most of the respondents - over 50% - lived in Reading for an average of 12 years, and were moderately friendly with their neighbours. More than half of the respondents (52 persons) said 'good-morning' to their neighbours, 15 'chatted over the fence', 24 'exchanged house visits' while 9 didn't speak to their neighbours.

There was relatively few 'exchange house visits.' Children of respondents were more likely to initiate house visiting through the medium of playing with neighbours children - than their parents. Where there were black neighbours, respondents were more likely to exchange house visits. A respondent seemingly said:

"I have no ill feelings about Mrs ------ (referring to her white neighbour), but there isn't much we can talk about, so why visit the lady's house.

Researcher: "Why do you visit Mrs. ------ (her black neighbour)?

Respondent: "Well that's a different matter. I knew Mrs ------ before she moved here, plus we come from the same district in St Andrew, so she is one of us."

Here one sees that, a respondent's decision not to visit a neighbour is not based solely on reasons of colour, but on a more complex set of social variables to which the respondent relates and identifies.
House visiting between neighbours, in Barbados is not a common practice. However more house visiting occurs among residents in rural parishes (St Andrew, St Lucy) than in non-rural (St Michael, St James). This is mainly because there are more social venues in the urban than the rural areas, where meetings can occur. I expected more 'house visiting' to occur among respondents, especially where neighbours were fellow West Indian, irrespective of nationality. It appears that living in England has affected the social habits of respondents. Instead of being openly hospitable, to all, they have become closed and introverted like the British.

I have observed that most respondents are suspicious of white neighbours. "You can't trust them. They laugh and talk with you yet stab you in the back. Haven't you looked at the way they smile? It never looks genuine."

Respondents are prepared to talk, laugh and exchange polite conversation, but find it difficult to have close relations with their white neighbours. Primarily because white people have a different socio-cultural background. Some of the obvious differences are, food, music and entertainment, to name a few. Although the members of each race are prepared to be polite to each other, they are unable to interact fully because of cultural differences and a lingering suspicion about each other. However, in neighbourhoods where there are few blacks, there was a higher level of interaction between respondents and their white neighbours.

The presence of many Barbadians and other West Indians living in the same neighbourhood provided respondents with opportunities for forming close relationships. Fifty-seven respondents noted that they had at least one close friend living in the same street, while 94 respondents reported that two of their closest friends were black.
The relationship with neighbours and other white residents was based mainly on mutual respect, rather than any meaningful social interaction. Furthermore most of the respondents had at least one relative living in close proximity, which meant that respondents could avoid interaction with white residents without experiencing any social isolation.

This pattern of social interaction spilled over into the wider community, there was a limited form of social interaction between respondents and white people. Relatively few respondents attended 'white churches' - Anglican and Catholic. There were few community activities which were attended by both races. The biggest social event to which all races participated was the annual local carnival.

From conversation with the Community Relations Officer, a local black J.P and from personal observation, few mixed (black/white) occurred. This might be due to the large number of marriageable black females and the high level of social interaction between respondents and the black members of the society.

How does the interaction between respondents and other individuals in the neighbourhood provide social support for respondents?

As was stated earlier, most respondents have near relatives and friends living in the same street or in the surrounding streets. There is a high frequency of social contact between respondents and relatives. The nature and level of this contact provides social support. Respondents report that they receive material and psychological support from relatives and close friends, during and after periods of stress. The nature of the relationship is such that respondents do not find it necessary to interact meaningfully with white residents in their neighbourhood.
Considering the nature and social setting of the Barbadian community, it is difficult to say whether the respondents displayed poor integration into the neighbourhood. On the other hand, there appears to be a very meaningful interaction between the respondents and fellow Barbadians and other West Indian residents in the neighbourhood.

On the other hand, there is a limited form of interaction between the respondents and white neighbours and other residents. Whether one should consider this to be poor integration into the neighbourhood is debatable. The respondents' point of reference is, relatives, fellow Barbadians and other West Indians. They appear to obtain all the social support they need from these three sources.

With due consideration to this observation/finding, I am unable to conclude that the respondents were poorly integrated in the neighbourhood. The issue turns on whether the limited interaction between the respondents and white neighbours and other residents, constitutes poor integration.
One potentially useful concept for operationalising ties to the community is the social network. As Murphy (1973) has suggested, the special utility of this concept is that it allows us to "draw into a single frame of reference the community net which anchors on or around an individual and those community settings which make up the patterns of collective interaction in the community."

The importance of community interaction for the study of stress, in relation to individual well-being is provided by the work of Stoute et al (1954) who studied heart disease in a small working class community of Roseto Pennsylvania. Gore (1973) commenting on Stoute's earlier finding, notes that the ethnic and cultural homogeneity of Roseto and its network of close-knit family and community relations were responsible for creating a highly stable environment which served to limit the amount of stress experienced by residents and mitigate the effects of crisis that did occur.

Finally, Wechsler and Pugh (1967) have conceptualised the supportive quality of community settings in terms of the interaction between personal and environmental characteristics. They noted that towns with large numbers of hospitalised individuals were those in which patients were in the minority relative to the non-hospitalised populations of their home communities on nine of the fifteen demographic characteristics. They speculated that individuals living in areas where few residents were similar to them may experience considerable social isolation and therefore separation from the usual sources of social support, while those in the majority are better protected from stress as a result of their greater access to supportive relationships.
In the light of this review the following hypotheses will be tested,

(1) Community interaction (interpersonal relationships) are positively related to poor mental health.

(2) Respondents who live in areas where they are residents of similar culture and nationality - speak the same language - experience less stress and psychological disturbance than those who have few or no residents similar.

(3) Community interactions (interpersonal relationship) with members of a similar culture and nationality provides an equally good, if not better, source of social support than interaction with wider society.

Three questions from the sociological questionnaire were selected which would give some indication of the level of community participation. Church attendance and membership of local social or sporting club(s) were the two main avenues through which community interaction could be established and maintained.

(1) How often do you attend church?

(2) How often did you attend church at home (Barbados)?

(3) Do you attend any local sporting or social club(s)?

If "yes" specify........

Social Clubs

The West Indian social club is the only ethnic club in Reading. Its patrons are predominantly Barbadians. It also functions as a meeting place for various social and cultural groups, including an international students association. It creates the opportunities for the West Indians to interact among themselves as well as others from the white society.

Findings

Sixty-five of the respondents attended a local sporting and social club. Of the 65 respondents, 45 males attended the West Indian club regularly - at least once a week - while 5 did not attend any social or sporting club.
Some of the 45 males who attended the West Indian social club also belonged to various other clubs in and around Reading, these were mainly sporting or social clubs at their place of work.

Of those not members of a social/sporting club, 36 were females. Females infrequently visited the West Indian club. Those who did visit were usually accompanied by a man. The marked absence of women at the club is due largely to the social stigma West Indian culture attaches to women who visit clubs. This point was emphasised when one of the proprietors told me how difficult it was for him to get his wife to assist in running the club.

The West Indian social club is the main venue for social activities for Barbadians living in Reading. There is a fortnightly dance, dominoes tournament and other activities which attract Barbadians from other cities, mainly London and Bath. In brief, the West Indian club is the nucleus of social activity for West Indians living in Reading.

**Attending Church**

Another avenue through which interaction between respondents and other members of the community can take place, is the church.

Church attendance has always been a social occasion for West Indians. The pre-service and post-service 'chat-ins' are the occasions when church members exchange good and bad news. It is the time when 'brotherly love flows', when comfort and succour is meted out by one's brethren.

Since immigrating to England church attendance among the respondents has dropped remarkably (See Table III). Fewer respondents attend 'ethnic' or 'established churches.' Respondents cite hypocrisy, racial discrimination and 'coldness' of church members as the main obstacle to their non-attendance.
In spite of poor attendance, the church continues to perform a useful, though limited role in creating and fostering a spirit of togetherness among its multi-racial congregation. The hope being, that this spirit of 'oneness' will extend beyond the church into the wider community. Some of the respondents pointed out that they made several white friends through attending church. It would appear that the growth of 'black' churches severely limit the integrating function of the 'established' - Anglican and Roman Catholic - churches.

Interaction between respondents and white members of the community is further negated or hindered by the development of various West Indian social activities which help to reinforce the cohesiveness of the 'sub-cultural' Barbadian/West Indian community. For example, there is the traditional West Indian 'bus excursion' commonly called 'day trip' in England. This brings Barbadians and other West Indians together. Then there is the weekly round of parties, dominoes and cricket which maintains contact between respondents and other West Indians.

**TABLE III U.K. BARBADIANS**

<table>
<thead>
<tr>
<th></th>
<th>In England</th>
<th>At Home</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>M</td>
</tr>
<tr>
<td>Frequently</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>Occasionally</td>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td>Rarely</td>
<td>16</td>
<td>14</td>
</tr>
<tr>
<td>Never</td>
<td>13</td>
<td>28</td>
</tr>
<tr>
<td>Total</td>
<td>50</td>
<td>50</td>
</tr>
</tbody>
</table>
Wechsler and Pugh (1967) have observed that individuals living in areas where there are residents with similar cultural backgrounds obtain community support when experiencing stressful situations.

How do respondents obtain social support through community interaction?

As I have shown, respondents interact strongly with relatives, other Barbadians and West Indians in their sub-cultural group, and poorly with white residents. During periods of stress or crisis, respondents obtain social support through their social bonds with fellow Barbadians and West Indians in their social network.

I have been unable to establish any meaningful form/type of social interaction between respondents and white members of the community. However, I have deduced from conversations with respondents, the Community Relations Officer and observations of the local community, that there is a strong community spirit among respondents, Barbadians and other West Indians. This 'spirit' was illustrated in 1977, when the son of a local black shopkeeper was arrested and beaten up by the police for an alleged crime. The black community's response against the actions of the police culminated in several demonstrations at the police station and court. The Community Relations Officer also reacted by cancelling all official (a series of police lectures for the year) and unofficial engagements with the local police.

In my opinion, this 'community spirit' is contributory to community support, which partly assist respondents during periods of crisis. It is the knowledge that all black residents are vulnerable to racial discrimination of one sort or another. Further, there are certain unique demographic features of the Barbadian population in Reading which assist in stimulating and maintaining a high level of intra-Barbadian and West Indian community interaction.
First, over 60% of the Barbadians living in Reading immigrated from two parishes, St Andrew and St Michael, consequently the respondents have their near relatives and extended kin living in Reading.

Second, Barbadians have settled in two main areas, the London Road and the Oxford Road. The shopping precinct is conveniently situated between these two areas. This facilitates frequent meetings between residents from the two areas.

Finally, Barbadians are the largest ethnic group in Reading. At the last census (1970), there were 1,395 Barbadians living in the County Borough of Reading, out of a total New Commonwealth minority of nearly 3,000. It is the combination of these factors which have created a strong community spirit among Barbadians and other West Indians living in Reading. This in turn is responsible for creating a stable environment which serves to mitigate the effects of crisis that the respondents experience.

Most of the respondents, especially females, with whom I had a discussion following the formal interview, said that they felt 'good' knowing that their relatives were living nearby, 'so dat if anything happen I can always go to them for help.'

The respondents did not regard the nearness of relatives as an encroachment on their privacy. The proximity of relatives living on the same street or neighbourhood is customary in Barbados.

The extent of interaction between the respondents and members of the white community is limited. This is mainly because of the cohesiveness and the size of the black community.

Most Barbadians/West Indians interact with white people through 'formal' channels, for example, at work, as neighbours, while shopping and on civil occasions. Further, Reading being a small town does not provide the variety and type of social activity which interest both blacks and whites. The major
vent which brings both races together is the annual carnival, organised currently, by the Community Relations Officer - Mr. Harvey DePass and his staff. Apart from church which provides a limited service, there are no other social institutions through which community interaction is generated. The value of community interpersonal relations is that it provides an additional source of protection, buffering the individual against stressful vents. I would hypothesise that the low incidence of mental ill health among the Barbadian community in Reading is due partly to the strong community support. Appendix VIII and IX have shown, over the period 1963-1978 only 18 Barbadians have been admitted to Fairmile Hospital (Reading and Oxford) as compared to Jamaicans. When one considers this on a ratio basis, Jamaicans have a higher rate of hospital admissions than Barbadians.

Discussion

Community interaction was found to be related to poor mental health. Community support is closely interrelated to neighbourhood and family support. Most of the respondents lived in neighbourhoods in which other family members resided. Neighbours were either fellow Barbadians or other West Indians e.g. Jamaicans or Grenadians). As a result of this geographical and social proximity, respondents tended to interact more with racial and cultural group, and less with white residents.

There are few avenues through which interaction between respondents and white residents can take place. These are:

1) At their work place, (2) through church attendance and (3) membership of white social clubs.
This distrust of white (British) society and its health care system was noted by Burke (1980). In a community study of Barbadians living in Reading, Burke (1980) found that his respondents had a deep distrust of white society and were reluctant to use the institutional care system. Respondents who had mentally ill relatives preferred to send them home (Barbados) rather than have them admitted to Fairmile Psychiatric Hospital.

However, despite the stated distrust, Burke's respondents probably decided to send mentally ill relatives home, because having them around would cause too much shame and embarrassment.

Conclusion

(1) Community interaction was found to be positively related to poor mental health.

(2) Respondents who lived in areas in which there was a high density of Barbadians experienced less stress than those respondents who lived in areas where the density of Barbadian was low.

(3) Respondents had a high degree of interpersonal relationship with members of their own racial ethnic group and a relatively low level of interaction with individuals from the host community.
Andrew, C., Tennant, C., and Vaillant, G.

Barnes, J.A.

Bell, R.R.

Bott, F.

Brown, G.W., Bailey, J. and Wing, J.

Brown, G.W., Bhrolchain, K.N. and Harris, T.

Bullock, R.C., Sigal, R., Weissman, M. and Paykel,E.

Burch, J.

Burke, D.P.A.

J. The contribution of social environment to host resistance. *American Journal of Epidemiology* 104: 107, 1976


Mental Disorders in Urban Areas University of Chicago Press, 1938.


Gove, W.R. 


Hammer, D., Adams, J.


Hammer, M. and Schaffer, A.


Hammer, M., Makiesky-Barrow, S., and Cutwirth, L.


Henderson, S.


Henderson, S., Byrne, D.G., Duncan, Jones, P., Adcock, S., Scott, R. and Steele, G.P.


Holmes, T.H.


Holmes, T.H. and Rahe, R.H.


adushin, C.


aplan, B.H., Cassel, J. and Gore, S.


, Harding, J.,

cklin, D. and cmillan, A.


Wechsler, H. and Pugh, T.  Fit of individual and community characteristics and rates of psychiatric hospitalisation.  

CHAPTER 16

THE COMPLEX INTERACTION OF FACTORS PREDICTING MENTAL HEALTH IN THE

BARBADIAN SAMPLE IN READING
Among the factors which are important for mental health in the Barbadian populations studied are social mobility and expectations of and planning for migration. In order to assess the relative importance of these and other factors and their possible interaction with other factors in determining particular kinds of stress, including that leading to poorer mental health, I have explored a variety of statistical techniques, including multiple regression, log-linear analysis, and analysis of variance based on interaction tables (Maxwell, 1962; Hope, 1968). Particular difficulties were encountered in handling simultaneously a large number of variables, most of which were non-linear in nature. Because of the large number of variables which needed to be analysed simultaneously I found log linear analysis (a technique still in its formative stages) difficult to handle.

Multiple regression, selecting variables which approximated to a linear trend with the appropriate dependent variable has given some useful insights, but the most interesting information has been yielded by the interaction tables. Since it is male migrants in Reading who seem to suffer the most stress (as reflected in their poorer mental health) I attempted an exploratory multiple regression analysis of variables which in males showed a significant, linear association with the dependent variable, the total score on the Middlesex Hospital Questionnaire. The technique of multiple regression (Hope, 1968) sorts correlations into an array according to the amount of variance they explain in a dependent variable, after each variable has been controlled on each other. It will be seen in Table 1 that the selected variables explain 59 of the variance in the total MHQ score in the Barbadian males (Reading sample), this is a surprisingly large amount of variance.
Table 7

Multiple Regression with Total Mental Health Score (MHQ) as Dependent Variable in 50 Barbadian Males in Reading

<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Simple R</th>
<th>Multiple R (after multiple regression)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moved to present address from within Reading</td>
<td>-.332</td>
<td>.33</td>
</tr>
<tr>
<td>Number of double beds in home</td>
<td>-.266</td>
<td>.42</td>
</tr>
<tr>
<td>Number of stressful life events</td>
<td>.343</td>
<td>.51</td>
</tr>
<tr>
<td>Negative reasons for migration</td>
<td>.258</td>
<td>.59</td>
</tr>
<tr>
<td>Number of clubs attended</td>
<td>-.265</td>
<td>.62</td>
</tr>
<tr>
<td>Fundamentalist church attended versus others</td>
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<td>Amount of variance explained</td>
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Certain material factors (moving within Reading, lack of crowding, number of beds in house) are perhaps indicators of material success and are associated with good mental health. Both educational failure (no certificates) and educational striving (further education but without necessarily gaining success) are associated with poorer mental health. Attending the more traditional West Indian churches, and attending frequently, is associated with better mental health, as in club attendance. Number of stressful life events on the Holmes-Rahe scale (adapted by Cochrane) is associated independently with poorer mental health, as is upward mobility. In sum, we can say that the groups of factors which independently and in combination predict poorer mental health are (a) Lack of material success; (b) Lack of educational success; (c) Attempted but not necessarily successful upward mobility; (d) Independently occurring stressful life events; (e) Lack of integration with West Indian churches and clubs. Presumably individuals for whom all of these constraints exist are seriously at risk for poorer mental health, and actual mental illness. Even if pattern of cause and effect are difficult to presume (incipient mental illness could cause detachment from potentially socially supportive networks for example) we can safely suggest that these factors interact with one another in complex ways in producing poorer mental health.

The interaction tables (Maxwell, 1962) enable us to establish particular patterns of interactions between variables, and particular combinations of constraints producing particular mental health outcomes. The disadvantage of these tables is that they can only handle a relatively small number of variables simultaneously. Table 2 illustrates the way these tables are constructed. Analysis of variance was used to establish the overall significance of variation on mental health outcomes in the final cells created by the interaction tables, and *a posteriori* comparisons were calculated to establish the significance of different combinations. I attempted to undertake the same type of analysis with both sets of data (Reading and Barbados) including social mobility, marital status, housing quality and for
The higher the MHQ mean score, the poorer the mental health.

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the migrants, pre-migration planning.
The results are as follows:

**Barbadian subjects in Barbados**

Sub-groups with good mental health, housing key variable:

(a) Male, no stress, community support, poor housing ($N = 16$) total MHQ mean score $18.81$

(b) Male, stress, community support, poor housing ($N = 9$) total MHQ mean score $18.82$

Sub-groups with poor mental health, housing key variable:

(c) Females, stress, community support, poor housing ($N = 6$) total MHQ mean score $29.3$

(d) Females, stress, no community support, good housing ($N = 4$) total MHQ mean score $27.75$

Comment: poor housing is not particularly significant for mental health in this group in Barbados; stress is not particularly harmful for males who have community support, but it is clearly harmful for females, even those with community support.

Sub-groups with good mental health, marital status key variable:

(e) Male, stress, no community support, not married ($N = 8$) total MHQ mean score $13.38$

(f) Male, no stress, community support, not married ($N = 31$) total MHQ mean score $18.90$

Sub-groups with poor mental health, marital status key variable:

(g) Female, no stress, no community support, unmarried ($N = 4$) total MHQ mean score $29.76$

(h) Female, no stress, community support, married ($N = 10$) total MHQ mean
(i) Male, no stress, community support, married (N = 5) total MHQ mean score 25.2

Comment: Unmarried males, with and without stress or community support, tend to have better mental health. Females, whatever their marital status tend to have poorer mental health.

Sub-groups with good mental health, social mobility key variable:

(j) Males, no stress, community support, not socially mobile up or down (N = 15) total MHQ mean score 17.60

Sub-groups with poor mental health, social mobility key variable:

(k) Females, no stress, no community support, not socially mobile up or down (N = 12) total MHQ mean score 33.45

(l) Males, stress, no community support, upwardly mobile (N = 5) total MHQ mean score 29.0

(m) Females, stress, community support, upwardly mobile (N = 5) total MHQ mean score 29.25

Comment: Upward mobility is stressful in terms of mental health outcome; lack of community support combined with upward mobility is particularly stressful.

Barbadian subjects in Reading

Subjects with good mental health, housing key variable:

(a) Male, no stress, community support, good housing (N =15) total MHQ mean score 22.10

(b) Female, no stress, community support, poor housing (N = 5) total MHQ mean score 21.33
Subjects with poor mental health, housing key variable:

(c) Female, stress, community support, good housing (N = 9) total MHQ mean score 30.60

Comment: For females stress can be a major factor in poor mental health, despite community support and good housing. Combinations of lack of stress and community support lead to good mental health, despite quality of housing.

Subjects with good mental health, social mobility key variable:

(d) Males, no stress, community support, not upwardly or downwardly mobile (N = 16) total MHQ mean score 21.0

(e) Females, stress, community support, not upwardly or downwardly mobile (N = 6) total MHQ mean score 22.30

Subjects with poor mental health, social mobility key variable:

(f) Female, stress, community support, upwardly mobile (N = 19) total MHQ mean score 30.32

Comment: Upward mobility associated with social stress has particularly poor mental health outcome for females.

Subjects with good mental health, marital status key variable:

(g) Males, no stress, no community support, married (N = 13) total MHQ mean score 23.15

(h) Males, no stress, community support, single (N = 12) total MHQ mean score 20.8

Subjects with poor mental health, marital status key variable:

(i) Females, stress, no community support, married (N = 6) total MHQ mean score 34.6

(j) Females, stress, community support, single (N = 7) total MHQ mean score
(k) Males, no stress, no community support, single (N = 6) total MHQ mean score 29.5

(l) Females, no stress, community support, single (N = 6) total MHQ mean score 32.5

Comment: Married males may need community support less than unmarried males; for females, being single is related to poorer mental health, despite the absence of stress, and the presence of community support.

Subjects with good mental health, positive plans prior to migration key variable:

(m) Male, no stress, community support, no plan (N = 8) total MHQ mean score 18.75

(n) Female, no stress, community support, plan (N = 10) total MHQ mean score 22.30

Subjects with poor mental health, positive plans prior to migration key variable:

Female, stress, community support/plan (N = 5) total MHQ mean score 32.8

Female, stress, community support, plan (N = 5) total MHQ mean score 30.60

Female, stress, no community support, plan (N = 4) total MHQ mean score 33.0

Comment: Pre-migration planning is no protector against social stress; but lack of planning can be counteracted with community support.

Subjects with good mental health, key variable high expectations of England and the English:

Female, low expectations, no stress, no community support (N = 5) total MHQ mean score 18.0
Males, no stress, community support, low expectations (N = 11) total MHQ mean score 21.36

Subjects with poor mental health, key variable high expectations of England and the English:

Male, low expectation, stress, no community support (N = 4) total MHQ mean score 31.2

Female high expectation, stress, community support (N = 10) total MHQ mean score 33.0

Comment: Low expectations are not powerful predictors of mental health per se, but interact with other factors.

Conclusions

In chapter 3 I showed that in terms of scores on the Middlesex Hospital Questionnaire, Barbadian migrants in Reading had poorer mental health than non-migrant Barbadians, and poorer mental health than the English normative sample. Moreover, the absence of significant sex difference in the scores for the Barbadian males in Reading suggested particular kind of psychological adjustment following migration.

The data from the interaction tables, summarised above, confirms the initial view that patterns of mental health are quite different in the two Barbadian samples. Patterns which appeared in the Barbadian sample in Barbados do not appear in Reading. All of the factors considered - housing, marital status, pre-migration plans, community support, sexual status, stress and social mobility - are important for the mental health of some groups. But these factors seem to interact with one and another in complex ways, and while the absence of stress and the presence of community support are crucial for some, the emerging model is one of dynamic, interactive relationships.

Clearly the patterns of adaptation of the Barbadians in Reading are not fixed,
and replication involving a longitudinal design would be valuable. Two inter­
esting questions have yet to be answered: How does the passage of the life

cycle, and the movement into old age effect the mental health of this

Barbadian group? And what mental health and identity problems do the younger,

second generation of Barbadians face?

The multiple regression analysis of variables which can be subjected to a

linear analysis shows that for the Barbadians in Reading a combination of

factors, variously weighted, can explain quite a large proportion of the

variance in total mental health score on the MHQ. We can conclude that no

single or definitive casual model can be identified in explaining mental

health in Reading sample. A wide variety of dynamic, interacting factors

ave to be considered, and future studies must look at change in these factors,
as well as change in mental health, over time.
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PART 4

RESEARCH FINDINGS OF BARBADIANS IN BARBADOS.
CHAPTER 17

THE COMMUNITY SAMPLE IN BARBADOS, MHQ. CORRELATIONS WITH STRESS AND OTHER SOCIAL INDICATORS.
In Part IV I analysed the relationship between stressful life events, psychological and socio-demographic variables in a sample of Barbadians living in the island of Barbados, West Indies.

This study replicates the study done with a sample of Barbadians living in Reading, England. The research instruments used in this study were, The Middlesex Hospital Questionnaire, to measure psychological disturbance, a Stress Inventory, to locate life stress and a Sociological Questionnaire, - constructed around a sort of hypotheses - to determine the relationship between socio-demographic variables and psychological impairment.

The individuals ability to cope with stress, is the main variable in the Stress-illness model. His ability to cope with stressful events depends on his physio-psychological constitution, but importantly on the social support he receives through social bonds with individuals in his primary network relations.

Medical epidemiology Cassel, J. (1974) and Kaplan, (1977) have pointed to a new observations of increased morbidity in groups deficient in social support. The single and widowed are generally recognised to have increased mortality and morbidity rates for many disorders. The important study by Berkman and Syme 1979) which was prospective in design, gave strong evidence for increased morbidity rates in those members of a general population sample who were efficient in social ties.
In the present study social support is analysed by an index constructed from several questions relating to the level of social contact between respondents and their primary network in the wider community.

Barbadian society, historically and contemporarily provides for easy and free interaction between people living in the same and neighbouring villages or locales. For example, in village Barbados the community is small with neighbours having a high degree of interaction - relationships established across two or three generations, hence there is little outward movement in networks. This facilitates the establishment of strong caring bonds between residents.

Methodology

The second study in the project was constructed among Barbadians living in Barbados. The sample was collected by random sampling. The sampling areas (Parishes) were selected on the basis of electoral wards/districts, named by U.K. Barbadian respondents. For example, over 40% of the U.K. Barbadian sample came from two wards - Bellplain and Walkers - in the Parish of St. Andrews. Every fifth house in the wards, was included in the sample, until the required representative sample was found.

Sample

The sample comprised 100 Barbadians, 50 males and 50 females. Sixty of the respondents were married, 33 unmarried, 5 widowed and 2 divorced or separated. The sample was matched as closely as possible with that of the first study done in Reading, England, for sex, age, marital status, occupational status and parish of residence.

The same three research instruments used in the Reading study were used in Barbados, with some minor modifications. The instruments were: The Holmes and Rahe Social Readjustment Rating Scale, modified by Cochrane and Robertson (1973),
Informal Interviews

After the informal interview, an informal discussion took place between respondents and myself. Information thus obtained considerably enhanced understanding of the respondent's social situation and ideas. There was a 100% response by individuals contacted.

Modifications To The Research Instruments

The Sociological Questionnaire was revised, because some of the questions were irrelevant to a Barbadian population, living in Barbados, e.g. 'How long have you been living in Reading?' In some instances questions were altered, e.g. 'Do white Barbadians regard you as their equal socially?' New questions were also included in the BA Barbadian questionnaire, e.g. 'Do you have any relatives living in Reading? Are you in regular contact with them? Have you ever emigrated?' The questionnaire used in Barbados contained 18 questions in comparison to 23 questions on the original questionnaire used in Reading.

The Middlesex Hospital Questionnaire was altered slightly. Words and expressions used - the original questionnaire had to be substituted. For example, Question 3.

Do people ever say you are too conscientious?
Altered to read:
Do people ever say you are too loyal and dedicated?

Question 7.
Have you felt as though you might faint?
Altered to read:
Have you had 'badfeels' or 'bad feelings'? 'Badfeels' in Barbadian creole means, feeling unwell, dizziness, the urge to vomit and pass out. These are
symptoms which usually precede fainting or 'passing out.'

**Question 31.**
The expression "strung up" was explained.

**Question 37.**
The expression "going to pieces" was explained.

The Stress Inventory remained unchanged.

The method of analysis used for the first study was replicated in the second study, with the following exceptions. The scale score of the Stress Inventory variable 60, was used in the second study in preference to the raw score, variable 59, because it correlated much more strongly with the socio-demographic variables and the sub-scales of the M.H.Q. The first study in Reading used the raw score, variable 87.

**Method of Analysis**

The data was first analysed for means and standard deviations. Further the relationship between psychological disturbance and stressful life events is analysed.

In order to examine the association between stressful events and socio-demographic variables the values of the (raw score) of the Stress Inventory was selected in preference to the scaled score, because the raw score is a better predictor of stress.

The measurement of the sociological variables, using ETA and Kendall's Tab B Test produced a number of significant values.
We will begin the analysis of the findings by examining the most significant values. These values are:

(1) Domestic factors.
   (a) family support
   (b) marital status
   (c) household accommodation and composition.

(2) Social factors.
   (a) social mobility
   (b) social class
   (c) religion.
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CHAPTER 18

DOMESTIC FACTORS

- FAMILY SUPPORT.
- MARITAL STATUS.
- HOUSEHOLD ACCOMODATION AND COMPOSITION.
- RELIGION.
Family Support.

The level of family contact between respondents and their relatives in Barbados is similar, yet different to that between respondents and their relatives in Reading, England. The varying nature - socio-cultural differences of the two societies accounts for the difference.

Barbadians living in Reading are in a 'foreign' cultural environment. For example, the structure of the family is centred around a nuclear family type. In Barbados, the extended family system, with the family unit consisting of parents, siblings, grandparent(s) and often aunts or uncles is still very common; despite pressure from external forces to become nuclear.

The social values of Barbadian society endorse and support kin group networks; which function as a mechanism for alleviating financial hardship and emotional stress.

In England State institutions have largely taken over the role of kin networks providing care of one sort or another. It is possible for an individual to be cared for by the State from birth until death. Such institutional supports does not exist in Barbados. There is a pension scheme for the elderly poor, but the monies are not given to fully support the elderly, merely to supplement assistance from relatives and benevolent friends. The pension scheme was devised with a built-in 'assistance clause' - namely that it is the responsibility of family members to assist destitute members of their family.

The nature of family support is more intensive and extensive in Barbados than in England. Family members who 'fall on hard times' and are destitute is an embarrassment to the family, therefore it is within the family's interest to 'save face' and render assistance to its members.
Family support was measured by an index comprising of five questions, which were concerned with the number of near relatives living in the same parish, who they were and the frequency of contact with them. Contact with relatives overseas was also considered to be important, because some respondents depended financially and psychologically on support from children and close relatives living overseas.

The questions are:

1. Do many of your near relatives live in this parish?

2. Who are they?

3. Do you contact each other?
   - Once a week.
   - Once a month.
   - Only on special occasions (e.g. Xmas, birthdays).
   - Never.

4. Do you have any relatives overseas?

5. Who are they?

6. In which country do they live?

7. Are you in regular contact with them?
   - Write often – twice a month.
   - Send money.
   - Telephone.
   - Other.

Ninety of the respondents reported that they had near relatives living in the same parish – more often the same street. The near relatives were primarily parents and siblings and extended kin – aunts, uncles and cousins. Contact with near relative was frequent. Seventy-eight of the respondents visited a
ear relative at least once a week (See Table 1). In those cases, here near relatives lived in the same street visiting occurred daily. There was therefore a high degree of contact between respondents and their relatives.

### Table 1

| Frequency of Contact With Near Relatives, Recorded by all Respondents (N = 100) |
|-------------------------------------------------|-----------------|
| Frequency of contact                           | No. of Respondents |
| Once a week.                                   | 78               |
| Once a month.                                  | 11               |
| Only on special occasions, (e.g. Xmas and birthdays). | 2               |
| Ever.                                          | 9                |
| Total                                          | 100              |

**Findings**

**Stress and Psychological Disturbance**

A negative correlation ($r = -.239$) was located between 'near relatives' and stressful life events. Respondents with no near relatives in the same parish experience more stress. ETA found a positive relationship between 'near relatives' and stressful events ($r = .232$). Here, respondents whose near relatives lived in the same parish experience less stress.

Further a significant pattern of association was found, which indicated that respondents who had their 'parents and siblings' living nearby and those who visited their relatives frequently (weekly) reported less stress ($r = .310$) ($r = .234$), and general psychological disturbance ($r = .203$) than those whose near relatives lived outside the parish and were visited rarely/infrequently. The presence of near relatives was associated with less disturbance.
Contact With Relatives Overseas

In addition to family contact within parishes most respondents - (70 persons) had near relatives in the vicinity. Twenty-two respondents had children living overseas. Contact with these family members was often infrequent. However, less than half of the respondents (28 persons) were in regular contact with relatives, sending and receiving letters at least twice a month. A small group of respondents (10 persons) received remittances regularly from relatives, these were mainly children sending monies to their parents.

It seems probable that recent advances in telecommunications - direct dialling between England and Barbados - has altered the nature of contact between respondents and their relatives overseas. Some respondents said that they preferred to telephone than write to relatives, because it gives them the opportunity to speak to other members of the family.

An association was noted between 'contact with relatives overseas' stress (.278) and psychological disturbance (.225 total MHQ). A further significant relationship was observed between respondents with children overseas and poor mental health. Respondents who were in regular contact with their children living overseas, recorded less stress (.208) and psychological disturbance (.231 total MHQ), than those respondents who were not in contact with near relatives, living overseas.

Sex Differences

When the data was adjusted for sex, a strong association was observed between contact with near relatives and poor mental health for male respondents. Male respondents whose 'near relatives' (r = .357 with total MHQ), ETA (.357 with total MHQ), 'parents and siblings' ETA (.401 with total MHQ), lived outside the parish and were infrequently contacted
(r = .365 with total MHQ), ETA (.376 with total MHQ), reported a significantly high level of poor mental health. No association was found for females.

Conclusion

In general family support is more intensive and extensive in Barbados than in England.

Respondents in Reading missed the contact they had in Barbados with their extended family and this showed in the association between contact with relatives overseas, stress and psychological disturbance.

Respondents who were regularly in touch with their relatives overseas recorded less stress and psychological disturbance than those who were not in regular contact with 'near' relatives overseas.

Family support has been demonstrated to have a significant relationship between levels of mental health; it acts as a measure alleviating levels of stress and psychological disturbance.
Marital Status

There has been much debate about the relationship between marital status and mental disorder (among married and unmarried women). Meile et al (1969) in a study designed to test this relationship noted that married had more disorder than unmarried among women of low educational attainment, both before and after introducing controls for age and employment status.

The issue here, turns on the role of married and unmarried women. Interestingly very little work - if any - has been done on the difference in psychiatric morbidity rates for married and unmarried men.

A review of the literature, now follows in which several hypotheses relating marital status to mental disorder will be discussed.

Socio-Economic Status and the Role of Married Women.

Gove (1972) and Gove and Tudor (1973) have asserted that the inconsistencies and ambiguities in the role of the housewife that emerged after World War II accounts for the higher rates of mental disorder currently found among women when compared with men. The hypotheses generated by the studies are:

(1) There are important differences in lower and middle class family organisation which are likely to produce differences in amount of psychological stress induced by the housewife role.

(2) Lower class married women are more likely than middle class married women to fill only one aspect of the housewife role, that of mother (Bell 1971; 54).
3. The lower class wife is more likely to view motherhood (and her children) as a source of problem and dissatisfaction than the middle class wife. (Langer and Michael, 1963: 341). This view was further supported by Veroff and Feld (1970) who found that for highly educated wives, being a parent was more gratifying than being a spouse; the association is reversed for less educated wives.

4. Lower class married women have more unwanted children (Westoff and Westoff, 1971: 221-24) than their middle class counterparts, increasing their confinement to the household which is a potential source of dissatisfaction/frustration.

5. The lower class compared to the middle class husband helps less with socialisation and child rearing, does fewer household duties, and is more likely to desert or divorce his spouse (Ca van, 1964)

6. Opportunities for gratification outside the marital role increase with socio-economic status. Middle class wife finds employment provides her with interesting and challenging career opportunities, and finds work gratifying. While the lower class working wife is likely to view employment as a supplement to their family income, to help make ends meet.

These studies point to the marital role as more stressful among low status than among high status married women. In sum, we can conclude that lower status married women, will have a higher prevalence of mental disorder than higher status married women. The impact of marital role on mental disorder is reflected in the relative differences in disorders between the married and never married within status categories.
Non-Married Women, Employment and Social Status.

There is little evidence for assuming variation by status in the role of never married women. Research done by Carter and Glick (1970) provides no useful information about never married adult women with low status. How does the high status married woman fare? The choice of singlehood among women has generally been viewed as a consequence of commitment to a career (Havens, 1973). However, it is often the case that women remain single to look after ageing parents or dependent siblings.

Despite the paucity of studies on unmarried women and psychiatric morbidity, Burvill and Finlay-Jones, in a community study of women, work and minor psychiatric morbidity, showed that non-married women had a lower rate of minor psychiatric morbidity if they were employed. The researchers found that employment was an important variable in determining the level of minor psychiatric morbidity (MPM). In the Community sample, there was no difference in the proportion with MPM between women with a high status job and those with a low status job. This was true of both married and non-married women in both the community and general practice sample.

In the general practice sample, working wives had a higher rate of MPM if they had a low status job, and all wives had a higher rate if their husbands had a low status job. None of the differences in either sample was found to be significant.

However, if employment does protect non-married women (as Finlay-Jones and Burvill, 1979, have shown) against minor psychiatric morbidity, the lack of difference between in upper and lower status jobs (which was true of all working women in the study) suggested that the status
and/or income of the job was not a relevant factor. It may be that the crucial quality of all protective factors, including employment, is the opportunity they provide for the women to form and maintain affectional social bonds. For a woman, outside employment might provide the chance to form a social bond with people with whom she shares common interests and experiences.

Not enough is known to warrant more speculation in this area. One can assume that the basic stresses of lower status life will generally be similar for married and never married low educated women; and that the low status woman is additionally disadvantaged by the stresses of the marital role.

In the light of this discussion the following hypotheses will be tested.

(1) Lower status married women will have a higher rate of poor mental health than higher status married women.

(2) Lower status married women will have a higher rate of poor mental health than higher status single/unmarried women.

(3) Married women who were employed had a lower rate of poor mental health than married women who were unemployed.

(4) Married men of high status had lower rates of poor mental health than single/unmarried low status men.
Findings.

A relationship was noted between marital status, stressful life events (.298) and psychological disturbance: symptom scales: Obsess. (.240), Som. (.313) and Hys. (.206). The nature of the difference was, that respondents who were unmarried experienced a higher level of poor-mental health than those who were married. (See Table I.)

The data was further adjusted for age and occupation. Occupation rather than education was used as an indicator of socio-economic status, because most of the respondents (84 persons) had never acquired further education, and 98 respondents were not currently acquiring further education. Only 4 respondents had been / or were attending university, while 9 were attending full / part time college.

Age

No association was found between marital status, age and stressful life events. However, a strong relationship was noted between marital status, age and psychological disturbance (.327 with total M.H.Q.). The nature of the difference indicated that unmarried male respondents of all ages reported a higher level of psychological disturbance than female. Further, it was observed that stressful life events varied across age groups. The age distribution of the sample was divided into three groups, 21-29, 30-39 and over 40s. See Table II.
Comparison of psychological distress (Table 3: 6 sub scales of the MHQ.) with social and demographic variables of the Sociological Questionnaire in 100 Barbadians of both sexes in Barbados - values of ETA with sociological variables dependent.

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Socio-dem. sub-scales of MHQ.

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<td>.745</td>
<td>.828</td>
<td>.782</td>
<td>.798</td>
<td>.716</td>
</tr>
</tbody>
</table>

The following variables were not significant: 3, 5, 6, 16, 23, 36, 38, 5, and 58.

Significant levels: .05 = .195
.01 = .255
.001 = .325
Table II - B.A. Barbadians

Age Distribution of Sample

<table>
<thead>
<tr>
<th>Age Range</th>
<th>No. of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>21-29</td>
<td>33</td>
</tr>
<tr>
<td>30-39</td>
<td>30</td>
</tr>
<tr>
<td>40-45</td>
<td>6</td>
</tr>
<tr>
<td>46-49</td>
<td>13</td>
</tr>
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<td>50-59</td>
<td>13</td>
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<tr>
<td>60-69</td>
<td>4</td>
</tr>
<tr>
<td>70+</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
</tr>
</tbody>
</table>

Married Respondents

Married respondents (more males than females) report the most stressful life events. The 21-29 age group, reported events which centred around new jobs, pay increases, wife pregnant, moving/purchasing new house and paying debts. The 30-39 age group, reported many of the events recorded by the 21-29 age group, and in addition 'heavy drinking' and 'quarrels with spouse.' The over 40s reported fewer events, which were mainly concerned with personal illness or injury requiring hospital treatment, death of a close friend or family member.

Female respondents of all age groups reported domestic problems which centred around, restriction of social life due to 'child minding', lack of employment and arguments with spouse. The males in the younger age group 21-29, experience greater restriction of social life than respondents in the older age groups.
Unmarried Respondents

Unmarried respondents (more male than female) reported the most stressful life events. The young unmarried males, 21-29 years reported events which related to unemployment, new job, change of responsibility at work, heavy drinking and breaking up with steady girlfriend. Respondents in the 30-39 age group reported events which centred around unemployment, promotion, heavy drinking and argument with girlfriend. The older age group, (over 40's) reported few events; these were concerned with retirement, personal illness or illness of a close friend or family member.

Age classification was useful to the extent that it provided additional information about the distribution of stressful life events in a given population over a working life period.
Household Accommodation and Composition

Research has shown that inadequate housing accommodation can lead to stress and disorganisation of family life (Musil, 1962 and Schorr, 1964). Family life in Barbados is somewhat different from that among Barbadians living in Reading, England. In Barbados it is fairly common to find a household comprising of husband, wife, children and extended relations; living in a two bedroom house in conditions which can best be described as crowded: the housing conditions were generally more crowded than Barbadian respondents living in Reading.

Most of the respondents lived in two-bedroom houses constructed from timber or three bedroom houses constructed with breeze/cement blocks; with few exceptions most of the respondents were owner-occupiers. From these observations I would hypothesise that:

1) Respondents living in crowded accommodations were likely to experience more stress and psychological disturbance (poor mental health) than those living in adequate accommodation.

2) The more children respondents had, the more likely they were to experience poor mental health.

3) Respondents who were members of a household with a family size of more than 7 persons, 2 bedrooms, 2 double beds, 1 single bed and an average bed density of more than 2, were more likely to experience poor mental health than respondents with smaller family size, 3 bedrooms, 2 double beds, 2 single beds and a lower bed density.
A measure of household accommodation and composition was derived from questions on the sociological questionnaire. These were:

1. How many people live in your house / flat?
   - number of adults 16+
   - number of children 5 - 15 years
   - number of infants 1 - 4 years

2. How many bedrooms do you have in your house / flat?

3. How many single beds do you have in your house / flat?

4. How many double beds do you have in your house / flat?

5. Do you consider your present home to be crowded?
Findings

Stress and Psychological Disturbance

An association was observed between household accommodation, stressful life events, and psychological disturbance. The nature of the difference was that respondents from households in which there was an average of 3 family members over 16 years (0.277*) (0.322 with total M.H.Q.), an average of 3 children 5-15 years (0.202*) (0.294 with total M.H.Q.) living in a three-bedroom house (0.205*) with an average bed density of 2.5 persons (0.424*) (0.351 with total M.H.Q.), experienced less stress and psychological disturbance than those respondents with more children, fewer bedrooms, and a higher bed density. A high bed density, above 2.5, was strongly associated with significant symptom scores: FFA (0.295), Phob. (0.302), Obses. (0.369), Som. (0.319), Dep. (0.312) and Hys. (0.424). (See Table III, *See Table IV.)

Further a strong relationship was noted between the number of children respondents had and poor mental health. Respondents who had an average of more than four children (notable 5-15 years) reported a high level of stress (0.490) and psychological disturbance (0.350 with total M.H.Q.); significant symptom scores above 5%, FFA (0.278), Obses. (0.314), Som. (0.288), Dep. (0.213) and Hys. (0.297). See Table I.

The respondents who reported that their homes were crowded reported significant levels of stress (0.295), no association was found with psychological disturbance.
**Table III B. A. Barbadians.**

**Household Accomodation and Composition, and Psychological Disturbance.**

Significant levels of association of all respondents \((N = 100)\).

Composition of psychological disturbance (symptoms scales of M.H.Q. 61-66) with sociological and demographic variables. ETA scores recorded.

<table>
<thead>
<tr>
<th>Socio-dem variables</th>
<th>Symptom scales of M.H.Q.</th>
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</thead>
<tbody>
<tr>
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<td>14. No of children 5-15 years</td>
<td>.278</td>
</tr>
<tr>
<td>18. No of double beds.</td>
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</tbody>
</table>

Significant levels.

- \(5\% = .195\)
- \(1\% = .255\)
- \(001\% = .325\)
27.4% have never visited.

Weekly experience less stress than those who
those with more

Taking weekly experience less stress than
respondents with parents and siblings

Some street/party experience less stress
respondents with near relatives in the same party

Regarding respondents experience less
p.30

Nature of Difference

SIP as Dependent Var.  

Value of PMA with

Nature of Difference

Variables

sex in Barttoreas

Regression of scale score of Stressful Life Events (SLE) with socio-demographic variables in 100 Barttoreas of

TABLE 1 AN BARDING

Lesser bedrooms
Less experience, less stress than those with 3
Response from households in which there were 3
members 5-15 yrs.

16. No of bedrooms

Less stress than those with more than 2 family
average of 2 family members 5-15 yrs. experience.
Response from households in which there was an

15. No of children

5-15 yrs.

14. No of children

2-11 yrs.

Adolescent accommodation

13. No of adults

17. No of bedrooms

2-15 yrs.

16. No of bedrooms

12. No of bedrooms

11. No of bedrooms

10. Reaction


8. Home crowded.

Crowded.

293

experience, less stress than those whose homes were
Response from households in which there were not crowded

205

Lesser bedrooms.
Less experience, less stress than those with 3
Response from households in which there were 3
members 5-15 yrs.

206

Less stress than those with 2 family
average of 2 family members 5-15 yrs. experience.
Response from households in which there was an

207

Less stress than those with 3 family
members 16+.
Response from households in which there were 3

208

Church of England or Roman Catholic
churches.
Response from households in which there were

284

Nature of Difference

Value of ETA with

Variable
In full or part-time employment experience less stress

Respondents from households in which 3 family members were

290 more those who blame themselves (family or society)

social and economic problems in Barbados experience less

Respondents who blamed the political parties for the

292 stress those who felt they did

regard them as their equal society experience less

Respondents who felt that white Barbadians did not

accommodation.

than those persons who wanted to move to get better

opportunities were experiencing less stress

of the family environment or because of job

Respondents who said they decided to move because

424 those who had a higher bed density

density or 3 persons experience less stress than

Respondents from households with an average bed

0.74

| Nature of Difference | Variable | Value of t with df 
|----------------------|----------|---------------------|
or nearly

experience more stress than those whose children spent at home

respondents who had children away only. (not living at home)

0°

stress than those with more children

respondents with an average of 3 children experience less stress

210

present occupation for a shorter period

5-10 years experience less stress than those in their

respondents who were in their present occupation for

201

less current occupation experience less stress

respondents whose father was in skilled or pro-

405

father's occupation

respondents whose father was in skilled or pro-

414

more stress than the downward mobile

respondents whose occupational status remained

422

present job

437 first job vs.

555 first job was manual

respondents whose first job was skilled or pro-

dependent ver.

value of t-test with sta &
36. 39, 41, 46, 47, 49, 50, 54, 55, 56.

37. The U.K. experience less stress than those who were in regular contact with relatives in the U.K.

38. The respondents who were in regular contact with relatives in the U.K. experienced less stress than those who had not experienced.

39. The respondents who had more stress than those who had not experienced.

40. The respondents who did not have to choose.

41. To which social class do you belong?

42. The value of the dependent var.

43. The nature of the difference.
Conclusion

The housing conditions of Barbadians in Barbados and in Reading vary markedly. Apart from the different structure of the houses/flats, there is a difference in family size. Barbadians in Reading have smaller families than Barbadians in Barbados. Most of the respondents in Barbados lived in two bedroom houses with spouse, children and often a member of their extended kin.

It was observed that those respondents who were members of a household with an average of more than 6 persons, 2 bedrooms, 2 double beds and 1 single bed and an average bed density of more than 2, were likely to experience a higher level of poor-mental health than those respondents with a smaller family size, 3 bedrooms, 2 double and 2 single beds and a smaller bed density.

The number of children respondents had was related to differing levels of poor-mental health. Those respondents who had an average of more than 4 children - (living in the household, 5-15 years) were at greater risk of experiencing poor-mental health, than respondents with fewer children. The number of children respondents had seemed indirectly related to crowded/uncrowded housing conditions.

Relatively few respondents reported that their housing conditions were crowded. Those who did, reported significant levels of high stress. However, during the course of the interview I discovered that there were many more households than was reported. This might have been due to the respondent's unwillingness to reveal his relative poverty or his genuine belief that his/her home wasn't crowded. It is probable that by admitting that their homes were crowded, respondents would be implying that they were incapable of
managing their domestic affairs; for example, having more children than they can house, or too poor to improve their housing conditions.

It is fairly common, especially among the working classes, to find that in a large family, one or more of the younger children sleep at a relative, e.g., grandmother or aunt. This helps to relieve the 'bed space' problem.

It is therefore probable that some of the respondents whose housing conditions appeared crowded, adopted this method of relieving the accommodation situation.
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CHAPTER 19

SOCIAL FACTORS

- HIGH ASPIRATIONS/SOCIAL MOBILITY.

- RELIGION.
Social Mobility

Social striving/high aspirations have been shown to be implicated in mental disorder (Kantoe, 1965a; Hutchinson, 1962). The debate about the role of social mobility centres around two hypotheses; social causation and social selection (Dunham, 1961; Dohrenwend and Dohrenwend, 1966). An index of social mobility was constructed from questions which were concerned with the respondents' occupational status over time. The questions were:

1) What was your first occupation?
2) What is your present occupation?
3) What is/was your father's occupation?

It was hypothesised that:

1) Respondents whose first and present occupation has remained manual experience poor mental health.
2) Respondents who are upwardly mobile are more likely to report a higher level of poor mental health than those who are downwardly mobile.
3) Respondents whose first job was manual reported a higher level of poor mental health than those whose first job was non-manual.

Mobility was measured at two levels. The 'first level' compared respondent's first occupation with his present occupation. The 'second level' compared respondent's present occupation with his father's occupation (intergenerational mobility).

Findings - 'First Level'

Most of the respondents reported that their first job was unskilled or semi-skilled. Twenty five percent of the sample contained respondents whose first occupation was teaching, nursing, civil service employment or some other white collar occupation.
It was noted that those respondents whose first job was manual/unskilled reported more stress (.255) and psychological disturbance (.303 with total IQ) than those whose first job was non-manual-white collar.

Another association was found between social mobility and poor mental health. Those respondents whose occupational status remained unchanged (first job versus present job) and those who were downward mobile recorded higher levels of stress (.314) and psychological disturbance (.303 with total IQ); symptom scales, phob. (r = -.254) and (+.221), som. (r = -.223) and (+.279) and hys. (+.273) than those who were upward mobile (See Table 1).

Second Stage

No relationship was found between 'second stage' social mobility (present occupation versus father's occupation) and stress. However, an association was observed between 'second stage' social mobility and psychological disturbance (.333 with total MHQ). The nature of the difference indicated that those respondents who were downwardly mobile reported a higher level of poor mental health than those who were upwardly mobile. Further analysis showed that the scores of poor mental health, for the downwardly mobile respondents were higher for those respondents whose fathers were in skilled professional occupations than for those whose fathers were in manual/semi-skilled occupations. In addition, upward mobile respondents whose fathers were in manual/semi-skilled occupations, reported higher scores of poor mental health than those fathers who were in skilled/professional occupations.
The only other significant pattern to appear, reflect an interaction between sex and occupational mobility. Males who were upwardly mobile show higher stress (.393) and psychological disturbance scores (.360 with total MHO) than upward mobile females. This suggests that the experience of upward mobility in the stratification system may serve to shield women from the otherwise more stressful life situations to which they are exposed.

The observed interaction between sex and occupational mobility may be particular to the Caribbean, Latin America and similar pre-industrial stratification systems where women are traditionally ascribed a low position in the status hierarchy (Pescalello, 1973).

Since women are generally denied opportunities for status achievement, their definition of self is highly dependent upon conditions established in the family of orientation. The relatively few women who are upward mobile through their own occupational efforts may demonstrate to themselves and others, an ability to cope with the formidable task of improving their life chances without reliance on a male (father or husband).

Women who are downward mobile, are likely to feel a sense of status loss with no realistic hope of regaining a position, comparable to that of the family of orientation.

Thus data suggest that while social mobility may be more stressful for men, the level of status achievement is a much more important determinant of psychological adjustment.

Conclusion

The findings from this section must be interpreted cautiously. The most intriguing results involved sex differences and their interaction with occupational mobility, the relatively small number of upwardly mobile "high achievers" in the sample precludes more extensive examination of these relationships.
With these cautions in mind the data in this section can be interpreted as partially supportive of the contention that social mobility is implicated in poor mental health.

Respondents whose first job was manual reported a higher level of psychological disturbance than those whose first job was skilled/non-manual. This difference is probably due to the social status of the occupation. A social stigma is attached to manual jobs. Manual jobs indicate failure, while white collar jobs infer that the occupant has acquired some level of educational attainment. White collar jobs are seen as pathways to upward social mobility and respectability. This view was best illustrated, about eighty years ago, when Barbadians refused to cut sugar-cane. Cane cutting as regarded as a 'hard' dirty job; everyone wanted a job that didn't involve hard/heavy physical labour. Foreign labour, mainly St. Lucians and Vincentians were employed. However, after an extensive 'resocialisation' programme cane-cutting was once more done by Barbadians.

The relationship between upward/downward mobility and poor mental health is not very clear cut. Those respondents who experienced a high level of poor mental health were the 'high achievers' while an intermediate or moderate level of poor mental health was found for those who had stable upper class patterns. The lowest level of poor mental health was evident for respondents who achieved upper status occupations compared to their father's. Those respondents with a lower social status than their father's recorded the highest level of poor mental health. This data suggests that both present status and social mobility have an influence on poor mental health.
Religion

Seventy-one of the respondents had a religious affiliation, and 29 reported having none. The breakdown was as follows.

Table V Religious Affiliation

<table>
<thead>
<tr>
<th>Religious Affiliation</th>
<th>Count</th>
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<tbody>
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<td>Methodist</td>
<td>14</td>
</tr>
<tr>
<td>Baptist</td>
<td>4</td>
</tr>
<tr>
<td>Pentecostal</td>
<td>3</td>
</tr>
<tr>
<td>Jehovah Witness</td>
<td>11</td>
</tr>
<tr>
<td>Seventh Day Adventist</td>
<td>2</td>
</tr>
<tr>
<td>Roman Catholic</td>
<td>4</td>
</tr>
<tr>
<td>Church of England</td>
<td>32</td>
</tr>
<tr>
<td>None</td>
<td>29</td>
</tr>
<tr>
<td>Other (Pilgrim Holiness)</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Of those respondents with a religion, 34 persons attended church frequently (at least once a week); of these 31 persons attended church during the week - excluding Saturdays and Sundays. This indicated a serious attachment to the religion. See Table VI below.

Table VI Frequency of Church Attendance

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequently (Wkly)</td>
<td>34</td>
</tr>
<tr>
<td>Occasionally (Mthly)</td>
<td>15</td>
</tr>
<tr>
<td>Rarely</td>
<td>10</td>
</tr>
<tr>
<td>Never</td>
<td>12</td>
</tr>
</tbody>
</table>
Findings with Respect to Religious Affiliation.

Stress and Psychological Disturbance.

The ETA test showed a relationship between religiosity and poor-mental health. Respondents who were members of "conformist" churches - Anglican and Roman Catholic - reported more stress (.284) and psychological disturbance (.348) than those respondents who were members of non-conformist churches, for example, Methodist, Baptist and Seventh Day Adventist. Further, respondents who rarely or never attended church recorded a high level of psychological disturbance in 4 of the symptom sub-scales, FFA (.400), Phob. (.249), Dep. (.218) and Hys. (.339) of the M.H.Q. (See Table 1)

Sex Differences.

More females than males attended church regularly. Although men showed an interest in church, they were not as zealous as women. Of the 31 respondents who attended church during the week, 21 were females.

From my observation of church attendance of revivalist sects, I have noticed that more females than males attend. Women tend to become more ecstatic and emotionally involved in the sermon than men do, perhaps acting out their anxiety and tensions, either by screaming, rolling on the floor or going into temporary trances.
Discussion

As we noted in Table II, 34 respondents attended church frequently - at least once a week. Of those who attended church regularly, 31 persons attended midweek church services (e.g. prayer meetings). This represents a fairly high level of religious adherence.

My findings have shown that respondents who attended non-conformist churches experience less stress and psychological disturbance than respondents who were members of orthodox churches (e.g. Church of England).

Members of non-conformist churches tend to take their religion more seriously than persons who belong to orthodox churches. Midweek church service is one of the features of non-conformist churches. Non-attendance by church members is usually regarded by the minister or preacher as a sign of weak religious commitment - members not prepared to sacrifice time and study for the work of God.

The difference between non-conformist and conformist church goers is probably due to the level of religious commitment. Non-conformist church goers use the medium of fellowship to release anxieties, tensions and to seek supplication from God in their daily struggle against social, economic and spiritual trials. The church performs a psychotherapeutic role - praying to God and communing with other members - acting as a mediating factor between the church goer and his stress.

It is possible too, that frequent church attendance represents psychological incorporation with group structures which protect mental health in a general way. It could be too, that those with good mental health are able to make such commitment, while those with poor mental health remain affiliated to marginal churches, or those with a more impersonal type of social organisation. Directions of cause are complex and difficult to elucidate.
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Srole, L., Langner, T.S.,
Michael, S.T., Opler, M.
and Rennie, T.
PART 5

COMPARISONS OF STRESSFUL LIFE EVENTS AND PSYCHOLOGICAL DISTURBANCE IN U.K. AND BA BARBADIANS
CHAPTER 20

STRESS AND SOME RELATED ASPECTS

- SEX DIFFERENCES IN RESPONSE TO THE STRESS INVENTORY - U.K. BARBADIANS.

- SEX DIFFERENCES IN RESPONSE TO STRESS INVENTORY - BARBADIANS IN BARBADOS.
CHAPTER 26

STRESS AND SOME RELATED ASPECTS

My focus is on the role of environmentally induced stress with respect to whether stressful events are important in the causation of psychopathology in the general population; the best evidence comes not from epidemiological studies of communities but rather from studies of individuals of groups under extraordinary conditions, e.g. war.

Despite the infrequency of such disasters, like famines, floods and wars, we know from epidemiological studies - summarised in Table I that psychopathology is not rare in the general population.

Table I

<table>
<thead>
<tr>
<th>Type of disorder</th>
<th>Median Proportion</th>
<th>Range</th>
<th>No. of studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>0.76%</td>
<td>0.0023-1.96</td>
<td>17</td>
</tr>
<tr>
<td>Affective psychosis</td>
<td>0.43%</td>
<td>0.0000-1.59</td>
<td>12</td>
</tr>
<tr>
<td>Neurosis</td>
<td>5.95%</td>
<td>0.305-75.0 (b)</td>
<td>25</td>
</tr>
<tr>
<td>Personality disorder</td>
<td>4.19%</td>
<td>0.23-14.5</td>
<td>19</td>
</tr>
<tr>
<td>Disorder</td>
<td>14.05%</td>
<td>1.25-63.5</td>
<td>27</td>
</tr>
<tr>
<td>Demoralisation</td>
<td>27.5%</td>
<td>3.4-69.0</td>
<td>17</td>
</tr>
</tbody>
</table>

Notes:
(a) Note that all percentages are adjusted for sex differences except for rates of 'demoralisation.'
(b) Includes Stirling County Study "Symptom Patterns" that are not necessarily considered 'cases' in the study.

Table I is taken from 'Stress and Mental Disorder,' J.E. Barnet et al 1979.

If stressful events play an important part in psychotherapy, then one can hypothesise that different events are involved for different people and that various combinations of events play a part.

This proposition has been investigated by various researchers, for both physical and psychological illness, (Dohrenwend, B.S. and Dohrenwend, B.P. 1974; Gunderson, E.K. and Rahe, R.H. 1974).

At this point, reference to a general paradigm of the stress response, which Selye (1956) formulated and translated into social and psychological terms by Dohrenwend, B.P. (1961) will help clarify the matter.

(See Figure I below).

The paradigm consists of four main elements.

(a) An antecedent stressor,
(b) conditioning or mediating factors,
(c) the general adaptation syndrome of non-specific, physical and chemical changes, indicating the intervening state of stress in an organism over time,
(d) consequent adaptive or maladaptive responses.

(See Figure I below).
With regard to the antecedent factors producing stress, Dohrenwend (1961) cites two extremes. At one end there is the average person in the community who suddenly experiences a pathogenic triad of stresses composed of fateful loss, physical illness and injury, and other events which severely disrupt social supports and leads to psychopathology. At the other extreme there is the chronic, psychiatric patient. For him stresses are contingent upon his own actions and are directly part of the process of re-admission. Fontanna, et al (1972) view these stresses not as antecedents but as the patient's attempt to cope with the onset of disorder, by behaving in such a way as to ensure hospitalisation.

In describing the organism's reaction to stress, Jenkins (1979) notes that, "the stage of alarm is characterised by acute rises in anxiety and fear if the stressor is a threat, or by rises in sorrow and depression if the stressor is a loss. If the stressor is particularly acute and potent, a brief state of shock or feeling confused may occur. Many of these are self correcting if the noxious stimulus is only of brief duration. If it continues the organism will move to a stage of resistance in which a variety of defences are called into play. If a person's perceptual defences, ego defences, and problem solving behaviours are adequate to overcome/escape the noxious situation, no psychiatric symptomatology of a continuing nature will develop. If the noxious stimuli are so strong as to overwhelm defences a 'pathological end-state' results."

Only a small proportion of the general population experienced highly pathological events, (Dohrenwend, B.S. and Dohrenwend, B.F.; Krasnoff, L and Adkenasy, A.R. 1978).

It is the intermediate range between these two extremes, in which the majority of the general population will be experiencing stressful life events over a given period of time. These events may or may not result in psychopathology.
It is here that modifying factors interact with life events in determining physical or psychological responses.

Why is it that among those exposed to a common stress some defend successfully, with minimal effort while others are unable to build effective defences? The answer lies partly in the different challenges or stresses, and capacities of individuals.

The three main aspects of the individual's adaptive capacity are at the (1) biological or physical level; that is, natural or acquired immunity against stress, (2) psychological level, ego strength, problem solving ability, flexibility and social skills. Mo Farlane et al (1980) reporting on a longitudinal study conducted in Ontario, Canada, observed that an important factor in determining whether stressful events will have an adverse affect on an individual depends on the individual's perception of not being in control. Mo Farlane et al (1980) further noted that a person's perception of not being in control "appears to fortify the impact of undesirable events, and the absence of either control or anticipation appears to strengthen the disruptive influence of desirable events." It would seem that a person's ability to influence undesirable events leads to feelings of helplessness and discouragement or to a state of giving-up, described by Schmale, (1958).

(3) interpersonal level, the adaptive capacity of the individual is raised by positive primary relationships and one's network of social supports. These levels of adaptive capacity may be thought as 'coping resources.' I would hypothesise that persons with a strong array of coping resources are less likely to have noxious circumstances/stressful life events/changes override their defences and lead to pathological end-states of a somatic or psychological/psychiatric form.
A comprehensive view of human health and illness requires us to consider the many levels on which human life is lived. Almost all interactions of people with their environment have, (1) interpersonal, (2) socio-cultural, (3) biological and (4) psychological implications. A multi-level approach is particularly useful in the study of stress and mental ill health. Among many possible examples, consider that, (a) stresses on the interpersonal level usually create anxiety at the psychological level; and (b) inadequacies or reactive defences at the socio-cultural level can foster a development of pathology in biological functioning, (Jenkins, C.D. 1978; Weinblatt, E.; Ruberman, W. Goldberg, J. Shaparœ, S. and Chaudhary, B. 1978).

The Role Of Modifying Factors In Stressful Life Events

As stated earlier, it is not merely the life event that causes stress, but rather the socio-psychological and physical environment of the recipient. At the onset, the event itself may be regarded as incorporating modifying factors. What appears to be the same event may differ in circumstances and may cause a variety of implications. Other stresses and supports in the social environment may modify the consequences. These would include external and internal mediating factors, such as; confiding relationships, several young children in the home, and lower class, (Brown et al, 1979), family support (Caplan, 1976) and psychological and physical constitution.

Chronic stressors may sometimes have a modifying effect and sometimes act like new events. For example, the high tolerance level of poor Blacks in the Southern States of America, towards poverty, is functional in helping them to cope with other related life events. They may come to see any additional suffering - or stressful life events - as just another harsh life situation which they must live with. We must therefore assume a large number of
There may be personality factors leading to greater vulnerability to events in general. There may be specific vulnerabilities e.g. depressive personality - a particular sensitivity to events involving major changes in life patterns and routine. Such vulnerabilities may be genetic or environmental in origin. All earlier life events may be seen as having influence to a greater or lesser degree, both pathogenic and protective in the learning of coping behaviour. There is a great deal of meaning in the often used saying, "once bitten, twice shy" - learning from one's mistakes.

The role of modifying factors in the stressor - illness model - is diagrammatically illustrated in Figure II (Paykel, 1978).

An aspect of stressful life events which is often overlooked is the relationship between life changes. The hypothesis is that deleterious life changes are capable of producing stresses which can, in turn lead to other life changes and stress. This process could be called "stress acceleration."

For example, the loss of a job, may lead to financial disruption, marital strains and possibly the break up of the family; as well as loss of friendships which were formed at work. In this formulation the more undesirable the life change, the greater the possibility of additional life changes - or stressors.

This process of "stress acceleration" which can be observed in the life of an individual, should not be confused with what Brenner (1971) called the 'multiplier effect of an individual's stress upon those of another.' For example, the effect on the entire family, of the financial and status loss of a head of the household.

It is possible that all life changes, whether inherently agreeable or disagreeable, may possess undesirable features. An example of agreeable cases are, the birth of a child, marriage and job promotion; each of these life changes may involve substantially increased responsibilities. For those
Figure II

Modifying factors between event and illness

Event

↓

Social support and stressor.

↓

Vulnerability to events

↓

Specific illness vulnerability

↓

Treatment seeking factors

↓

Specific treated illness.

Event

↓

Exact nature, preparation, threat, symbolic significance, undesirability.

Social support and stressor.

↓

Confiding relationships, supportive spouse, parents, friends, good finances and employment.

Vulnerability to events

↓

Personality, vulnerability overall and to specific events, defences, coping mechanisms, previous experience of events.

Specific illness vulnerability

↓

Genetic or environmental vulnerability to specific illness, other pathogens, early illness processes, biological mechanisms. Habitual psychological reaction patterns. Cultural conditioning and model of behaviour and coping style.

Treatment seeking factors

↓

Illness behaviour; referral patterns.

Source: S. Paykel - Causal relationship between clinical depression and life events.
individuals who are unprepared for such responsibilities, desirable life changes may become stressful. In general, then, probably all desirable life changes are potentially stressful to the extent that they may carry the risk of role failure. If this is the case, they are in fact undesirable.

Given my focus on the role of socio-environmental factors, it is necessary for me to ask such questions as: What kinds of life events and in what combinations, are causally associated with heightened levels of anxiety related illnesses?

As Dohrenwend, B.S. (1973) wisely cautioned, the problem of examining life events in the intermediate range, together with their relationship to internal and external mediating factors is complex. Bearing in mind the difficulty of the task that lies ahead, I will attempt to analyse what kind of life events are causally associated with stress, for respondents in my study, by examining stressful life changes as reported on the Life Event Inventory. I shall first analyse, life events reported by U.K. Barbadians.
Sex differences in response to Stress Inventory - U.K. Barbadians

**Male Respondents**

Forty-five male respondents experienced one or more of 33 stressful life events. The items most frequently reported were:

<table>
<thead>
<tr>
<th>No. of times Reported</th>
<th>Weights of S.R.E.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Change in hours or condition</strong></td>
<td></td>
</tr>
<tr>
<td>of present job.</td>
<td>9</td>
</tr>
<tr>
<td>Income increase substantially by 25%</td>
<td>38</td>
</tr>
<tr>
<td>Death of an immediate family member.</td>
<td>10</td>
</tr>
<tr>
<td>Death of a close friend.</td>
<td>8</td>
</tr>
</tbody>
</table>

Some items, which were only moderately reported included:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Breakup with steady boy or girlfriend.</td>
<td>7</td>
</tr>
<tr>
<td>Income decrease by 25%</td>
<td>5</td>
</tr>
<tr>
<td>Unemployment (of head of household)</td>
<td>5</td>
</tr>
<tr>
<td>New neighbours.</td>
<td>5</td>
</tr>
<tr>
<td>Involvement in fight.</td>
<td>5</td>
</tr>
<tr>
<td>Increase in the number of arguments with other family member (e.g., children)</td>
<td>5</td>
</tr>
<tr>
<td>Son or daughter left home.</td>
<td>5</td>
</tr>
</tbody>
</table>

Thirty-eight of the 50 respondents said that they had increased their personal income by at least 25%. This rapid economic growth might on the surface appear as inherently desirable, but as Brenner (1973) has shown, increases in incomes are usually associated with job promotion, marriage, higher birth rates, and greater consumption demands. Nearly all of these changes involve anxieties over fulfillment of responsibilities or demands. For a
certain proportion of persons who are anxious these changes may be undesirable. Abrupt economic changes regardless of direction can be stress provoking. A recent article in the Observer Newspaper of February 1980, discussing suicide in California, noted that suicide among the children of wealthy blacks was higher than among children of poor blacks in New York. Desirable changes, whether measured in terms of increases in income or other social indices of success, can be undesirable.

However undesirable, changes such as unemployment, income loss, death of a family member or close friend are substantially more generative of pathology. The important point here is, that undesirable changes can lead to a loss of roles - in the case of unemployment or income loss - and a severe disruption in the individual's social bonds and social support network - in the case of death.

**Female Respondents**

All of the female respondents (50 individuals) reported 36 of the 48 stress items. The items most frequently reported were as follows:

<table>
<thead>
<tr>
<th>Item</th>
<th>No. of times reported</th>
<th>Weights of S.R.E.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarrel with neighbours.</td>
<td>14</td>
<td>26</td>
</tr>
<tr>
<td>Income increase substantially (25%).</td>
<td>13</td>
<td>35</td>
</tr>
<tr>
<td>Income decreased substantially (25%).</td>
<td>15</td>
<td>62</td>
</tr>
<tr>
<td>Death of a close friend.</td>
<td>10</td>
<td>55</td>
</tr>
<tr>
<td>Immediate family member seriously ill.</td>
<td>13</td>
<td>59</td>
</tr>
<tr>
<td>Increase in the number of arguments with spouse</td>
<td>10</td>
<td>55</td>
</tr>
</tbody>
</table>

Eighty-eight respondents experienced changes in their incomes. A large number of respondents (14 - or 28%) quarrelled with their neighbours. An even
larger number of respondents (30 or 60%) reported having some association with serious illness and death:— death of a close friend (10), death of an immediate family member (7) and immediate family member seriously ill.

Here I will discuss three life events which were most frequently reported by the respondents, these are; income decrease substantially, quarrel with neighbours and close association with serious illness and death. I have omitted any discussion on income increase, because it would replicate what was said for male respondents.

Analysis Of Female Data – Life Events

Quarrel with neighbours

Fourteen of the female respondents quarrelled with their neighbours. Despite the low weight (26) given to this event, many of the female respondents found a dispute between themselves and their neighbours stressful. After the formal interviewing was finished, most of the respondents entered into a conversation about their living and working experience in England. On such occasions the disharmony between neighbours — irrespective of race, colour or class — would be mentioned. The disharmony was more stressful if both neighbours had children. The children were often drawn into the dispute by parents not allowing them to visit each other. There were cases in which the respondents allowed their children to play with the neighbours' children, even though there was a dispute between parents, on these cases the neighbours were black.

Quarrels between neighbours have consequences for the respondents social interaction with the other families in the immediate area. Such quarrels invariably led to a 'coolness' between families. Interestingly men rarely entered into such disputes or were the instigators of them. It was predominantly a female preserve.
A bad economic climate in Britain effects females in the job market worse than it does males.

In Reading most of the immigrant women are employed in light industries or/and hospital services. Most of the females are married and some single respondents are in part-time employment, either because they cannot find full-time employment or because family demands are too great. Table 2 shows a breakdown of the number of female respondents employed and the nature of the employment.

<table>
<thead>
<tr>
<th>Nature of Employment</th>
<th>No. Employed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full-time</td>
<td>21</td>
</tr>
<tr>
<td>Part-time</td>
<td>15</td>
</tr>
<tr>
<td>Do Not Work</td>
<td>14</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>50</strong></td>
</tr>
</tbody>
</table>

More than half of the female respondents admitted having changed from full-time to part-time jobs. They cited redundancy at their place of work as the most frequent cause.

For those women in part-time employment and especially those unemployed a decrease or loss of income effects them both economically and psychologically. A drop in income and/or the loss of a job means that they are more dependent on their husband's income to purchase personal items and household goods. Female respondents found this a very stressful period, a time when they become bored and easily irritated. All the respondents - those in part-time but
especially those unemployed, including full-time housewives - said how bored, miserable and dependent they felt being at home. They were all eager to be gainfully employed.

The respondents admitted further, that these feelings often led to disputes between their spouse and other family members. Incidents which they would overlook normally, became major issues. They felt unable to control these outbursts.

**Association With Illness And Death**

A point of controversy in the life events literature is the question of what type of events are most stressful or what aspects of events make them stressful. A key dimension in life events is the undesirable or threatening character. A number of recent studies illustrate the significance of undesirable events (Paykel, 1978; Mueller et al, 1977; Gertsen et al, 1974 and Vinokur and Selzer, 1975). These studies have found that undesirable events are linked with psychiatric symptoms or disorders.

Thirty of the female respondents were closely associated with 'serious illness and death' - 'death of immediate family member' (7), 'death of a close friend' (10), and 'immediate family member seriously ill' (13). These events are generally considered to be undesirable and stressful.

Paykel, (1978) found that undesirable events showing the strongest relationship to depression, involved exits from the social field (e.g. death of a close family member or friend, separation, family member leaves home). He estimated that the risk of developing depression for persons experiencing such exits from events was six and one-half times the normal rate. He further noted that the majority of events capable of provoking onset of depression involved a loss. Losses in Brown's (1978) terms are quite similar to exits, and generally involve reductions in social bonds and social networks relationships.
Serious illness of a family member, like death, entails a loss and a severe disruption of personal role and network activity. The stressfulness of the events is closely tied to the degree of disruption it causes in social network.

Serious illness can lead to a loss of income, disruption in role performance vis-a-vis other family members, increased expenditure in treating malady and emotional distress for family members and friends.

However, undesirable events (e.g. death of an immediate family member) may not be as pathologically damaging as one might suppose; it depends on how independent or dependent one's network relationship are.

The bereavement literature emphasises the importance of supportive relationships in overcrowding the crisis of death (Mc Kinlay, 1972). As Neuller (1980, p. 187) reminded us, "the degree to which network disruption can be absorbed without psychological damage to the focal individual, may be dependent in large on the availability of adequate substitutes for the disrupted or lost relationship(s)."

Further analysis of the stress inventory reveals that the stress items female U.K. Barbadians recorded most frequently were significantly more dissimilar than male stress events, (See Table 3). These are:

<table>
<thead>
<tr>
<th>No.</th>
<th>Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>Quarrel with neighbours.</td>
</tr>
<tr>
<td>13</td>
<td>Income decrease substantially by 25%.</td>
</tr>
<tr>
<td>24</td>
<td>Immediate family member seriously ill.</td>
</tr>
<tr>
<td>34</td>
<td>Increase in the number of arguments with spouse.</td>
</tr>
<tr>
<td>39</td>
<td>Trouble or behaviour problems with own children.</td>
</tr>
</tbody>
</table>
Male respondents recorded fewer dissimilar events. These are:

<table>
<thead>
<tr>
<th>No.</th>
<th>Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>Income increase substantially by 25%</td>
</tr>
<tr>
<td>18</td>
<td>Involvement in fight</td>
</tr>
</tbody>
</table>
## Table 3 U.K. Barbadian Males and Females

### Breakdown Of Stress Inventory By Sex - Male/Female N = 100

**Part I (Ask Everybody)**

<table>
<thead>
<tr>
<th>No.</th>
<th>Item</th>
<th>No. Reporting</th>
<th>Weight of Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Unemployment (of head of household)</td>
<td>M: 5 F: 7</td>
<td>68</td>
</tr>
<tr>
<td>2.</td>
<td>Trouble with superiors at work.</td>
<td>M: 2 F: 1</td>
<td>40</td>
</tr>
<tr>
<td>3.</td>
<td>New job in same line of work.</td>
<td>M: 0 F: 3</td>
<td>31</td>
</tr>
<tr>
<td>4.</td>
<td>New job in new line of work.</td>
<td>M: 2 F: 3</td>
<td>46</td>
</tr>
<tr>
<td>5.</td>
<td>Change in hours or conditions in present job.</td>
<td>M: 9 F: 8</td>
<td>31</td>
</tr>
<tr>
<td>6.</td>
<td>Promotion or change of responsibilities at work.</td>
<td>M: 0 F: 1</td>
<td>39</td>
</tr>
<tr>
<td>7.</td>
<td>Retirement.</td>
<td>M: 0 F: 1</td>
<td>54</td>
</tr>
<tr>
<td>8.</td>
<td>Moving house.</td>
<td>M: 0 F: 1</td>
<td>42</td>
</tr>
<tr>
<td>10.</td>
<td>New neighbours.</td>
<td>M: 5 F: 8</td>
<td>18</td>
</tr>
<tr>
<td>11.</td>
<td>Quarrel with neighbours.</td>
<td>M: 2 F: 14*</td>
<td>26</td>
</tr>
<tr>
<td>12.</td>
<td>Income increased substantially (25%).</td>
<td>M: 38* F: 13</td>
<td>35</td>
</tr>
<tr>
<td>13.</td>
<td>Income decreased substantially (25%).</td>
<td>M: 5 F: 15*</td>
<td>62</td>
</tr>
<tr>
<td>15.</td>
<td>Going on holiday.</td>
<td>M: 4 F: 8</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>Event</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>---</td>
<td>----------------------------------------------------------------------</td>
<td>-----------</td>
<td>------------</td>
</tr>
<tr>
<td>16.</td>
<td>Conviction for minor violation (e.g. speeding or drunkenness)</td>
<td>0 0 34</td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td>Jail sentence</td>
<td>2 0 75</td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td>Involvement in fight</td>
<td>5 0 38</td>
<td></td>
</tr>
<tr>
<td>19.</td>
<td>Immediate family member sent to prison</td>
<td>4 5 61</td>
<td></td>
</tr>
<tr>
<td>20.</td>
<td>Death of immediate family member</td>
<td>10 7 69</td>
<td></td>
</tr>
<tr>
<td>21.</td>
<td>Death of a close friend</td>
<td>8 10 55</td>
<td></td>
</tr>
<tr>
<td>22.</td>
<td>Immediate family member seriously ill</td>
<td>4 13 59</td>
<td></td>
</tr>
<tr>
<td>23.</td>
<td>Gain of new family (immediate)</td>
<td>2 4 43</td>
<td></td>
</tr>
<tr>
<td>24.</td>
<td>Serious restriction of social life</td>
<td>4 5 49</td>
<td></td>
</tr>
<tr>
<td>25.</td>
<td>Period of homelessness (hostel or sleeping rough)</td>
<td>2 0 51</td>
<td></td>
</tr>
<tr>
<td>26.</td>
<td>Serious physical illness or injury requiring hospital treatment</td>
<td>1 2 65</td>
<td></td>
</tr>
<tr>
<td>27.</td>
<td>Prolonged ill health requiring treatment by own doctor</td>
<td>4 6 48</td>
<td></td>
</tr>
<tr>
<td>28.</td>
<td>Sudden and serious impairment of vision or hearing</td>
<td>1 3 59</td>
<td></td>
</tr>
</tbody>
</table>

**Section II. Ask those who have been married**

<table>
<thead>
<tr>
<th></th>
<th>Event</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>32.</td>
<td>Marriage</td>
<td>0 1 50</td>
<td></td>
</tr>
<tr>
<td>33.</td>
<td>Pregnancy (or of wife)</td>
<td>0 2 49</td>
<td></td>
</tr>
<tr>
<td>34.</td>
<td>Increase in the number of arguments with spouse</td>
<td>3 10 55</td>
<td></td>
</tr>
<tr>
<td>35.</td>
<td>Increase in the number of arguments with other family members (e.g. children)</td>
<td>5 8 43</td>
<td></td>
</tr>
<tr>
<td>36.</td>
<td>Trouble with other relatives (e.g. in-laws)</td>
<td>0 2 38</td>
<td></td>
</tr>
<tr>
<td>37.</td>
<td>Son or daughter left home</td>
<td>5 4 44</td>
<td></td>
</tr>
<tr>
<td>38.</td>
<td>Separated from wife, husband or children</td>
<td>2 0 54</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>39.</td>
<td>Trouble or behaviour problems in own children.</td>
<td>2</td>
<td>9x</td>
</tr>
<tr>
<td>41.</td>
<td>Divorce.</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>42.</td>
<td>Marital separation.</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>43.</td>
<td>Marital reconciliation</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>44.</td>
<td>Wife begins or stops work.</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

Section III. Ask those who have never been married

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>45.</td>
<td>Break up with steady boy or girl friend.</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>46.</td>
<td>Problems related to sexual relationship.</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>47.</td>
<td>Increase in number of family arguments (e.g. with parents).</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

Total number of items reported. 33 36
Sex Differences in Respondents to Stress Inventory - BA Barbadians

Male Respondents

Forty-three male respondents experienced one or more of 20 stressful life events (See Table 4). Seven respondents experienced no stressful events. The most frequently reported events were:

Table 4

<table>
<thead>
<tr>
<th>Event</th>
<th>No. of times reported</th>
<th>Weight of SRE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate family member starts drinking</td>
<td>20</td>
<td>65</td>
</tr>
<tr>
<td>Income substantially increased (25%)</td>
<td>17</td>
<td>35</td>
</tr>
<tr>
<td>Death of an immediate family member</td>
<td>9</td>
<td>69</td>
</tr>
</tbody>
</table>

Other items only moderately reported were:

<table>
<thead>
<tr>
<th>Event</th>
<th>No. of times reported</th>
<th>Weight of SRE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income substantially decreased (25%)</td>
<td>5</td>
<td>62</td>
</tr>
<tr>
<td>Prolonged ill health requiring treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>by own doctor</td>
<td>4</td>
<td>48</td>
</tr>
<tr>
<td>Increase in number of arguments with spouse</td>
<td>2</td>
<td>55</td>
</tr>
</tbody>
</table>

During my period of research in Barbados, 1977-78, various personal observations were made. Many of these observations assisted in explaining the occurrence of stress in the population. Let us consider the most frequently reported stress items.

(1) Heavy drinking has recently become a cause for concern for both families and government health officials. This has resulted in various government sponsored educational programmes, designed to inform the public of the social and physical consequences of alcohol consumption. For many years the consumption of rum has been a commonplace, but in the last ten years the heavy consumption of alcohol has given rise to many problems, for example, families appear to experience increased disruptions.
Further heavy drinking is stress related from two aspects.
(a) Individuals may drink to relieve stress caused by boredom, unemployment, poverty and frustration resulting from unfulfilled goals.
(b) Heavy drinking is very likely to produce stress, by disrupting family relations, and other social networks.

(2) Income increase was the second most frequently reported stressful event. A substantial increase in income can produce stress for individuals. An income increase usually results in greater purchasing power. Individuals are better able to purchase various consumer durables and other items they always wanted. Purchasing such items may involve heavy repayments or major alterations in life style, thereby resulting in additional stress to the individual.

This analysis is pertinent to Barbadian society which has become very competitive with individuals striving towards goals in a climate of limited opportunity under pressure to show an improvement in their standard of living.
Several factors appear to be responsible for this development. One of these factors is a change in the drinking habits of Barbadians - instead of drinking mainly rum, more people are able to purchase a wider range of alcoholic beverages, for example, whisky, gin, vodka, etc.
Everyone is caught up in purchasing a property, a car or indulging in expensive consumption, in order to 'keep up' with others around them. This appears to be one of the major contributors to stress in Barbados, and one which may particularly affect the upward mobile.

(3) Death of an immediate family member was the third most frequently reported stressful event. Here, a fateful loss brings about its effect at least in part, through constriction or alteration of the social network; since bereavement of a loved one certainly is a disruption of the network. For those respondents who depend heavily on the financial and emotional support of extended family, disruption of the social network, caused by a death has considerable consequences. I was reminded of this by a respondent who had recently buried his grandmother. Still in a bereaved state, he said:

"When that old lady died, I almost died. I don't know how I managed to be standing here. She was everything to me. She looked after me from the time I was four years old, until she died. It was the greatest loss I have ever had. I don't know how I am going to manage without her. I feel so weak and down, that I don't even want to eat. These days I don't feel like doing anything."

Here, bereavement threatens to overwhelm the internal and external protective factors exposing the respondent to an episode of poor mental health. Although not yet fully investigated the above observations constitute future interesting research into social change in the Barbadian society.

Female Respondents

Forty female respondents reported that they experienced one or more of 20 stressful events, (See Table 5). Ten respondents reported no stressful events. The most frequently reported events were: (See Table 6).
Table 5: BA Barbadian male and female

Item analysis of stress Inventory between male and female respondents

<table>
<thead>
<tr>
<th>No.</th>
<th>Item</th>
<th>No. Reporting</th>
<th>Scale of</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>M  F</td>
<td>Item</td>
</tr>
<tr>
<td>1.</td>
<td>Unemployment (of head of household)</td>
<td>5  6</td>
<td>68</td>
</tr>
<tr>
<td>2.</td>
<td>Trouble with supervisor at work.</td>
<td>0  0</td>
<td>40</td>
</tr>
<tr>
<td>3.</td>
<td>New job in same line of work</td>
<td>0  0</td>
<td>31</td>
</tr>
<tr>
<td>4.</td>
<td>New job in new line of work</td>
<td>0  0</td>
<td>46</td>
</tr>
<tr>
<td>5.</td>
<td>Change in hours or conditions in present job.</td>
<td>1  2</td>
<td>31</td>
</tr>
<tr>
<td>6.</td>
<td>Promotion or change or responsibilities at work.</td>
<td>0  0</td>
<td>39</td>
</tr>
<tr>
<td>7.</td>
<td>Retirement</td>
<td>0  0</td>
<td>54</td>
</tr>
<tr>
<td>8.</td>
<td>Moving house</td>
<td>0  0</td>
<td>42</td>
</tr>
<tr>
<td>9.</td>
<td>Purchasing own house (taking out mortgage)</td>
<td>0  0</td>
<td>40</td>
</tr>
<tr>
<td>10.</td>
<td>New neighbours</td>
<td>0  0</td>
<td>18</td>
</tr>
<tr>
<td>11.</td>
<td>Quarrel with neighbours</td>
<td>0  0</td>
<td>26</td>
</tr>
<tr>
<td>12.</td>
<td>Income increased substantially (25%).</td>
<td>17* 4</td>
<td>35</td>
</tr>
<tr>
<td>13.</td>
<td>Income decreased substantially (25%).</td>
<td>5  1</td>
<td>62</td>
</tr>
<tr>
<td>14.</td>
<td>Getting into debt beyond means of payment.</td>
<td>0  0</td>
<td>66</td>
</tr>
<tr>
<td>15.</td>
<td>Going on holiday</td>
<td>0  0</td>
<td>29</td>
</tr>
<tr>
<td>16.</td>
<td>Conviction for minor violation (e.g. speeding or drunkeness)</td>
<td>0  0</td>
<td>34</td>
</tr>
<tr>
<td>17.</td>
<td>Jail sentence</td>
<td>0  1</td>
<td>75</td>
</tr>
<tr>
<td>18.</td>
<td>Involvement in fight</td>
<td>2  0</td>
<td>38</td>
</tr>
<tr>
<td>19.</td>
<td>Immediate family member starts drinking heavily.</td>
<td>20  20</td>
<td>65</td>
</tr>
<tr>
<td>20.</td>
<td>Immediate family member attempts suicide</td>
<td>0  0</td>
<td>66</td>
</tr>
<tr>
<td>21.</td>
<td>Immediate family member sent to prison</td>
<td>0  0</td>
<td>61</td>
</tr>
<tr>
<td>Item</td>
<td>Code</td>
<td>Count</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>------</td>
<td>-------</td>
<td></td>
</tr>
<tr>
<td>22. Death of immediate family member.</td>
<td>9</td>
<td>5</td>
<td>69</td>
</tr>
<tr>
<td>23. Death of a close friend.</td>
<td>7</td>
<td>3</td>
<td>55</td>
</tr>
<tr>
<td>24. Immediate family member seriously ill.</td>
<td>2</td>
<td>6</td>
<td>59</td>
</tr>
<tr>
<td>25. Gain of new family.</td>
<td>1</td>
<td>1</td>
<td>43</td>
</tr>
<tr>
<td>26. Problems related to alcohol or drugs.</td>
<td>2</td>
<td>0</td>
<td>59</td>
</tr>
<tr>
<td>27. Serious restrictions of social life.</td>
<td>2</td>
<td>0</td>
<td>49</td>
</tr>
<tr>
<td>28. Period of homelessness (hostel or sleeping rough).</td>
<td>0</td>
<td>0</td>
<td>51</td>
</tr>
<tr>
<td>29. Serious physical illness or injury requiring hospital treatment.</td>
<td>6</td>
<td>4</td>
<td>65</td>
</tr>
<tr>
<td>30. Prolonged ill health requiring treatment by own doctor.</td>
<td>4</td>
<td>4</td>
<td>48</td>
</tr>
<tr>
<td>31. Sudden and serious impairment of vision or hearing.</td>
<td>0</td>
<td>0</td>
<td>59</td>
</tr>
<tr>
<td>32. Marriage.</td>
<td>1</td>
<td>0</td>
<td>50</td>
</tr>
<tr>
<td>33. Pregnancy.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>34. Increase in number of arguments with spouse.</td>
<td>2</td>
<td>7*</td>
<td>55</td>
</tr>
<tr>
<td>35. Increase in number of arguments with other immediate family members (e.g. children).</td>
<td>3</td>
<td>2</td>
<td>43</td>
</tr>
<tr>
<td>36. Trouble with other relatives (e.g. in-laws).</td>
<td>0</td>
<td>0</td>
<td>38</td>
</tr>
<tr>
<td>37. Son or daughter left home.</td>
<td>0</td>
<td>1</td>
<td>44</td>
</tr>
<tr>
<td>38. Separated from wife, husband or children.</td>
<td>0</td>
<td>0</td>
<td>54</td>
</tr>
<tr>
<td>39. Trouble or behaviour problems in own children.</td>
<td>0</td>
<td>5*</td>
<td>49</td>
</tr>
<tr>
<td>40. Death of spouse.</td>
<td>0</td>
<td>1</td>
<td>86</td>
</tr>
<tr>
<td>41. Divorce.</td>
<td>0</td>
<td>0</td>
<td>75</td>
</tr>
<tr>
<td>42. Marital separation.</td>
<td>0</td>
<td>0</td>
<td>70</td>
</tr>
<tr>
<td>43. Marital reconciliation.</td>
<td>0</td>
<td>0</td>
<td>53</td>
</tr>
<tr>
<td>44. Wife begins or stops work.</td>
<td>0</td>
<td>0</td>
<td>34</td>
</tr>
<tr>
<td>45. Break up with steady boy or girlfriend.</td>
<td>8*</td>
<td>3</td>
<td>51</td>
</tr>
<tr>
<td>46. Problems related to sexual relationships.</td>
<td>0</td>
<td>0</td>
<td>54</td>
</tr>
<tr>
<td>47. Increase in the number of family arguments (e.g. with parents).</td>
<td>5</td>
<td>3</td>
<td>43</td>
</tr>
<tr>
<td>48. Break up of family</td>
<td>0</td>
<td>0</td>
<td>77</td>
</tr>
<tr>
<td>Event</td>
<td>No. of times reported</td>
<td>Weight of SRE</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>-----------------------</td>
<td>---------------</td>
<td></td>
</tr>
<tr>
<td>Immediate family member starts drinking</td>
<td>20</td>
<td>65</td>
<td></td>
</tr>
<tr>
<td>Unemployment (of head of household)</td>
<td>6</td>
<td>68</td>
<td></td>
</tr>
<tr>
<td>Immediate family member seriously ill</td>
<td>6</td>
<td>59</td>
<td></td>
</tr>
<tr>
<td>Increase in number of arguments with spouse</td>
<td>7</td>
<td>55</td>
<td></td>
</tr>
</tbody>
</table>

Most of the other items were moderately reported.

Let us consider 3 of the most frequently reported stressful events.

(1) Heavy drinking by a family member was the most frequently recorded stressful life change reported by females. The sex of heavy drinkers was not recorded. However, from personal observation, it would appear that the majority of heavy drinkers were men.

(2) Family member seriously ill:

Serious illness of a family member/near relative is usually a period of stress for most respondents. Illness disrupts social roles within the family. If the ill member is head of the household (parent) the disruption is even greater. Apart from disrupting roles, illness creates stress because of the family's emotional attachment to the ill relative. Further, there is the uncertainty - depending on the nature of the illness,
Is he/she going to recover? Will his illness be chronic? Will he die? It is the uncertainty, lack of control over recovery, disruption of the social support networks, that creates the greatest element of anxiety and stress for other family members. Such anxieties were expressed by both males and female respondents when discussing sick relatives.

I will now consider some of the more common stressors experienced by most family members in any society, and discuss how they would be managed or coped with in a Barbadian cultural environment.

The stressors for consideration are:

1. Unemployment (of head of household)
2. Death of immediate family member
3. Teenage unmarried family member becomes pregnant.

Unemployment (of head of household)

In most paternalistic western societies, the inability of the main breadwinner to provide for his family, is generally regarded as a potentially stressful situation. Within Barbadian society, such a person although unhappy and frustrated at not being able to work, is supported financially by small subventions from his parents, siblings other relatives and friends. His female partner or spouse, if not fully employed, engages in various home-based
money earning pursuits, for example, making confectionary, dressmaking/smocking and other forms of handicrafts. The earnings from these activities assist the family in meeting some of its daily needs, until the main breadwinner is re-employed. Here the all embracing support mechanism of the extended family protects the main breadwinner and his family from starvation and reduces the level of stress and anxiety caused by being unemployed.

**Death of Immediate Family Member**

The death of a family member is usually a time of grief and acute stress. The level of emotional disturbance is usually due to the important position or role the deceased person held or performed in the family unit. If the deceased person was the mother of young children, then her role vis-a-vis the surviving children is usually taken over by her mother and/or female siblings. The father of the children, whether he is a 'partner' or husband agrees to this arrangement.

Very often the children either go and live with their maternal grand parents or remain in their own home, under the guidance of a female relative. The disciplining of the children is shared between the parent and near relatives of both parents. Here the problem of finding someone to care for and supervise the children is minimised, the socio-psychological disturbance the children would have experienced if placed in an institution or adopted by 'strangers', is considerably reduced.

**Teenage Unmarried Family Member Becomes Pregnant**

Several studies of West Indian family patterns refer to the high illegitimacy rate among people from the Caribbean. What the researchers fail to note, is that illegitimacy is not a problem in West Indian societies, as it probably is in developed industrialised societies.
The unplanned pregnancy of a young Barbadian creates very little anxiety in the family unit. Admittedly there is some degree of shame experienced by both the expectant mother and her parents. Rarely is the expectant daughter asked to leave the parental home. There is usually very little pressure from other siblings and relatives for the expecting daughter to leave home. In cases where the daughter leaves, she is usually housed by a maternal aunt or sympathetic relative living in the same locality; therefore contact with family and other relatives remains unbroken. The support the expectant daughter receives from her primary network relationships (e.g. siblings and near relatives) is functional in reducing stress and anxiety which this new experience produces.

Conclusion

We have identified 7 life events which male B.A. Barbadians have most frequently reported as a cause of stress; while female B.A. Barbadians have reported 4 stressful events.

A closer examination of the Stress Inventory indicates that there is very little significant dissimilarity between the life events recorded by male and female respondents, (See * in Table 5 ). However, female respondents reported more 'domestic problems' - increase in number of arguments with spouse and trouble and behavioural problem - than males.

Comparative Analysis Of Stress Inventory - U.K. and B.A. Barbadians

Most of the events reported by respondents from both samples are socially undesirable and can result in a disruption in the respondent's social network. The relative importance of each item is determined not by the item's desirability, by emotions associated with the item, not by the meaning of the
item for the individual, but rather the amount of disruption to personal social networks and the relationship of this disruption to the onset of poor mental health.

U.K. female Barbadians reported significantly more stressful events (10) than B.A. female Barbadians (1), (See * in Table 7 ). Conversely there was relatively little significant difference in stressful events reported by U.K. and B.A. male Barbadians, (See * in Table 8 ). However, U.K. Barbadians (male/female) reported more socially undesirable events than B.A. Barbadians.

Marital status was noted to have some relationship with stressful life events. U.K. Barbadians who were married reported more stressful events than the unmarried. Not only did married respondents reported more stressful events, but the events were more disruptive of family relationships. For example, more married than unmarried - mainly females - reported the following events.

- Quarrel with neighbours.
- Increase in the number of arguments with spouse.
- Increase in the number of arguments with other immediate family members.
- Behavioural problems with own children.

These events were regarded by over 60% of respondents to be the main cause of strained relationships between family members. During the informal interviews respondents cited arguments with spouse and children as the most stressful.

The events unmarried respondents experienced were of lower stress value, than those reported by married respondents. Unmarried respondents experienced stressful events which centred around arguments with parents and siblings. It would appear from this finding that despite the 'protective nature of marriage' married respondents experienced more stress than unmarried respondents.
<table>
<thead>
<tr>
<th>No.</th>
<th>Item</th>
<th>B.A.</th>
<th>U.K.</th>
<th>Weights of S.R.E.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Unemployment (of head of household)</td>
<td>6</td>
<td>7</td>
<td>68</td>
</tr>
<tr>
<td>2.</td>
<td>Trouble with superiors at work.</td>
<td>0</td>
<td>1</td>
<td>40</td>
</tr>
<tr>
<td>3.</td>
<td>New job in same line of work.</td>
<td>0</td>
<td>3</td>
<td>31</td>
</tr>
<tr>
<td>4.</td>
<td>New job in new line of work.</td>
<td>0</td>
<td>3</td>
<td>46</td>
</tr>
<tr>
<td>5.</td>
<td>Change in hours or conditions in present job.</td>
<td>2</td>
<td>8</td>
<td>31</td>
</tr>
<tr>
<td>6.</td>
<td>Promotion or changes or responsibilities at work.</td>
<td>0</td>
<td>1</td>
<td>39</td>
</tr>
<tr>
<td>7.</td>
<td>Retirement.</td>
<td>0</td>
<td>1</td>
<td>54</td>
</tr>
<tr>
<td>8.</td>
<td>Moving house.</td>
<td>0</td>
<td>1</td>
<td>42</td>
</tr>
<tr>
<td>9.</td>
<td>Purchasing own house (taking out mortgage).</td>
<td>0</td>
<td>1</td>
<td>40</td>
</tr>
<tr>
<td>10.</td>
<td>New neighbours.</td>
<td>1</td>
<td>8*</td>
<td>18</td>
</tr>
<tr>
<td>11.</td>
<td>Quarrel with neighbours.</td>
<td>0</td>
<td>14*</td>
<td>26</td>
</tr>
<tr>
<td>12.</td>
<td>Income increased substantially (25%).</td>
<td>4</td>
<td>13*</td>
<td>35</td>
</tr>
<tr>
<td>13.</td>
<td>Income decreased substantially (25%).</td>
<td>1</td>
<td>15*</td>
<td>62</td>
</tr>
<tr>
<td>14.</td>
<td>Getting into debt beyond means of repayment.</td>
<td>0</td>
<td>1</td>
<td>66</td>
</tr>
<tr>
<td>15.</td>
<td>Going on holiday.</td>
<td>0</td>
<td>8*</td>
<td>29</td>
</tr>
<tr>
<td>16.</td>
<td>Conviction for minor violation, (e.g. speeding or drunkeness).</td>
<td>0</td>
<td>0</td>
<td>34</td>
</tr>
<tr>
<td>17.</td>
<td>Jail sentence.</td>
<td>1</td>
<td>0</td>
<td>75</td>
</tr>
<tr>
<td></td>
<td>18. Involvement in fight.</td>
<td>19. Immediate family member starts drinking heavily.</td>
<td>20. Immediate family member attempts suicide.</td>
<td>21. Immediate family member sent to prison.</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>20*</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Description</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>-------------------------------------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>42</td>
<td>Marital separation.</td>
<td>0</td>
<td>3</td>
<td>70</td>
</tr>
<tr>
<td>43</td>
<td>Marital reconciliation.</td>
<td>0</td>
<td>3</td>
<td>53</td>
</tr>
<tr>
<td>44</td>
<td>Wife begins or stops work.</td>
<td>0</td>
<td>0</td>
<td>34</td>
</tr>
<tr>
<td>45</td>
<td>Break up with steady boy or girl friend.</td>
<td>3</td>
<td>6</td>
<td>51</td>
</tr>
<tr>
<td>46</td>
<td>Problems related to sexual relationship.</td>
<td>0</td>
<td>1</td>
<td>54</td>
</tr>
<tr>
<td>47</td>
<td>Increase in number of family arguments,</td>
<td>3</td>
<td>2</td>
<td>43</td>
</tr>
<tr>
<td></td>
<td>(e.g. with parents).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>48</td>
<td>Break up of family.</td>
<td>0</td>
<td>0</td>
<td>77</td>
</tr>
<tr>
<td>No.</td>
<td>Item</td>
<td>B.A.</td>
<td>U.K.</td>
<td>S.R.E.</td>
</tr>
<tr>
<td>-----</td>
<td>----------------------------------------------------------------------</td>
<td>------</td>
<td>------</td>
<td>--------</td>
</tr>
<tr>
<td>1</td>
<td>Unemployment (of head of household).</td>
<td>5</td>
<td>5</td>
<td>68</td>
</tr>
<tr>
<td>2</td>
<td>Trouble with superiors at work.</td>
<td>0</td>
<td>2</td>
<td>40</td>
</tr>
<tr>
<td>3</td>
<td>New job in same line of work.</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>New job in new line of work.</td>
<td>0</td>
<td>2</td>
<td>46</td>
</tr>
<tr>
<td>5</td>
<td>Change in hours or condition in present job.</td>
<td>1</td>
<td>9*</td>
<td>31</td>
</tr>
<tr>
<td>6</td>
<td>Promotion or change of responsibilities at work.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Retirement.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Moving house.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Purchasing own house, (taking out mortgage).</td>
<td>0</td>
<td>4</td>
<td>40</td>
</tr>
<tr>
<td>10</td>
<td>New neighbours.</td>
<td>0</td>
<td>5</td>
<td>18</td>
</tr>
<tr>
<td>11</td>
<td>Quarrel with neighbours.</td>
<td>0</td>
<td>2</td>
<td>26</td>
</tr>
<tr>
<td>12</td>
<td>Income increased substantially (25%)</td>
<td>17</td>
<td>38*</td>
<td>35</td>
</tr>
<tr>
<td>13</td>
<td>Income decreased substantially (25%)</td>
<td>5</td>
<td>5</td>
<td>62</td>
</tr>
<tr>
<td>14</td>
<td>Getting into debts beyond means of repayment.</td>
<td>0</td>
<td>2</td>
<td>66</td>
</tr>
<tr>
<td>15</td>
<td>Going on holiday.</td>
<td>0</td>
<td>4</td>
<td>29</td>
</tr>
<tr>
<td>16</td>
<td>Conviction for minor violation (e.g. speeding or drunkenness).</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Jail sentence.</td>
<td>0</td>
<td>2</td>
<td>75</td>
</tr>
<tr>
<td>18</td>
<td>Involvement in fight.</td>
<td>2</td>
<td>5</td>
<td>38</td>
</tr>
<tr>
<td>19</td>
<td>Immediate family member starts drinking heavily.</td>
<td>20*</td>
<td>0*</td>
<td>65</td>
</tr>
<tr>
<td>Event Description</td>
<td>Yes</td>
<td>No</td>
<td>Percentage</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------</td>
<td>-----</td>
<td>----</td>
<td>------------</td>
<td></td>
</tr>
<tr>
<td>Immediate family member attempts suicide</td>
<td>1</td>
<td>0</td>
<td>66%</td>
<td></td>
</tr>
<tr>
<td>Immediate family member sent to prison</td>
<td>1</td>
<td>1</td>
<td>61%</td>
<td></td>
</tr>
<tr>
<td>Death of immediate family member</td>
<td>9</td>
<td>10</td>
<td>69%</td>
<td></td>
</tr>
<tr>
<td>Death of a close friend</td>
<td>7</td>
<td>8</td>
<td>55%</td>
<td></td>
</tr>
<tr>
<td>Immediate family member seriously ill</td>
<td>2</td>
<td>4</td>
<td>59%</td>
<td></td>
</tr>
<tr>
<td>Gain of new family (immediate)</td>
<td>1</td>
<td>2</td>
<td>43%</td>
<td></td>
</tr>
<tr>
<td>Problems related to alcohol or drugs</td>
<td>2</td>
<td>0</td>
<td>59%</td>
<td></td>
</tr>
<tr>
<td>Serious restriction of social life</td>
<td>2</td>
<td>4</td>
<td>49%</td>
<td></td>
</tr>
<tr>
<td>Period of homelessness (hostel or sleeping rough)</td>
<td>0</td>
<td>0</td>
<td>51%</td>
<td></td>
</tr>
<tr>
<td>Serious physical illness or injury requiring hospital treatment</td>
<td>6</td>
<td>1</td>
<td>65%</td>
<td></td>
</tr>
<tr>
<td>Prolonged ill health requiring treatment by own doctor</td>
<td>4</td>
<td>4</td>
<td>48%</td>
<td></td>
</tr>
<tr>
<td>Sudden and serious impairment of vision or hearing</td>
<td>0</td>
<td>1</td>
<td>59%</td>
<td></td>
</tr>
<tr>
<td>Marriage</td>
<td>1</td>
<td>0</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>Pregnancy (or of wife)</td>
<td>0</td>
<td>0</td>
<td>49%</td>
<td></td>
</tr>
<tr>
<td>Increase in number of arguments with spouse</td>
<td>2</td>
<td>3</td>
<td>55%</td>
<td></td>
</tr>
<tr>
<td>Increase in number of arguments with other immediate family members (e.g. children)</td>
<td>3</td>
<td>5</td>
<td>43%</td>
<td></td>
</tr>
<tr>
<td>Trouble with other relatives (e.g. in-laws)</td>
<td>0</td>
<td>5</td>
<td>43%</td>
<td></td>
</tr>
<tr>
<td>Son or daughter left home</td>
<td>0</td>
<td>5</td>
<td>43%</td>
<td></td>
</tr>
<tr>
<td>Separated from wife, husband or children</td>
<td>0</td>
<td>2</td>
<td>54%</td>
<td></td>
</tr>
<tr>
<td>Trouble or behaviour problems in own children</td>
<td>0</td>
<td>2</td>
<td>49%</td>
<td></td>
</tr>
<tr>
<td>Death of spouse</td>
<td>0</td>
<td>1</td>
<td>75%</td>
<td></td>
</tr>
<tr>
<td>Divorce</td>
<td>0</td>
<td>1</td>
<td>70%</td>
<td></td>
</tr>
<tr>
<td>Marital separation</td>
<td>0</td>
<td>1</td>
<td>70%</td>
<td></td>
</tr>
<tr>
<td>Marital reconciliation</td>
<td>0</td>
<td>0</td>
<td>53%</td>
<td></td>
</tr>
<tr>
<td>Wife begins or stops work</td>
<td>0</td>
<td>2</td>
<td>34%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Description</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>-------------------------------------------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>45</td>
<td>Break up with steady boy or girl friend.</td>
<td>8</td>
<td>7</td>
<td>51</td>
</tr>
<tr>
<td>46</td>
<td>Problems related to sexual relationship.</td>
<td>0</td>
<td>1</td>
<td>54</td>
</tr>
<tr>
<td>47</td>
<td>Increase in number of family arguments</td>
<td>5</td>
<td>2</td>
<td>43</td>
</tr>
<tr>
<td></td>
<td>(e.g. with parents).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>48</td>
<td>Break up of family.</td>
<td>0</td>
<td>0</td>
<td>77</td>
</tr>
</tbody>
</table>
The direction of the relationship between marital status and stressful events, among (B.A.) Barbadians in Barbados is different. Here, married respondents - mainly women - experienced fewer stressful events than unmarried respondents. The events B.A. Barbadians reported were:

- Immediate family member starts drinking.
- Increase in the number of arguments with spouse.
- Death of an immediate family member.

The close proximity of near relatives has been noted to be positively associated with stressful events. Over 70% of the respondents in both samples lived near close relatives - parents and/or siblings. Further those respondents whose close relative (parents or siblings) lived nearby reported better mental health than those respondents who lived near uncles, aunts and cousins.

The nearness of immediate family members resulted in a high level of contact. B.A. Barbadians reported a higher frequency of contact with relatives than U.K. Barbadians. This finding is consistent with the openness of social life in Barbadian society. These findings and observations lead us to conclude that B.A. Barbadians had better mental health than U.K. Barbadians.
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Jenkins, C.D.

Jenkins, C.D.

McFarland, A.H., Norman, G.R.

Roy, R. and Scott, D.J.

Mr. Kinlay, J.B.


CHAPTER 21

A COMPARATIVE ANALYSIS OF PSYCHOLOGICAL DISTURBANCE AND STRESSFUL LIFE EVENTS AMONG U.K. BARBADIANS AND BARBADIANS IN BARBADOS.
CHAPTER XI

A COMPARATIVE ANALYSIS OF PSYCHOLOGICAL DISTURBANCE AND STRESSFUL LIFE EVENTS AMONG U.K. BARBADIANS AND BARBADIANS IN BARBADOS.

Psychological disturbance and stressful life events in U.K. Barbadians.

All Respondents

Stressful life events measured by the raw (var. 87) and scale weighted score (var. 88) of the schedule of Recent Event (S.R.E.) were strongly associated with psychological disturbance in all the sub-scales and the total score of the Middlesex Hospital Questionnaire, (M.H.Q.). The weighted/scale score (var. 88) was better related to psychological disturbance than the raw score (var. 87) - no explanation can be offered for this finding. However the raw score returned higher scores on the phobic (.904) and the somatic (.858) scales than the weighted score (See Table I). A similar result was observed on correlation analysis (See Table II). Possible reasons for this finding will be discussed later.

Sex Differences

There is a marked difference between the score returned for the male and female respondents. Male respondents were strongly correlated with all the symptoms sub-scales - when measured by the raw score - while female showed no correlation between stressful life events and psychological disturbance. The raw score of the S.R.E. was better related to psychological disturbance than the weighted/scale score. High scores above the .001% level were recorded on five of the sub-scales of the raw score (var. 87); FFA (r = .482), Phob. (r = .982), Obsess. (r = .728), Som. (r = .874) and Dep. (r = .732), (See Table III). As was noted in the findings on all respondents above, the phobic, obsessional and somatic sub-scales recorded the highest significant scores. This finding seems to suggest that male respondents who experience stressful life events are more likely than female respondents
TABLE I  U.K. BARBADIANS

Significant levels of association of male/female respondents, N = 100.
Association of sub-scale of M.H.Q. with raw score (var. 87) of the S.R.E.
ETA values recorded.

<table>
<thead>
<tr>
<th>Nature of variable</th>
<th>Sub-scale of the M.H.Q.</th>
<th>S.R.E. all respondents (var. 87 raw score)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FTA</td>
<td>89</td>
<td>.370</td>
</tr>
<tr>
<td>PHOB.</td>
<td>90</td>
<td>.904</td>
</tr>
<tr>
<td>OBSESS.</td>
<td>91</td>
<td>.665</td>
</tr>
<tr>
<td>DOC.</td>
<td>92</td>
<td>.858</td>
</tr>
<tr>
<td>DEP.</td>
<td>93</td>
<td>.649</td>
</tr>
<tr>
<td>ANX.</td>
<td>94</td>
<td>.459</td>
</tr>
<tr>
<td>TOTAL M.H.Q.</td>
<td>95</td>
<td>.373</td>
</tr>
</tbody>
</table>

Significant levels.

\[
5\% = .195 \\
1\% = .255 \\
001\% = .325
\]
**TABLE II. U.K. BARBADIANS**

Significant levels of correlation coefficient of male/female respondents (N = 100). Correlation of sub-scales of M.H.Q. with S.R.E. raw score (Var. 87) and weighted score (Var. 88 of the S.R.E.)

<table>
<thead>
<tr>
<th>Nature of variable</th>
<th>Sub-scales</th>
<th>S.R.E. All respondents N = 100 variable from M.H.Q.</th>
<th>Raw Var. 87</th>
<th>Weighted Var. 88</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFA</td>
<td>89</td>
<td>.305</td>
<td>.198</td>
<td></td>
</tr>
<tr>
<td>Phobia</td>
<td>90</td>
<td>.782</td>
<td>.047</td>
<td></td>
</tr>
<tr>
<td>Obsess.</td>
<td>91</td>
<td>.595</td>
<td>.149</td>
<td></td>
</tr>
<tr>
<td>Somatic</td>
<td>92</td>
<td>.768</td>
<td>.126</td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>93</td>
<td>.606</td>
<td>.121</td>
<td></td>
</tr>
<tr>
<td>Hysteria</td>
<td>94</td>
<td>.313</td>
<td>.292</td>
<td></td>
</tr>
<tr>
<td>Total M.H.Q.</td>
<td>95</td>
<td>.250</td>
<td>.244</td>
<td></td>
</tr>
</tbody>
</table>

Significant levels

- 5% level = .195
- 1% level = .255
- 001% level = .325
TABLE III U.K. BARBADIANS

Significant levels of correlation coefficient of male/female respondents (N = 100). Correlation of sub-scales of M.H.Q. with raw score (87) and scale score (88) of the S.R.E. in U.K. Barbadians.

<table>
<thead>
<tr>
<th>Sub-scales of M.H.Q.</th>
<th>S.R.E.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Raw Var. 87</td>
</tr>
<tr>
<td></td>
<td>M</td>
</tr>
<tr>
<td>FFA</td>
<td>89</td>
</tr>
<tr>
<td>Phobia</td>
<td>90</td>
</tr>
<tr>
<td>Obsess.</td>
<td>91</td>
</tr>
<tr>
<td>Somatic</td>
<td>92</td>
</tr>
<tr>
<td>Depression</td>
<td>93</td>
</tr>
<tr>
<td>Hysteria</td>
<td>94</td>
</tr>
<tr>
<td>Total M.H.Q.</td>
<td>95</td>
</tr>
</tbody>
</table>

Significant levels

.05% level = 0.27
.01% level = 0.35
.001% level = 0.45
Discussion

Here I begin an analysis of the possible reasons why respondents in Barbados and Reading, England, differentiate significantly high on the symptom scale of the MHQ.

To date no study has been done on the prevalence of poor mental health/mental illness of Barbadians in England. Further, no articles have been written on the implication of stress and psychological disturbance, at the clinical or non-clinical level.

My interpretation of the data has resulted from my training in psychiatry and sociology, but more importantly from my close analysis and knowledge of Barbadians and Barbadian society.

There is no supporting evidence, that is, research study, of my observations. My analysis marks the beginning of what I hope will be further research into the social origins of psychological disturbance among Barbadians in Barbados and England.

Throughout the U.K. Barbadian study it has been noted that the variables on the sociological questionnaire and stress inventory were strongly related to the phobic, obsessional and somatic sub-scales of the MHQ.

It would be useful at this point to attempt to find out why the phobic, obsessional and somatic sub-scales consistently return higher scores than the other sub-scales; free floating anxiety, (FFA), depression (Dep) and hysteria (Hys).

Why do U.K. (Barbadians) respondents score highly on the phobic, obsessional and somatic sub-scales?

What is there about the respondents or/and their life experiences that contributes to such high scores?
Let's begin by examining the 3 sub-clinical categories; Phobia, Obsessionality and Somatising.

(1) Phobia

Phobia is a neurotic or anxiety trait, the person who is phobic, experiences morbid anxiety, is insecure and adjustment to his environment is usually precarious. His anxiety may arise from unresolve conflicts between his aims and desires and the limitation imposed on them by reality. Further anxiety may develop from threatening external circumstances, involving loss of love, and rejection, loss of status and prestige, loss of occupation and wealth.

As stated earlier, Barbadians emigrated to England with high aspirations, aims and expectations about England and English people. Coming to England was the fulfillment of a dream. For many it wasn't simply a means/way of escaping crushing poverty in Barbados, but rather a cultural and educational pilgrimage. Many respondents had forsaken 'respectable' white collar occupations: policeman, teachers, and civil servants to emigrate to England. England offered a better 'way of life' and a higher standard of living. They left their families, loved ones, friends and a culture of which they had grown accustom, for a different culture and country. Soon after settling in England, the immigrants realised that reality had contrived to cheat them of their aims and aspirations, their status and prestige, deny them access to better jobs and wealth, subject them to racial abuse and hostility, reject and treat them as third class citizens and finally threaten them with possible eviction - repatriation.
Puzzled and bemused by such treatment, they reflect on the England of their dreams, the England that they read about - and had been taught to love and respect - the England that had promised so much but offer so little to its 'children.' Surely this was no way for a loving 'mother' to treat her 'children'.

Trapped in real life situations, in which the alternatives are all unattractive, constantly aware of the ever changing immigration and citizenship laws, many respondents display phobic anxiety. Given the socio-economic and racial difficulties black immigrants encounter in English society, it is a small wonder that many don't become mentally unwell.

One may be tempted to say that there is something in the psychological make-up of the Barbadian respondents and black people in general, that predisposes them to mental illness. It is not within the scope of this study to explore fully the psychological and physiological reasons for phobic anxiety. Suffice it to say that the physiological and psychological constitution of respondents play a part in illness; the extent of which I am unable to assess. However, I am of the opinion that environmental and cultural factors play a major role in the respondents onset of poor mental health. I would therefore hypothesise that it is the combination of unfulfilled goals, aspirations and expectations, disillusionment and frustration in life experiences, and inadequate coping resources that account for the high scores on the phobic scale.
Obsessionality

Unlike phobic which is neurotic based, obsessionality is personality centred. Mild obsessional traits are quite common in normal people, but are more marked in obsessional personalities. The obsessional individual is in fact trying to control the expression of unconscious forbidden feelings and impulses, usually those of an aggressive and sexual kind. Many of the forbidden feelings and impulses cannot be completely repressed, and find expression in a distracted form; in some obsessional-compulsive-symptoms which serve as symptoms for the original impulses.

Obsessional personality is particularly vulnerable when faced with demands arising out of changing circumstances, such as changes at work, involving new responsibility, changes in environment, involving new relationships and changes in 'way of life'/culture - as a result of immigration. Should the individual lack flexibility, he is unable to make necessary adjustments and tries to impose his own rigid patterns on others. If he cannot do so, he may develop an underlying fear that he will be unable to control events any longer. This acts as a stimulus to underlying hostility.

Faced with stressful circumstances the obsessional person, in this way, develops anxiety, depressive and obsessional symptoms. Sometimes the disorder seems to grow slowly from the gradual exaggeration of the obsessional traits of the pre-disposed person and it may not be possible to determine an actual time of onset or relate it to any particular circumstances. Occasionally the disorder occurs in a person who has previously had no marked obsessional traits. The onset is thus usually sudden and often related to stressful events.
We have noted that obsessional traits are found in all normal people to a greater or lesser degree. These traits become exaggerated when the individual(s) experience stressful events.

For most Barbadian respondents migration was not a stressful process. However, with few exceptions most respondents were relatively unprepared for the difficulties migration presented. It was not migration itself that was stressful but rather the new and varied circumstances which respondents encountered, as a result of migrating. One of the most demanding of the new circumstances was the English 'way of life.'

Somatising

Somatising represents another avenue, through which stress is manifest. An individual under stress is inclined to give a morbid label to complaints he would normally shrug off. He may compensate by manifesting a physical symptom.

Psychiatrists in Chinese cultural areas have noted that the tendency of Chinese, when experiencing intense stress, to prevent somatic complaints in the place of psychological complaints (Yap, 1974; Tseng, W.S. 1975; Tseng, W.S. and Hsu, J. 1969; Rui et al, 1966, 1973; Lin, T.Y. 1953 and Gaw, A. 1976).

Somatising also exists in Western society, but to a much smaller degree than in Chinese cultural setting. Some of the common symptoms are tiredness, dizziness, pains in the upper back, described as rheumatism and stomach pains.
a doctor - this view is shared by the Superintendent of the Barbados Mental Hospital. As they are experiencing physical discomfort, individuals are likely to attend a general practitioner's surgery than a psychiatrist. The G.P.s treat the presenting complaints without checking for psychological problems.

Health care in Barbados is largely private. This encourages individuals to purchase care wherever they choose. Therefore when one doctor's medicine doesn't relieve the symptoms, individuals visit another doctor until they 'find' the medicine that works. By this time the underlying psychological problem might have been resolved. The individual never enters the sick role, hence many people suffering possibly from neurotic illnesses never reach a psychiatrist, much less the mental hospital. This observation goes some way in accounting for the low level of neurosis found in Barbados. This more observation is applicable to neurosis than psychosis. Bearing these fact in mind, I would hypothesise that the high level of somatising noted among U.K. Barbadian respondents - as indicated on the somatic sub-scales of the M.H.Q. - reflects to a large measure traditional cultural ways of reacting to stress.

Respondents were mildly confident that they knew and understood English culture, as a result of their own English sub-cultural experience. They soon realised that to live and work in England involved making major physical, social and cultural changes to their lives. It necessitated establishing new relationships and changes in type and nature of work. Sheila Patterson (1963) in her book, Dark Strangers, recounts the difficulties West Indians encountered at work, during their first years in England. They were accustomed to industrial type jobs, of which the conveyor belt dictated the speed of work; hence their productivity rate was much lower than white workers. Employers considered them lazy, talkative and an employment risk. It took some time for both employers and immigrants to resolve their respective difficulties. Although most first generation respondents have seemingly adapted to life in England, they remain relatively unattached to English culture. They cling
tenaciously to their own traditional cultural principles and ways; especially life style and child rearing. From my discussions with respondents it became clear that they felt that the English way of life had contributed significantly to the gradual erosion and alteration of their family structure. Desperate to maintain some Barbadian/West Indian cultural continuity, when principles and ideals all around them are crumbling, respondents try to enforce traditional family discipline and control over their children. The consequences of which, have been frequent arguments and disputes between parents and children, which threaten the stability and unity of the family.

A respondent agonising over her lost battle to discipline her children and keep her family together noted:

"I came to this country and work hard, and I try my best to get on with white people, after all this is they country. I tried to give the children the best I could afford. I brought them up without a father. I have tried talking to them but it is no use. They want to live like their white friends, coming in all hours of the night and expect me to open my door. When I was they age I couldn't dere come so late, my mother would tar my behind. It's really heart breaking when you think how much you do fuh children and they then leave. This society is terrible, it's no place to bring up children. I know several parents who are having trouble with their children. If I knew that mine were going to turn out so bad, I would have left them in Barbados."

Here, this respondent realised that in order to function in English society she had to adjust and interact with white members of the society. However, she was not prepared to adopt an English way of life nor alter her beliefs values and ideas about child rearing. Her inflexibility led to strained relationships with her children and finally their departure. Left on her own, without those she loves around her, witnessing her own cultural decay, this respondent is likely to become anxious and manifest obsessional symptoms.
Psychological disturbance and stressful life events in Barbadians (BA) in Barbados.

All respondents

Stressful life events were measured by the raw (Var. 59) and weighted score (Var. 60) of the S.R.E. Both measures of stress, (raw and weighted scores) were strongly associated with the following sub-scales; FFA., Som., and Dep., of the M.H.Q. (See Tables IV-V). Due to the non-linearity of the data ETA indicated a better association between stress and psychological disturbance than correlation analysis. However the weighted score (Var. 60) was strongly correlated to FFA., Som., and Dep., sub-scales of the M.H.Q. This finding is similar to that recorded by ETA.

Sex differences

When psychological disturbance and stressful events are analysed by sex, an interesting difference occurs. Stressful events measured by the weighted score (Var. 60), and recorded by male respondents correlated better with psychological disturbance than scores for female respondents (See Table VI). Male respondents recorded significantly high scores on the phobic, somatic and obsessional scales, while female recorded high scores on FFA., Som., and Dep., sub-scales.

This finding for BA Barbadian male respondents (measured by weighted score) appear to be similar to that for U.K. Barbadians (measured by raw score). It would seem that male respondents in both societies react to stressful life changes in much the same way. Women tend to react differently. Female respondents score significantly high on FFA., Som., and Dep., scales; these scales will be discussed later.
### Table IV BA Barbadians

Comparison of scale score (Var. 60) and raw score (Var. 59) of the S.R.E. with sub-scales of the M.H.Q. in 100 Barbadians of both sexes in Barbados.

ETA values recorded *.

<table>
<thead>
<tr>
<th>Variables of the M.H.Q.</th>
<th>Var. 59</th>
<th>S.R.E Var. 60</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFA</td>
<td>61</td>
<td>.418</td>
</tr>
<tr>
<td>PHOB.</td>
<td>62</td>
<td>.275</td>
</tr>
<tr>
<td>OBSESS.</td>
<td>63</td>
<td>.257</td>
</tr>
<tr>
<td>SOM.</td>
<td>64</td>
<td>.331</td>
</tr>
<tr>
<td>DEP.</td>
<td>65</td>
<td>.238</td>
</tr>
<tr>
<td>HYS.</td>
<td>66</td>
<td>.239</td>
</tr>
<tr>
<td>Total M.H.Q.</td>
<td>67</td>
<td>.540</td>
</tr>
</tbody>
</table>

Significant levels.

- .05% = .195
- .01% = .255
- .001% = .325


**TABLE V. BA BARBADIANS**

Significant levels of correlation coefficient of all respondents (N = 100).

Correlation of raw score (Var. 59) and (Var. 60) of the S.R.E. with sub-scales of the M.H.Q. (Var. 61 - 67).

<table>
<thead>
<tr>
<th>Variables of the M.H.Q.</th>
<th>S.R.E.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Raw</td>
</tr>
<tr>
<td></td>
<td>Var. 59</td>
</tr>
<tr>
<td>FFA</td>
<td>61</td>
</tr>
<tr>
<td>Phobia</td>
<td>62</td>
</tr>
<tr>
<td>Obsess.</td>
<td>63</td>
</tr>
<tr>
<td>Somatic</td>
<td>64</td>
</tr>
<tr>
<td>Depression</td>
<td>65</td>
</tr>
<tr>
<td>Hysteria</td>
<td>66</td>
</tr>
<tr>
<td>Total M.H.Q.</td>
<td>67</td>
</tr>
</tbody>
</table>

Significant levels.

- 5% = .195
- 1% = .255
- 001% = .325
TABLE VI BA BARBADIANS

Significant levels of correlation coefficient of male/female respondents (N = 50). Correlation of sub-scales of M.H.Q. with raw score (Var. 59) and Scale score (Var. 60) of the S.R.E. in BA Barbadians.

<table>
<thead>
<tr>
<th>Sub-scales of the M.H.Q.</th>
<th>Raw-Var. 59</th>
<th>Weighted Var. 60</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>F</td>
</tr>
<tr>
<td>FFA</td>
<td>61</td>
<td>-.013</td>
</tr>
<tr>
<td>Phobia</td>
<td>62</td>
<td>-.100</td>
</tr>
<tr>
<td>Obsess.</td>
<td>63</td>
<td>-.140</td>
</tr>
<tr>
<td>Somatic</td>
<td>64</td>
<td>-.004</td>
</tr>
<tr>
<td>Depression</td>
<td>65</td>
<td>-.117</td>
</tr>
<tr>
<td>Hysteria</td>
<td>66</td>
<td>.155</td>
</tr>
<tr>
<td>Total M.H.Q.</td>
<td>67</td>
<td>-.040</td>
</tr>
</tbody>
</table>

Significant levels

.05% level = 0.27
.01% level = 0.35
.001% level = 0.45
As we have noted, Barbadians in Barbados tend to manifest Free Floating Anxiety, Somatic and depressive symptoms, while U.K. Barbadians present Phobia, Obsessional and Somatic symptoms. Interestingly somatising is the one symptom which is common to both groups of Barbadians irrespective of sex.

Let us now consider the most significant symptom scales recorded by BA Barbadians: FFA., Som., and Dep.

Free Floating Anxiety

The term anxiety denotes a state of inner emotional disquiet or feeling of tension commonly aroused by some challenge or threat to physical or psychological well-being. The individual's discomfort may vary in degree from mere uneasiness to extreme terror.

The state of anxiety is thus a manifestation of adaptive changes evoked in both the mental and physical field; it is a normal response to the various difficulties and potential dangers occurring in everyday life.

Morbid anxiety is associated with depressive and obsessional symptoms. Anxiety states often arise from frustrated ambitions in a climate of limited opportunity, a feeling of powerlessness over one's future and unresolved conflicts. Anxiety may be "free floating" and unattached to anything or it may be generalised and everything then becomes a source of concern. Anxiety states are rather more common in women than men.

How does this outline of free floating anxiety apply to Barbadians? What is there about Barbadian society that engenders frustration and anxiety?

There is considerable pressure on individuals to become successful, to acquire higher/further education, to obtain a 'respectable' white collar job, to own property, to have a car, in brief to be upwardly mobile.
This level of pressure has been fueled in some measure by relatively easy access to loans from banks and other lending agencies; these loans are used mainly not to generate wealth, but to 'purchase' a higher standard of living, to buy cars, washing machines, other consumer durables and to purchase and erect properties.

The repayments of these loans and higher purchase payments have increased the financial burden on most families. In a letter to the Nation newspaper (May 1978) entitled "hanging your hat higher than your hand could reach", a concerned subscriber described the financial hardship and embarrassment many people experience when firms repossess their goods because of non-payment of loans. According to the subscriber such incidents were fairly common. Here upward striving was a potential source of physical and emotional stress for many people; they were living beyond their means in order to be seen as successful.

Further, Barbados is a small island with predominantly 'two crops'- sugar and tourism - and a few light industrial estates dotted around the island. These provide jobs for the bulk of unskilled and semi-skilled people.

Individuals who acquire further education, for example, professional qualifications or degrees, find it difficult to obtain jobs. There are few opportunities available for both qualified and unqualified persons. In this climate of limited opportunity, unfulfilled ambitions, a 'purchased' standard of living and goal striving stress, anxiety is 'free floating'.

For many people - especially the young - who see no realisation of their goals, working as a 'bellhop'/waiter, maid or beachcomber, is better than doing nothing. These are the lucky ones, others have to content themselves by spending their days at the beach or pursuing some unfulfilling exercise.
Free floating anxiety is more strongly marked in BA Barbadians than U.K. Barbadians, primarily because the anxiety and stress is pervasive, it extends into several areas of the individual's life, his future. No longer possible to escape from this stressful situation, through immigration, the individual is left to battle as best as he may with life and what it offers.

Depression

Everyone is liable to a greater or lesser extent, to brief variations in mood, such changes are not described as symptoms of depression unless sustained and in sufficient degree.

Although depression can be classified into reactive and endogenous, this distinction is far from easy. For example, problems at work might appear to be the cause of a patient's depression. However, it could be that such problems may have only occurred because of his difficulty in concentration. External stresses and physical illness may be precipitating factors but often there is no clear reason for the onset.

Depression as a symptom is, however, distinct from depression as a psychiatric disorder. It is therefore more likely to assume that the high scores returned by respondents on the depression scale, indicate depressive symptoms rather than depression as an illness/mental disorder. However, if there are several depressive symptoms present, for example, the presence of fatigue, early morning waking, weight loss and ideas of unworthiness they strongly point to the diagnosis of a depressive state, even though the individual might not appear to be obviously depressed.

Applying this general outline of depression and in particular depressive symptoms, it would appear that BA Barbadians experience a significantly high level of depressive symptoms (400) above .001%.

Why do respondents record a high level of depressive symptoms?
As we discussed earlier, Barbadian society engenders competitiveness and goal frustration. This frustration is located primarily among the lower middle and working classes. These are those for whom job opportunities are few and upward mobility is blocked. Respondents in this category can see no way of improving their standard of living. They feel powerless, hopeless and apathetic. Faced with these harsh life situations respondents are likely to manifest depressive symptoms. This is well illustrated by a middle age married respondent, for whom unemployment has caused much stress. Commenting on his present circumstances, he said:

"Being unemployed is tough, especially if you have been in steady employment for most of your life. Sometimes I don't feel like getting out of bed. I mean, what for? Sometimes I spend all night thinking about how to support my wife and kids and can't find any solution to the problem. I suppose the thing that really gets me down is when I think that I cannot really do much about it. Sometimes I spend days looking for something to do. I often wonder what my children think about me, they probably think I am lazy. Ah, well what's the use."

Feeling a sense of unworthiness and self reproach, this respondent attempts to accept his lack of control over his immediate goal employment.

Depressive feelings are found not only among the unemployed but the 'trapped' employed, those for whom the pathways to promotion and upward mobility are few and relatively unaccessible. As a male respondent remarked:

"Life in Barbados isn't bad at all, all you need is a little money. The main problem is that jobs are hard to find. Even when you find one, promotion prospects are poor. Most of the bosses are senior people, they are young and they aren't moving either, so you could find yourself stuck at the same position for years, who want that? Take my job, for instance, (Customs Officer) the chance of my getting promotion there is bleak. There are so many guys in front of me; plus you got to be in with the man at the top. It's really annoying. Sometimes I take a few days off sick, when I get fed-up. I
don't like the job, but I just cannot leave it like that, what would I do?"

From my informal interview with respondents, I noted that dissatisfaction with life circumstances and position was one of the main causes of stress. Depressive symptoms were one of the many ways in which this stress was manifested.

**Somatising**

Another sub-clinical category of neurosis which has been consistently significant (.419) above .001%, for BA Barbadians is somatising. As when discussed for U.K. Barbadians, somatising implies the psychological symptomatology of emotional stress - disturbance. From my observation and life experience in Barbados, I would hypothesise that somatising is fairly common. By presenting physical complaints, of emotional disturbance - which is culturally acceptable - respondents do not enter the sick role. However, presenting emotionally disturbed symptoms, is more likely to result in the respondents entering the sick role and being labelled.

These are some of the main factors which possible accounts for a high level of somatising among BA Barbadians.

**Summary**

From our discussion we have noted that free floating anxiety (FFA), Somatising (Som.) and Depression (Dep.) are the most consistently significant manifestations of stress among BA Barbadians.

The competitive nature of Barbadian society, limited jobs availability and opportunities for upward mobility have produced anxiety in many respondents. Some who are unemployed and see no jobs prospects, others who are 'trapped' in occupations they don't like and can forsee no promotion.
The social circumstances, while potentially stressful for U.K. Barbadians appear to have a more severe effect on BA Barbadians because of the geo-social and economic factors of the island. It is a small - 168 square miles - elitist, underdeveloped country, with two main crops, sugar and tourism. In this socio-economic climate with no national health service, poverty and suffering is more chronic. The main source of relief for many is the continuing supportive function of the external family and social network.
Conclusion

We have observed that U.K. Barbadians experience more and different stress that BA Barbadians and, overall have poorer levels of mental health. The stress U.K. Barbadians experienced frequently centred around, disappointment and dissolutionment with migration. They left Barbados with high hopes and ambitions only to find that these were dashed against a bedrock of racial discrimination and hostile social rejection. These experiences produced stress which manifested itself mainly as, phobic (phob.), obsessional (obsess.) and somatic (som.) symptoms.

The main reasons seem to be, in my analysis:

(1) The respondents were black immigrants, in a new and different socio-cultural environment to which they had to adapt.

(2) With a history of servitude to the white man.

(3) They were socialised into an English sub-culture, which praised all things white/British.

(4) They were made to believe that they had special rights and privileges entering Britain, because of their long association and loyalty.

I would hypothesise that the unique nature of these circumstances is primarily responsible for the onset of stress and phobic, obsessional and somatic symptoms among U.K. Barbadians.

In contrast, the stress Barbadians in Barbados experienced were manifest mainly as free floating (FFA), Somatising anxiety (som.) and depression (dep.). Here, the life circumstances of respondents in Barbados were somewhat different from those of U.K. Barbadians. They were not immigrants experiencing racial hostilities, but they experienced similar stress related to goal-striving in a climate of limited opportunity. Opportunities in Barbados were limited because of the physical resources of the island, and not the colour of the
respondents skin. The competitive, elitest nature of Barbadian society meant that while many attempted to be upwardly mobile, few achieved their goals. The inability to achieve upward mobility had severe consequences for Barbadians and their families.

For Barbadians in Barbados, anxiety was not 'attached' or centred upon one or a set of circumstances - like racial discrimination for U.K. Barbadians - but upon several aspects of their life experience, not having enough to feed and clothe one's family. Stress for Barbadians in Barbados was pervasive and debilitating. It engendered feelings of hopelessness. This was aptly summed by an unemployed young male respondent.

Researcher: "How is life treating you?"

Respondent: "Ugh, terrible. It's tough man. There is just isn't anything to do. Occasionally I get a job, but what's that. There are about 200 people chasing one lousy job, and the only way you can get it, is if you got a 'god-father.'
When I am not working I spend most of my time with the othe guys, 'liming' - relaxing - around, chatting and so, it gets me down sometimes. I suppose the only thing that cheers me up is being with other guys. They crack a lot of jokes, that keeps my spirits up. Sometimes I think if its bad for me with five O'levels, and no responsibility, it must be worse for some of them who have families to support. I don't know how they manage. I suppose their parents, sisters and brothers help them out. To tell you the truth I really cannot take this thing any longer. I am trying to get to Canada, but that's pretty difficult right now. When you out of work, it's a real tough thing. You see friends who working dressing up and going places and you can't budge. I really wouldn't like to end up like some of these guys."
It is the hopelessness, of not being able to see one's way out of, or improving the present situation that produces considerable anxiety. Such feelings are more common among men than women because men are more upwardly mobile. Both U.K. and Barbadian male respondents, who experienced stress, were strongly associated with psychological disturbance (See Tables III + VI).

Christopher Bagley (1976) in a paper 'Sequels of Alienation, a Social psychological view of adaptation of West Indian Migrants in Britain,' provides an overview of the adjustment of West Indians to British society, he adequately outlines the view held by the researcher about stress and its impact on black (Barbadian) immigrants to Britain.

He considers stress factors as contributing to the apparent higher rates of mental illness in West Indians in Britain compared with the indigenous population. He sees the fact that opportunities for advancement are limited by racial discrimination as a particular cause of stress for West Indians. He identifies two ideal types of relationships between migrant and host.

(1) **Assimilation** in which the migrant group is dispersed and absorbed into the host community.

(2) **Plural accommodation** in which the migrant group retains its own culture and separate identity and at the same time is accepted by the host community. However these two 'ideal' types or situations are often not realised and tensions continue to exist between cultural groups.

The failure to achieve better levels of occupation, income and housing produces a situation of alienation. One type of stress which may contribute to the higher rates of mental illness among West Indians is the frustration of not being able to advance in British society because of racial discrimination and limited opportunities.
The more stress factors present, the more likely a person is to become mentally unwell. As the social disadvantages affect black minority groups more than the host community in Britain, the former may be more prone to poor-mental health, as my survey has shown.
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Yap, P.M.  
CHAPTER 22

CULTURE, MIGRATION AND POOR MENTAL HEALTH

- CULTURE RELATED TO THE CONCEPT OF POOR MENTAL HEALTH.
CHAPTER 22

CULTURE, MIGRATION AND POOR MENTAL HEALTH

To most men and women the way of life of their community is its most precious possession. To outsiders who have their own habits and assumptions, this way of life or culture, often appears incongruous.

Benton, J. (1961)

It is necessary to begin this chapter with a caution. Beware of the gross semantic chasms that lie beneath the seemingly objective and scientific surface of transcultural psychiatry. Even the relationship between the terms "mental health" and "mental illness," is a trap for the unwary, for as Marie Jahoda (1958) points out "for many writers mental ill health does not mean merely the reciprocal absence of "mental health." Many persons belong in a vaguely bounded middle category, characterised neither by positive mental health nor by definite mental illness," (but by varying degrees of health, through to poor mental health).

It is the questionable size and composition of the middle category that produces part of the semantic difficulty, for each authority sets the boundaries at different points on the scale.

In this chapter attention is given to the relationship between culture, (way of life), migration and poor mental health. We shall start by first defining culture and its relationship to poor mental health. Secondly, the relationship between migration and poor mental health and thirdly, conclude by analysing the association between culture, migration and poor mental health.
The concept of culture is often used to explain differing patterns and variations in a community’s tolerance of people with psychological troubles. There are many definitions of culture. In simple terms, Clyde Kluckhohn (1949) states that culture is,

(1) man’s social legacy
(2) the pattern of the environment created by him
(3) a design for living
(4) the channel of biological processes
(5) a way of thinking, feeling and behaving
(6) a group’s distinctive way of living, and
(7) a regulator of our lives.

Moreover he maintains that culture both produces needs and provide means for fulfilling them and also supply "a set of blue-prints for human relations."

In their comprehensive work "Culture: A Critical Review Of Concepts And Definitions," Kroeber and Kluckhohn (1952) formulate culture as the "... patterns explicit and implicit, of and for behaviour acquired and transmitted by symbols, constituting the distinctive achievement of human groups including their embodiments in artifacts; the essential core of culture consists of traditional ideas and especially their attached values." (pp 357).

Culture is learned in a general sense, but is always undergoing modification because of their twin aspects of vicarious behaviour, memory and imagination. Some parts of it are learned by striving for goals, or problem solving. Some of it is learned on a trial and error basis. Still others
are absorbed as a result of familiarity, and still other parts fall into place quite suddenly.

Culture is an important concept in the psychiatry of rural migrants, urbanised foreigners and developing peoples. It is fundamental to our understanding of poor mental health and mental illness, because man is a biosocial organism not only shaped by his own interaction with others, and influenced by customs, but also endowed with a cultural legacy. Moreover the individual's biological and spiritual needs and the means by which they are gratified, frustrated or sublimated - the conflict intrinsic to poor mental health - are culturally as well as biologically determined. Any view of the mentally unwell that does not place him in a cultural perspective is bound to be myopic.

Further, culture includes "the patterned family and social influences and the means of symbolic communication forged into a way of life, affirmed and reaffirmed in the common core of custom, and most importantly always having a significant discernable meaning and value for the individual."

For me, culture is seen as a 'way of life' lived by individuals in a particular group (J. Murphy 1976). This is essentially a descriptive rather than a dynamic approach to defining culture. However, beginning with a descriptive attitude/or approach, does not imply that it is antithetical to a dynamic one. Nor does it deny that the dynamics or cultural changes are important in this study. If we are to discover what effect cultural change has in promoting poor mental health, it is evident that we need a concept by which the environment can be described in a meaningful way at different points in time.

No one will dispute that 'way of life'/culture is relevant to an understanding of human behaviour. The problem is no longer to prove that culture makes a difference but to find out how and what difference it makes. This can become evident by analysing cultural change, in terms of differences in the
'way of life' of the two populations—Barbadians.

In other words, if we look at the 'way of life' of Barbadians before immigration and compare it with their present 'way of life' and the difficulties they encounter in the host society, it would give us some idea of the factors involved in promoting poor mental health. It would also explain why Barbadians in Reading, England have poorer mental health than Barbadian in Barbados.

Kluckhohn (1944) states that cultures supply "blue-prints for human relations." These blue-prints encompass pathological as well as healthy patterns. Just as blue-prints differ and change, the manifestations of mental disorder vary among such wide ranging groups as the Eskimos with Piblokto and South Eastern Asiatics with Amok, Algonkian hunters with Windigo psychosis, Chinese with Suk-Yeong, New Guineans with Lulu, Nekoa madness and Japanese with Kitsunetsuke. They may even vary among those in close proximity, as among ethnic groups in the United States. Wallace (1970) notes, "most such 'ethnic psychosis' which reflect in their behaviour the specific cultural content of the victim's society, are simply local varieties of a common disease process by which human beings are vulnerable. In this light, then, all mental disorders must be considered to replicate in symptomatic content the victim's past and present cultural environment." (pp 218-219).

Thus poor mental health and mental illness exist in all cultural groups, culture in turn may determine the form in which it appears.

Culture Related To The Concept Of Poor Mental Health

One of the central tasks of comparative studies in transcultural psychiatry is to examine the various manifestations of so-called mental ill health in various cultures and the provisions therein for dealing with them. Here we will concern ourselves in looking at the relationship between culture and poor mental health, from the findings of the two studies on Barbadians living in Reading, England and in Barbados.
The treatment or relief of poor mental health is essentially a social process consisting of a set of techniques, a system of beliefs and concepts and a system of social relations.

The techniques employed in identifying, treating or relieving poor mental health are dependent on the way in which beliefs, concepts and social relations interact to determine the way, behaviour is perceived, labelled and evaluated as deviant within a particular society. This raises the question: Do phenomena labelled poor mental health go unlabelled elsewhere? Deviance cannot be studied in different societies independent of cultural norms and local patterns of normative behaviour. (Fabrega, 1974; Kleinman 1976; Levine, 1973; Gove, 1975 and Young, 1976). This is an important point, when we come to discuss the ways/methods Barbadians, in Reading employ in dealing with poor mental health.

Considering the relationship between culture and poor mental health further, a number of questions emerge. Does the concept of mental health, inescapably involve culturally biased value judgements or are there possible valid generalisation that can be made about faulty physiology or socialisation that tend to produce distress systems definable as 'poor mental health' irrespective of culture?

Do phenomena labelled poor mental health go unlabelled elsewhere?

What are the effects of geographic and social mobility, or acculturation or change of cultures on mental health and emotional well being?

Is mental health of Reading Barbadians poorer than that of the indigenous (white) U.K. population?

Essential to a discussion on the influence of culture on poor mental health is a description of the cultural background of U.K. Barbadians.

**Barbadian culture, background and characteristics - 'way of life.'**

Barbadian culture has been shaped and formed by Anglo-African folkways, values and norms. Out of this milieu has developed a basic national
culture and character.

Barbadians are mobile, individualistic, diligent, somewhat reserved (and at times aloof). They resist the imposition of strong internal social controls. They have a high regard for education, law and order. They are high status seekers and are very class conscious. They had high expectations of full and immediate acceptance by the mother country, believing that they had a special relationship with Britain, through the long and loyal association with the British monarchy. They saw themselves as "Little Englanders."

Religion and religious services acquire profound meaning. Church is an integral part of the community, where people meet every Saturday (for Seventh Day Adventists) and Sunday, dressed in their best, to sing and engage in fellowship. Church attendance in Barbados is high, almost 70% of the total population are regular church goers (Clifford S. Hill, 1963).

"Socialising" is an important of Barbadian life. It is usually very informal, and is done in small groups of individuals. As the island is very small most places are easily accessible and friends call on each other unannounced. Visiting friends is a weekly occurrence, (for the young it is a nightly occurrence) and it is often spontaneous. At such gatherings current political and cricketing issues are debated, rum and other alcoholic spirits are drunk and dominoes played. This is mainly a male Women do less visiting than men. The younger women meet their friends at work or at various social functions, for example, parties and shopping. Housewives and older older women tend to engage in house visits.
'Madness' as viewed in Barbadian Society

Culture has influenced the way Barbadians perceived deviant behaviour, in particular 'madness'. The label is given primarily to observed behaviour, which people associate with madness. Hence a 'depressed' person is not usually labelled mad. Secondly the label is affixed on inference drawn from the quality of one's actions. "It is de actions which show us if a man is mad or not. First thing people say 'look at dah madman." Further, as I have noted in Chapter 6, the 'mad' label is less strictly applied by villagers when describing mad behaviour of the local madman.

The openness of the mad label means that a wide range of bizarre, amusing and foolish behaviour is accommodated within the community. The mad label is only affixed when it refers to or describes unpredictable, violent, homicidal behaviour.

The primary cause of madness, noted by BA Barbadians was 'studiation,' which means worry, concentration and the anxiety of learning. "Too much thinking of any kind on any subject os potentially dangerous to yuh mental well being."

Other causes include, 'digging' at elusive dreams and worrying about them, lining colds, loss of teeth and malicious intentions of others, resorting to trickery and obeah.
In brief, madness is seen as being caused by factors external to the individual and by the ill will of others. Here we see how strange and odd behaviour is widely tolerated, and the mad label applied less rigidly.

In contrast, in England the mad label is more readily affixed to odd and strange behaviour than it is in Barbados. Barbadian immigrants live between two cultures and as such it is difficult to evaluate the effect of a bi-cultural situation on the development of poor mental health. However, I have noted from my working experience and research observation that when overwhelmed by stress, West Indian immigrants tend to display culturally specific forms of emotional disturbance, for example, over religious indulgence, praying and imploring help from God, and "paranoid" ideas associated with obeah, or white persecution.

Let's take our analysis a step further and attempt to answer some of the questions posed at the beginning of the discussion.

(1) Does the concept of mental health inescapably involve culturally biased value judgements, or are there possible valid generalisations that can be made about faulty physiology or socialisation that tend to produce distress systems definable as poor mental health irrespective of culture?

The concept of mental health and its opposite mental illness is determined mainly by societal attitudes towards and beliefs about what constitutes mental health. In every society individuals within the society experience varying forms of emotional disturbance. Whether this disturbance is labelled mental illness depends on the nature and extent of the deviant behaviour and the society's attitudes to it. However in every society there are individuals who will manifest acute emotional disturbance, which might be due to faulty physiology or socialisation or both.
Our findings have shown that faulty socialisation, disruption or lack of social support systems are probably partly responsible for producing emotional distress for many respondents. We have also noted that physiological and psychological constitution plays an important part in making the individual more or less vulnerable to emotional disturbance.

(2) Do phenomena labelled poor mental health go unlabelled elsewhere? We have shown from our previous discussion on the imagery of madness that Barbadians have an 'open' attitude and a high degree of tolerance of strange, odd or 'mad' behaviour. Consequently behaviour which goes unlabelled in Barbados is labelled in England. For example, it is fairly common in Barbados to see individuals walking to and fro on the main shopping centre talking loudly to themselves shouting praises to the Lord and abuse to passers-by - generally behaving in a manner which would result in being admitted to a mental hospital in England and being labelled psychotic. In Barbados such persons are viewed as objects of amusements. The word mad may be used by some passers-by in a jocular manner, as a descriptive expression. It is only when he becomes dangerous, violent, threatening life and property that the mad label is affixed; otherwise he is free to roam the streets.

The mislabelling of West Indian immigrants - who become emotionally disturbed - as "schizophrenic" is one of the major shortcomings of British psychiatrists. Most of them are ignorant about the cultural background of their black patients. They are therefore unable to professionally interpret the presenting behaviour. Failing to do so, they rely on their textbook definition of schizophrenia to classify West Indians. Often, enough consideration is not given to the short nature of the distressing episode, and to the fact that such episodes are not typical of schizophrenia.
For me, the behaviour most of these patients manifest, is best described as poor mental health, a temporary psychological reaction to overwhelming stressful circumstances or situations, such as, frustration because of upward social mobility and difficulties of acculturation.

(3) What are the effects of geographic and social mobility, or acculturation, or change of cultures on mental health and emotional well being?

The mass movement of a large number of people from their homeland and culture, to a foreign land and culture, many miles away, usually results in social and emotional dislocation. It entails leaving family and friends, disrupting social bonds and network for a different society which provides no real source of identity. It was the feeling of insecurity, loneliness, strangeness of food, changes in climatic conditions, way of life, leisure of activity and a host of social variable which impinge upon respondents, threatening mental health and emotional well being.

Further respondents enter the socio-economic structure at a low status position, earning poor wages in mainly manual jobs. Having become integrated and to some extent acculturated into English society, they try to improve their social position and standard of living by being upwardly mobile. They shockingly discover that the colour of their skin debars them from achieving their goals. Faced with these obstacles and frustrations respondents are likely to undergo varying levels of poor mental health.

(4) Is the mental health of the Reading Barbadians poorer that that of the indigenous (white) U.K. population?

The findings of my study conducted in Reading, England, have shown that U.K. Barbadians have poorer mental health than the indigenous (white) U.K. population and Barbadians in Barbados, (See Table 1) Why is there this difference? Is it due to the culture shock, acculturation or social selection? Is it due to the amount and type of stress immigrant Barbadians encounter? Has the migration process acted as a catalyst in producing poor mental health among U.K. Barbadians?

Standard deviations are given in brackets.

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A comparison of MAI (CMI) sub-scales mean scores in Barabadian and U.K. groups
Migration And Poor Mental Health

Definition

In most countries of the world migration is a widespread phenomenon with far reaching consequences for the individual, families and societies conceived.

Migration occurs when people move within one community, from one community to another in the same country, or from one community in one country to another community in another country (Friesseur D.H. 1974), as in the case of Barbadians in Reading.

Another variable in the relationship is poor mental health. Poor mental health, for the purpose of this study, may be defined as, a general feeling or state of being unwell, but not necessarily ill, to the extent that medical (psychiatric) assistance is needed. Poor mental health may be viewed as a sub-category of "mental illness."

The Relationship

There is a big difference between political refugees or deported persons, for whom migration is involuntary and people who migrate to another country voluntary, looking for better opportunities, for example, Barbadians - See Chapter on Reasons For Migrating.

In studying the relation between migration and poor mental health certain variables should be considered, the degree and quality of change in the social environment, geographical distance, the circumstances in which migration took place, the cultural, social and economic characteristics of the migrants themselves (Morrison, 1973).
It appears, from the work of myself and others, that it is not migration itself that generates vulnerability to poor mental health, but other factors, such as conditions in the host country, for example, poverty, stereotypes and prejudice towards immigrants etc, and characteristics of immigrants themselves, pre-existing vulnerability, the stress of adaptation to a new country and/or discrimination in the host.

**Nature of the Difference**

Differences among people of different ethnic groups and people of the same ethnic group, but living in different cultural environments seem to be explained by transformations in the characteristics and cultural identity of the immigrating group.

We have shown by our earlier discussion that there are marked differences between Barbadian and English cultural background and characteristics, their 'way of life.' Barbadians in Reading have experienced steady and gradual erosion of their traditional values and belief; this depends on the degree of acculturation.

We have also shown that Barbadians in Reading experience a variety of stressors which heighten their vulnerability to poor mental health as the means on the NHSS have shown U.K. Barbadians have poorer mental health, male (25.76), females (27.82), than Barbadians in Barbados, male (19.12), female (25.76) (See Table I.). This raises a few questions. What is the relationship between migration and poor mental health. Why do Barbadians in Reading have poorer mental health than Barbadians in Barbados.

These differences may be explained along three lines, psychodynamic, socio-psychological and sociological. The psychoanalytical oriented reader is directed to Eastide (1971) and the socio-psychological reader is referred to Baravel and Xuring (1971) and De Allmeida's (1970, 1975) work. Here we
shall proceed with the sociological hypotheses.

Sociological Hypotheses

There are three main hypotheses, that can be put forward to explain the relationship between migration and poor mental health. They are that immigrants may be drawn from populations with rates different from those of the host population they join; that the process of immigration itself affects the mental health of migrants, and that there is a selection for immigration on the basis of factors related to poor mental health. It is not possible to test these hypotheses directly in this study, but there are some leads to an indirect test of these hypotheses.

Hypothesis I

Immigrants may be drawn from populations with rates different from those of the host population they join.

This hypothesis requires evidence on prevalence of poor mental health in the home population from which immigrants are drawn. We are unable to make a direct comparison between prevalence of poor mental health in home (Barbados) and host populations. However we have shown that Barbadians in Barbados have better mental health than Barbadians living in Reading. Further, comparing our Reading data with the latest definitive normative English group, presented by Crown and Crisp (1980), we can observe from the total score of the KHT that there is relatively little difference in mental health between BA Barbadians (males 19.12, females 25.76) and the English adult normative group (males 19.45, females 23.85). Few differences appear, and those that do imply that BA Barbadians have better mental health (See Table I.).

Having produced such evidence, it then becomes very difficult to compare figures, because of the difference in the culture and "way of life" of the two societies. We need to go a step further and examine the underlying
factors involved in the differences in poor mental health of the two populations.

Hypothesis II

The process of migration affects the mental health of migrants.

This hypothesis is only plausible in a rather tenuous form on the basis of data presented in my study. Strictly, of course, it is necessary to have information on the mental health of immigrants before and after their migration. In the absence of pre-migration data we are forced to rely on post migration rates of poor mental health based on the findings of my community study.

My study revealed that Barbadian immigrants living in Reading had poorer mental health than Barbadians in Barbados and the indigenous (English U.K. population). It is again necessary for us to locate what factors are involved in determining the difference in poor mental health. Another variable which may be involved in determining this difference in poor mental health is: (the degree and quality of change in the social circumstances).

Variables In The Migration - Poor Mental Health Model

(1) Degree And Quality Of Change In The Social Circumstances.

For most Barbadian immigrants to Britain, immigration has occasioned major changes in their social environment. Most of the migrants who came to Britain/England were in the 20-39 age group. This was a young, healthy population of migrants. The first and most direct change immigrants experience was physical. The cold, damp, grey English weather was a major experience for the people from a tropical country.

A large number of immigrants were in white collar, civil servant occupations in Barbados; they gave up their jobs to work as bus conductors, railway...
guards, shunters, tea ladies-at Lyons-and other jobs in the service industries. These were jobs which the white working class had vacated for cleaner, higher paid, higher status jobs. With few exceptions, these jobs involved manual menial tasks, and were of low status. For those who were in middle class occupations at home, this was psychologically disturbing. As one respondent pointedly reminded me, "these were jobs Barbadians wouldn't be seen dead doing at home."

From my personal experience - from being a teacher in Barbados to a student nurse in England - I can endorse what the respondent said. Not accustomed to menial tasks, it was an unforgettable experience for me, when I realised the amount of faeces and urine cleaning and other dirty tasks involved in nurse training. Being a 'newcomer,' I was given what I considered, more than my fair share of dirty task. Many of my friends and I had some difficulty in adjusting to our new and strange social circumstances. Although most sponsored immigrants were given some information about the job before migrating, they were relatively unprepared and surprised when they later discovered the true nature of the job. This was a distressing period for some immigrants. Some of them tried to tolerate the conditions, while others sought other jobs. The frustrating aspect of their situation was, that there were few jobs which didn't involve heavy manual and menial task (S. Patterson 1968).

Findings from my sociological questionnaire have revealed a strong, significant association, above 1% in probability between poor mental health and some socio-demographic variables. The most significant variables are listed below.

<table>
<thead>
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<th>Variable</th>
<th>Value of ETA with total MHQ scale</th>
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<tbody>
<tr>
<td>Contact with near relatives</td>
<td>297</td>
</tr>
<tr>
<td>No. of years lived in England</td>
<td>400</td>
</tr>
<tr>
<td>Reasons for visiting friends</td>
<td>345</td>
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Infrequent contact with near relatives and close friends was found to be closely associated with poor mental health. Respondents who visited infrequently tended to have a constricted social network and a limited source of social support.

Further, former parish of residence - in Barbados - was found to provide a source of social bond for many respondents. For example, respondents who emigrated from the parish of St. Andrew all knew each others relatives directly or indirectly before emigrating.

Length of residence in England, was observed to have a relationship with poor mental health. Respondents who were resident in England for an average of 15 years report better mental health than those who were resident for a shorter period. It would appear that 15-20 years was the optimum period at which acculturation was conducive to mental health. Conversely the less acculturated, the greater the likelihood of respondents experiencing poor mental health.
The housing situations of some respondents were found to be contributory to poor mental health. Respondents whose housing situations hadn't changed and who were currently living in crowded conditions reported poor mental health.

Pre-migration intentions and expectations about England and the English were found to be related to poor mental health. Before migration, respondents had developed a set of ideas and expectations about England and what opportunities it offered. When they later found out that life in England for the black man, was by far, more difficult than expected, they became disillusioned.

Such feelings of disillusionment and frustration were more widespread among upwardly mobile blacks. Respondents who have acquired or were acquiring further education, and those who were occupationally mobile recorded the highest level - above .001% - of association with poor mental health. Apart from these significant variables, U.K. Barbadians encountered many and varied forms of stress, which contributed to poor mental health. Some of these are cited below.

Some stressful factors for U.K. Barbadians. Based on questionnaires and interviews the following are identified:

1. Unsuccessful goal-striving.

2. Economic problems,
   a) unemployed for long periods.
   b) employed in poorly paid, manual jobs for many years without promotion.
   c) not earning enough to assist poor relations at home.

3. Bad housing in urban slum areas.

4. Membership in a minority group with all the stereotypes and various forms of racial discrimination and harassment.
Disillusionment

Barbadians’ expectations about England were considerably influenced not only by their motives, but by preconceptions about England and the special cultural and historical relationship with Britain. As we have shown elsewhere (Chapter 14) the preconceptions and anticipated relationship that Barbadians had were at variance with reality. This was a major factor in impending accommodation and increasing disillusionment, resulting in stress and psychological disturbance to the immigrants.

Barbadians had an outmoded, distorted image of the ‘mother country,’ derived from experience of an upper class colonial service, armed forces, traders, planters, exposure to British orientated educational system and social exclusiveness of the local British elite. (Patterson S. 1966). They were shocked by the work-a-day, decolonised drably affluent Britain today. They found it difficult to believe that this was the same country that they had read and heard about, had identified with and expected so much from. What had gone wrong?

Respondents recalling their initial experience in England, remarked, that they were surprised to find life in England so “hard.” One respondent said, “I felt fed-up, I didn’t know England was like this, I would have preferred to suffer at home.” Another noted, “if I had money I would have caught the next plane home.” These remarks are still pertinent to West Indians in contemporary Britain, most of whom have been resident for more than twelve years. Respondents reflecting on their life in England acknowledged that they only began to feel very fed-up, frustrated and disappointed after being resident for over five years. It was after this time that they began to realise, that accumulating their ‘nest-egg’ obtaining academic qualifications and returning home would not be easily realised.
For some respondents, coming to England was a big mistake. This is further reinforced when such immigrants return home and witness the socio-economic betterment of relatives and friends who haven't migrated. This highlights the living standards between the two groups, and results in the immigrant experiencing stress; because he realises that he has to redouble his efforts - acquire more money - if he wishes to resettle in his homeland.

**Disappointment and Frustration**

Barbadians came to England for economic and educational reasons, whether it is a question of accumulating a nest-egg or the acquisition of a skill or profession - the initial intention of most economic migrants has always been to return home as soon as the object of migration was achieved. This twin goal of economic and/or educational achievement and return was in reality only achieved by a small proportion of Barbadians.

Among such migrants there is usually a close correspondence between intentions, working ability and expectations of the receiving society.

In the early years Barbadians were characterised by impermanent intentions. Low wage jobs, high expectations of high wages, educational advancement and complete acceptance by the receiving society. This combination of characteristics led to poor working performance - because of job dissatisfaction, high job turn over (in search of better paid jobs). These characteristics slowed the pace of acceptance until intentions became permanent, expectations more modest and better paid jobs obtained. However, this did not markedly improve the position of the immigrant. Today, despite a mark change in settlement intentions, and many years of toil, Barbadians are still in mainly unskilled jobs. Admittedly there had been upward mobility for some, but for the majority it has been very frustrating and disappointing. They still have not achieved their original plan.
Realising that their stay in England would be longer than planned, many immigrants sent for their families; wives to help achieve goals, children to obtain a 'good British education.' The immigrants hoped that the British schools would help their children to secure better jobs than they themselves had. In this they were soon to be disappointed. The British employer's resistance to place black school-leavers in jobs other than manual and semi-skilled remained as high as with adult immigrants (Rose E.J.B. 1969).

During my interview with respondents, unsuccessful goal striving frustration and disappointment, both with British society and with themselves were factors which were uppermost in the respondents minds. They had not only failed themselves, in achieving their goals, but had witnessed their children's failure.

Rejection

"There is confrontation between workers from colonial economic context and the free and organised (white) working class of the metropolitan countries. The confrontation takes place in marginal areas of employment where jobs must be filled, yet cannot be filled from the metropolitan working class" (Rex 1973). This is an apt description of the situation. Barbadian immigrants entered. They were employed to work at menial jobs which the white working class refused to fill.

The colonial powers encouraged their imperial subjects to believe that they were part of the Great British Empire, which they had helped to build, and they had a claim to recognition in the metropolitan society. Barbadians culturally identified themselves with Britain. They did not see any thing African about their culture. Anthony Trollope, writing in 1866 noted that "the West Indian negro knows nothing about Africa, except that it is a term of reproach." This concept of false identity has been reinforced by educated West Indians. Dr. Hugh Springer (Barbadian) writing in
the Caribbean Quarterly 1967, admonished that "it is necessary to see ourselves in perspective, as far as we can and to recognise that ours is..... a part of that great branch of civilisation that is called Western civilisation. Our culture is rooted in Western culture and our values in the main are the values of the Christian faith." This statement illustrates the persistent refusal by many Barbadians, especially those of the middle class, to come to grips with their past. It is no wonder that Barbadians were shocked and dismayed, when they were openly refused by English society, no recognition was given. The imperial subjects found themselves in manual marginal jobs, which were spurned by the metropolitan working class. They were assigned whatever form of accommodation in which ever part of the city that was least attractive. They were made to feel unwelcome and to realise that their colour - black - condemned them to third class citizenship.

Barbadians were visibly and audibly different. All the stories and stereotypes about the negroid looking people - West Indians of African decent surfaced.

For those immigrants who aspired to supervisory, technical or administrative posts, poor English, a heavy creole accent and a dark skin were drawbacks, if not definite blocks. They were denied access to status conscious occupations, particularly those involving contacts with the public, where vocabulary, timbre and accent were considered important. They were denied such occupations primarily because they were black.

Barbadians whose first jobs involved contact with the public - bus conductors, railway guards - experienced great difficulty in being promoted to non-manual and supervisory jobs, in spite of the fact that they were academically qualified.

Those Barbadians, who in rare occasions were accepted, were light-skinned and the often made comment was, "he is so English that everyone forgets his colour."
Colour is an important factor in the lives of most West Indians living in contemporary Britain. Racial discrimination is now more direct and obvious than in the 1960's, and it is still very much with us.

Racial Discrimination - A Form of Rejection

The most depressing aspect of racial discrimination in Britain has been its blanket application. No matter what occupation or educational achievement a black man acquires, he finds himself without recognition and respectability in British society. That rare specimen of a black man on whom respectability is confirmed, invariably has become 'white' in order to gain acceptance.

Respondents in my study in Reading, frequently referred to the lack of respect shown to black people, by whites, commenting, "white people got no respect for us, they would treat yuh like durt if yuh not careful." Fanon (1967) reminds that reciprocal recognition was totally negated in the encounter of the man of colour with the white man...... who behaves according to the dictates of long established patterns, established through slavery. He further warns that, where desire for recognition (by the man of colour) is constantly frustrated, there is an internal struggle and conflict which can lead to stress and possible psychological disturbance. However, unable to constantly adopt avoidance reactions, the man of colour becomes violent towards the white man.

Some of the recent 'black riots' in England do embody many aspects of socio-economic and cultural deprivation of the black man. His self-worth impaired, desire for recognition frustrated and thwarted, the black man draws attention to his oppressed situation by a recourse to violence and destruction.
Hypothesis III

There is a selection for migration on the basis of factors related to poor mental health.

This hypothesis takes the form of differential selection for migration depending upon the difficulties involved in achieving relocation. However, poverty, lack of contact with Western culture, poor communication and distance present great obstacles to migration, and where failure to achieve acceptable living standards in the country of origin cannot be attributed to personal failure, it may be only the most stable members of the population can overcome these obstacles and become immigrants.

Where, however, migration is relatively easy and the country of origin is not very different from the host country, it may be those who have failed to adjust or be successful in their home environment who self select to migrate. They would bring their psychological problems with them.

This raises two important questions: Firstly what are the particular characteristics of the immigrants themselves? and secondly, what were the circumstances in which migration took place?

Circumstances In Which Migration Took Place

Migration from Barbados to the U.K. was on a voluntary basis, either through sponsored or unsponsored schemes. Financial assistance, in the forms of government loans, to cover travelling expenses was available. Accommodation was usually provided by the recruiting agency - for example, British Railways Board - for persons migrating under government sponsored schemes. On arriving immigrants experienced few housing and employment difficulties. What kind of characteristics did the migrants have? Why were they prepared to leave their homeland, and journey to a distance land, many miles away? What effect did the distance have on them?
Particular Characteristics Of The Migrants Themselves

The migrants, irrespective of their socio-economic position were eager to leave Barbados, because the prospect of social and economic betterment was poor. For them their future was in England. There was an air of excitement and joy about coming to England and relief at being able to leave Barbados.

Successful completion of the migration process was a major achievement. There was considerable competition to migrate. The migration process began by first registering one's name at the labour exchange, stipulating what type of job was being sought. After a method of selection, which was known only to the civil servants dealing with such matters, (stories of bribery were rife), the successful applicant was instructed in a pre-migration study course which was held at Richmond's School, and lasted four weeks. Tuition was given in English, oral and written arithmetic, C.S.D. and English History, supplemented by films. At the end of the course there was an examination. Those individuals who passed the examination were finally selected to emigrate. This process of migration, ensured, to a large extent, that an intelligent, able-bodied population be selected. This meant that by and large they were not psychologically marginal.

However, female immigrants do present a different picture. Most female immigrants came to England on initiation from family members, relatives, spouse or friends. They experienced no rigorous selection process like the men did. So long as the female had a work permit, a valid passport and air ticket and she was free to enter England. Subsequently the immigration laws made it difficult for family members, relatives and others to obtain visas. It was still relatively easy to emigrate.
(2) Geographical Distance

The migrants travel some 2,000 miles from their homeland to a foreign land, to a country they had never seen, nor set foot on. They had heard so much about it, that they had identified it as the 'mother country,' a place they longed to see. The painfully crushing factor in the migration process was the distance. For other immigrants, Irish, Poles, Hungarians and other Europeans there was easy access and relatively cheap travel when they wanted to return home. For Barbadians this was not the case. During periods of loneliness, illness, 'depression,' immigrants were unable to catch a train, bus or boat to visit their homeland. The cost of travel between England and Barbados was prohibitive. Many stories have been told by migrants who spent five to ten years accumulating their air fare. Another factor which hindered home visits was the additional costs. These were, purchasing clothing and other articles for relatives and friends.

Conclusion

The relationship between migration and poor mental health is rather complex; several factors are implicated. Our discussion focused on three main hypotheses.

(1) that immigrants may be drawn from populations with rates different from those of the host population they join.

(2) that the process of migration itself affects the mental health of migrants, and

(3) that there is a selection for immigration on the basis of factors related to poor mental health.
Our findings have indicated that there is relatively little difference in rates of poor mental health between Barbadians in Barbados and the indigenous (white) U.K. population. The few differences that appear imply that Barbadians have better mental health than the U.K. (white) population. From this finding we can tentatively infer that U.K. Barbadians came from a population which does not have poorer mental health than the host population they joined.

However, our findings reveal that U.K. Barbadians have poorer mental health than indigenous Barbadians, and the U.K. (white) population.

Our second hypothesis posits that the process of migration affects the mental health of migrants. This seems plausible, because the marked difference in poor mental health (for U.K. Barbadians) seemed to have occurred after migration. How can we prove hypothesis II? Strictly speaking we cannot from our present data. It is necessary to have information on the mental health of immigrants before and after migration. In the absence of pre-migration data, we have to rely on post-migration rates of poor mental health based on our findings. Here we have found that a multiplicity of socio-economic and cultural factors have operated to create stressful life situations for our respondents, resulting in varying rates of poor mental health.

These findings only partly support hypothesis II. It may be, as hypothesis III noted, that there is a selection for migration on the basic factors related to poor mental health. In other words, those respondents who were selected for migration possibly had faulty psychological or physiological constitutions. Once again, we are unable to directly prove this hypothesis, because there is no pre-migration data on our respondents. We therefore have to rely on a set of pre-migration factors such as:

1. The circumstances in which migration took place
2. Particular characteristics of the migrants themselves
From our discussion of these factors we have shown that U.K. Barbadians were closely screened before being selected for migration. They were personally highly motivated. In many instances this high level of motivation has turned to disenchantment, when faced with racial barriers inhibiting social mobility. The distance between Barbados and England was found to be a source of anxiety for a number of respondents, mainly females, who had left children, parents and loved ones at home. In many respects geographic distance aggravated periods of loneliness, because respondents were cut off from their former sources of social support and network. Here we have examined some of the factors relating to migration and poor mental health.

**Culture**

As was discussed earlier, another important variable in the complex web of defining and diagnosing mental illness is culture. Several theories have been developed to explain these kinds of cross-cultural differences in types, rates and outcomes (Dohrenwend and Dohrenwend, 1973).

Of greatest importance in the process are the belief system of the society and the extent to which the patient has power over his role as a sick person. In societies such as Ceylon, the West Indies and Mauritius where beliefs about mental illness centre around supernatural causation; where the person is not held responsible for his illness, where his 'self' remains unchanged, he can shed the sick role quickly and easily. In contrast, in, for example, Western developed countries where psychiatric illness are believed to involve personality change and personal responsibility, the sick person receives many messages telling him that something is seriously wrong with his self. His self-perception and behaviour may conform to these messages and his illness may have a long duration.
The nature of the treatment system too may contribute to the patients outcome. In peasant societies where treatments are highly ritualised and where practitioners are not bureaucratically organised, patients and their families retain control over illness - confirming messages and the patients may easily drop the sick role and return to 'normality'. In many Western societies, like England, treatment systems are both comprehensive and bureaucratic, the patient may become engulfed in this system and find little reward and little opportunity for shedding the sick role.

Thus, how societies process the mentally ill person once the illness has been recognised may be a crucial factor in explaining cross-cultural differences in rates and prognosis for psychiatric illnesses.

The key question facing cross-cultural studies in medicine and psychiatry lie on the illness side of the dichotomy. To focus only on the disease side, is to strip the question of culture and the deviant behaviour of its chief significance. It is absolutely important that we obtain information about cultural background presenting patients before we can begin to understand the nature of their deviant behaviour. We have noted that Barbadian respondents, mainly those living in London have reported that a major cause of madness was the "pressure of life in this society", difficulty in finding a job, securing decent accommodation, police harassment and the social injustices resulting from racial discrimination. Unable effectively to utilise the traditional network support system and to personally cope with stressful life events, they react by committing crimes and/or displacing hypothetically by manifesting psychological disturbance.

In Reading we have noted that while respondents experience similar stressful life events as fellow Barbadians in London, they seem to cope better. This was observed from the low rate of psychiatric hospitalisation. From a total Barbadian population of 1,390 persons (1971 Census figures), only 18 persons were admitted to Fairmile Hospital - psychiatric hospital serving the catchment area of Berkshire - during the period 1963 - 1978. (See Appendix VII).
There are several factors which could possibly account for the low rate of hospitalisation. Probably the most important factor was noted by Burke (1980). He found that Barbadians in Reading were reluctant to use the psychiatric services. They preferred to send ill relatives home - Barbados. While this is an interesting observation, Burke's study suffers from a major short-coming. His sample was comprised of only 20 respondents, which possibly misrepresents the true rate of under-utilisation of the psychiatric services. Looked at in another way the 20 respondents possibly indicate the low level of diagnosed psychiatric morbidity, among Barbadians in Reading. However, I would hypothesise that the low rate of psychiatric hospitalisation among Barbadians in Reading is probably due to the:

1. Cohesive nature of the Barbadian/West Indian community.
2. High level of pre-migration social contacts/familiarity - most of the Barbadians in Reading come from two parishes - areas of residence - St. Michael and St. Andrew.
3. Social support during periods of extreme alienation.
4. Geographical nearness of family members.

These factors probably act as buffers, protecting community members from the noxious effects of stress. However, if the individual's perceptual defences, ego defences, problem solving behaviours and social support bonds are inadequate to overcome the stressful life situations, a pathological end - state will result.

A recent 'Skin' programme (July 1981) on mental health - has shown that West Indians are being admitted to mental hospitals and psychiatric units in ever increasing numbers. Many of them being mis-diagnosed.

What is the black community doing to rescue its members from these institutions? At this point in time we are standing, gazing helplessly as our brothers, sisters, parents and friends are diagnosed, hospitalised and stigmatised -
"Once mad always mad," a label which further restricts the employment prospects of blacks.

Black people must be made aware of how they are reacting to stress in this society, by committing crimes and displacing hypothetically, by manifesting psychological disturbances. These reactions will necessarily produce the criminal and mad label, both of which are subtle forms of social control and racism, exercised by British society to keep blacks in their place. In a recent T.V programme - 'Skin' - November, 1980 - the presenter reported on the increasing rate of psychiatric morbidity among blacks in England. She further noted that many individuals were being diagnosed incorrectly and hospitalised, because most British psychiatrists lacked a cultural understanding of the presenting 'patient.'

The main consequence of the 'new cross-cultural' approach is its systematic attention to cultural differences in response to traumatic and stressful situations. This relates to the nucleus of the relationship of culture, migration and poor mental health.
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<table>
<thead>
<tr>
<th>Author(s)</th>
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<td>Young, A.</td>
<td>Some implications of medical benefit.</td>
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APPENDIX I

The Barbados Shipping and Trading Co., Ltd. has expanded from the 'Big Six' of 1920 - 46. The subsidiaries of the B.S.T. Co. Ltd. in 1974 were Da Costa Musson Ltd; Manning, Wilkinson and Challenor Ltd; Gardiner Austin and Co. Ltd; Bulkley Estates Ltd; Tractors; Musson (Jamaica) Ltd; Super Centre Ltd. (a supermarket chain, the biggest in the island). Other companies wholly owned by subsidiaries were Da Costa & Co; Stevedores Ltd; Seawell Air Services; Fort Royal Garages Ltd; Perkins and Co. Ltd. and Ince and Co. Ltd.

Companies controlled by subsidiaries were Applewhites Ltd. and West Indian Records (Barbados) Ltd.

In 1970 links were made with Sun Farms (a vegetable and garden enterprise), Orange Hill Plantation, Banks Beer, as well as many areas in the tourist industry. Shareholdings were taken out in Phama-Chem Ltd; Barbados Nail Co. and Long Life Tinse and Towell Plastics, (Bds.) Ltd.

In 1968 B.S.T. and Co. Ltd. had an investment interest in Sun Crest St. James, (a tourist resort apartment scheme); substantial shares in Bitumale (Jamaica) Ltd., and Caribbean Milling Ltd. (Jamaica).

Through Musson Ltd. (Jamaica) the B.S.T. also had substantial shares in Elite Shirts; Toberts Manufacturing; S.W. Wilson and Co. and Barbados distilleries. The B.S.T. Co. has substantial investments, not only in Jamaica, but in the Leeward and Windward islands.

SOURCE:
From Annual Report and Accounts of the B.S.T. Co. Ltd. 1966 - 73.
EYSENCK PERSONALITY INVENTORY
by H. J. Eysenck and Sybil B. G. Eysenck

PERSONALITY QUESTIONNAIRE

FORM A

NAME................................. AGE....................

OCCUPATION............................... SEX...................

N= [ ] E= [ ] L= [ ]

Instructions
Here are some questions regarding the way you behave, feel and act. After each question is a space for answering "YES" or "NO".

Try to decide whether "YES" or "NO" represents your usual way of acting or feeling. Then put a cross in the circle under the column headed "YES" or "NO". Work quickly, and don't spend too much time over any question; we want your first reaction, not a long-drawn out thought process. The whole questionnaire shouldn't take more than a few minutes. Be sure not to omit any questions.

Now turn the page over and go ahead. Work quickly, and remember to answer every question. There are no right or wrong answers, and this isn't a test of intelligence or ability, but simply a measure of the way you behave.
FORM A

1. Do you often long for excitement? [ ] Yes [ ] No
2. Do you often need understanding friends to cheer you up? [ ] Yes [ ] No
3. Are you usually carefree? [ ] Yes [ ] No
4. Do you find it very hard to take no for an answer? [ ] Yes [ ] No
5. Do you stop and think things over before doing anything? [ ] Yes [ ] No
6. If you say you will do something do you always keep your promise, no matter how inconvenient it might be to do so? [ ] Yes [ ] No
7. Does your mood often go up and down? [ ] Yes [ ] No
8. Do you generally do and say things quickly without stopping to think? [ ] Yes [ ] No
9. Do you ever feel "just miserable" for no good reason? [ ] Yes [ ] No
10. Would you do almost anything for a dare? [ ] Yes [ ] No
11. Do you suddenly feel shy when you want to talk to an attractive stranger? [ ] Yes [ ] No
12. Once in a while do you lose your temper and get angry? [ ] Yes [ ] No
13. Do you often do things on the spur of the moment? [ ] Yes [ ] No
14. Do you often worry about things you should not have done or said? [ ] Yes [ ] No
15. Generally, do you prefer reading to meeting people? [ ] Yes [ ] No
16. Are your feelings rather easily hurt? [ ] Yes [ ] No
17. Do you like going out a lot? [ ] Yes [ ] No
18. Do you occasionally have thoughts and ideas that you would not like other people to know about? [ ] Yes [ ] No
19. Are you sometimes bubbling over with energy and sometimes very sluggish? [ ] Yes [ ] No
20. Do you prefer to have few but special friends? [ ] Yes [ ] No
21. Do you daydream a lot? [ ] Yes [ ] No
22. When people shout at you, do you shout back? [ ] Yes [ ] No
23. Are you often troubled about feelings of guilt? [ ] Yes [ ] No
24. Are all your habits good and desirable ones? [ ] Yes [ ] No
25. Can you usually let yourself go and enjoy yourself a lot at a gay party? [ ] Yes [ ] No
26. Would you call yourself tense or "highly-strung"? [ ] Yes [ ] No
27. Do other people think of you as being very lively? [ ] Yes [ ] No
28. After you have done something important, do you often come away feeling you could have done better?  
   YES  NO
29. Are you mostly quiet when you are with other people?  
   YES  NO
30. Do you sometimes gossip?  
   YES  NO
31. Do ideas run through your head so that you cannot sleep?  
   YES  NO
32. If there is something you want to know about, would you rather look it up in a book than talk to someone about it?  
   YES  NO
33. Do you get palpitations or thumping in your heart?  
   YES  NO
34. Do you like the kind of work that you need to pay close attention to?  
   YES  NO
35. Do you get attacks of shaking or trembling?  
   YES  NO
36. Would you always declare everything at the customs, even if you knew that you could never be found out?  
   YES  NO
37. Do you hate being with a crowd who play jokes on one another?  
   YES  NO
38. Are you an irritable person?  
   YES  NO
39. Do you like doing things in which you have to act quickly?  
   YES  NO
40. Do you worry about awful things that might happen?  
   YES  NO
41. Are you slow and unhurried in the way you move?  
   YES  NO
42. Have you ever been late for an appointment or work?  
   YES  NO
43. Do you have many nightmares?  
   YES  NO
44. Do you like talking to people so much that you never miss a chance of talking to a stranger?  
   YES  NO
45. Are you troubled by aches and pains?  
   YES  NO
46. Would you be very unhappy if you could not see lots of people most of the time?  
   YES  NO
47. Would you call yourself a nervous person?  
   YES  NO
48. Of all the people you know, are there some whom you definitely do not like?  
   YES  NO
49. Would you say that you were fairly self-confident?  
   YES  NO
50. Are you easily hurt when people find fault with you or your work?  
   YES  NO
51. Do you find it hard to really enjoy yourself at a lively party?  
   YES  NO
52. Are you troubled with feelings of inferiority?  
   YES  NO
53. Can you easily get some life into a rather dull party?  
   YES  NO
54. Do you sometimes talk about things you know nothing about?  
   YES  NO
55. Do you worry about your health?  
   YES  NO
56. Do you like playing pranks on others?  
   YES  NO
57. Do you suffer from sleeplessness?  
   YES  NO

PLEASE CHECK TO SEE THAT YOU HAVE ANSWERED ALL THE QUESTIONS
ITEMS SELECTED FOR THE SHORTER VERSIONS OF THE QUESTIONNAIRE

ITEMS SELECTED FOR THE THREE 56-QUESTION QUESTIONNAIRES

'The 36 "Best" Items'

1  2  3  4  7  11  12  14  15  16  17  20  21  23  26  30  35  36
37 38 39  40  41  42  43  45  46  47  49  50  51  52  54  55  56  58

Balanced for 'Agreement Set'

1  2  7  12  14  15  16  17  20  21  26  27  28  30  31  32  33  35
36 39 40  41  42  43  45  46  47  49  50  51  52  53  54  55  56  58

'Physical Illness' Items Removed

7  9  11  14  18  19  20  21  32  28  30  34  35  36  37  38  39  40
41 42 43  45  46  47  49  50  51  52  53  54  55  56  57  58  59  60

ITEMS SELECTED FOR THE 12 -, 20 - AND 30- ITEM QUESTIONNAIRES

(Note: The number before each item indicates its position in the 60 item questionnaire)

HAVE YOU RECENTLY:

7. been able to concentrate on whatever you are doing?
14. lost much sleep over worry?
35. felt that you are playing a useful part in things?
36. felt capable of making decisions about things?
39. felt constantly under strain?
40. felt that you couldn't overcome your difficulties?
42. been able to enjoy your normal day to day activities?
46. been able to face up to your problems?
49. been feeling unhappy and depressed?
50. been losing confidence in yourself?
51. been thinking of yourself as a worthless person?
54. been feeling reasonably happy, all things considered?

- THESE ARE THE 12 BEST ITEMS.
6. - been getting out of the house as much as usual?
8. - been feeling on the whole you were doing things well?
10. - been satisfied with the way you've carried out your task?
13. - been taking things hard?
47. - found everything getting on top of you?
55. - been feeling nervous and strung up all the time?
58. - found at times you couldn't do anything because your nerves were too bad?

HAVE YOU RECENTLY:

20. - been having restless, disturbed nights?
27. - been managing as well as most people would in your shoes?
31. - been able to feel warmth and affection for those near to you?
32. - been finding it easy to get on with other people?
33. - spent much time chatting with people?
41. - been finding life a struggle all the time?
45. - been getting scared or panicky for no good reason?
52. - felt that life is entirely hopeless?
53. - been feeling hopeful about your own future?
56. - felt that life isn't worth living?

- THESE ARE THE 30 BEST ITEMS

ITEMS SELECTED FOR THE 30-ITEM GHQ USED IN THE UNITED STATES

7 14 15 16 20 21 26 27 28 31 32 35 36 39 40 41 42 43 45
46 47 49 50 51 52 53 54 55 56 58

These are the '30 best' items, except that items 30 and 33 were withdrawn on the advice of American colleagues and replaced by items 15 and 16, since the former items were not easily understood by some respondents. Three further items had minor alterations to the wording to make them more comprehensible in the vernacular (original wording in parentheses).

HAVE YOU RECENTLY:

27. - been managing as well as most people would in your place? (shoes)
47. - found everything getting too much for you? (on top of you)
55. - been feeling nervous and strung up all the time? (strung up)
APPENDIX IV.
PSYCHOLOGICAL TESTS - 22 ITEM SCALE
(Langner, 1962.)

ITEM

1. I feel weak all over most of the time.

2. I have had periods of days - weeks or months when I could not take care of things because I could not get going.

3. In general, would you say that most of the time you are in high (very good) spirits, good spirits, low spirits, or very low spirits?

4. Every so often I feel hot all over.

5. Have you ever been bothered by your heart beating hard?

6. Would you say that your appetite is poor, fair, good or too good?

7. I have periods of such great restlessness that I cannot sit long in a chair (cannot sit still very long).

8. Are you the worrying type?

9. Have you ever been bothered by shortness of breath when you were not exercising or working hard?

10. Are you ever bothered by nervousness (irritable, fidgety, tense)?

11. Have you ever had any fainting spells (lost consciousness)?

12. Do you have any trouble getting to sleep or staying asleep?
13. I am bothered by acid (sour) stomach several times a week.

14. My nerves seem to be alright (good).

15. Have you ever been bothered by cold sweats?

16. Do your hands ever tremble enough to bother you?

17. There seems to be a fullness in my head or nose much of the time.

18. I have personal worries that get me down physically (make me physically ill).

19. Do you feel somewhat apart even among friends (apart, isolated, alone)?

20. Nothing ever turns out for me the way I want it to.

21. Are you ever troubled with headaches or even pains in the head?

22. Do you find that you sometimes cannot help wondering if anything is worthwhile anymore?
AGE, SEX, REASONS FOR ADMISSION, DIAGNOSIS AND WARD ADMITTED.

Key:  G/F       Grassfield Ward.
     T/H       Tamarind House.
     A       A Ward.

AGE.                      STATUS - HALE.

1. 63: Confused and hallucinated, destructive to neighbour's property - thinks he is in Glendairy (the local prison).
     ? Senile Dementia.  G/F

2. 37: Unlawfully assaulted petrol pump attendant, believes he has won £000's on Vernons pools.
     ? Paranoid delusions.  A

3. 18: Charged with loitering with another rastaman, smokes ganja, malnourished with marked confusion.
     appears vague (no diagnosis)  A

4. 79: Tried to burn his clothes and other property.
     ? Senile Dementia  G/F

5. 42: Suffering from visual and auditory (V/A) hallucinations with persecution ideas.
     ? Paranoid Schizophrenia.  G/F

6. 48: Killed his wife, has no memory of event, keeps talking about how nice he was to his children, now they turn against him. Serving part of his sentence 'life imprisonment' in the mental hospital. Has suicidal ideas.
     ? Psychotic illness.  A

7. 69: Damaged neighbour's property. Complained that neighbours are "putting heat on my back, they are also working on my mouth making it lopsided." "I have to chew this piece of orange skin to stop my mouth from going lopsided." "I have no right down here, only mad people can down here."
     On remand from court, for observation and assessment.  A
walking all over his body, also strange strangling sensation around his neck.

Hypochondrasis G/F

9. 28:
Complain of getting blackouts, dark eyes, pounding in his head, and feeling weak and nervous. History of violence towards his wife.

Depression G/F

10. 18:
Patient witnessed a shooting incident, subsequently started acting strangely. Appears confused, giggling and laughing to himself for no apparent reason.

Simple schizophrenia T/H

11. 23:
Very talkative, has spates of aggression, suffers from delusions of grandeur.

Schizophrenia T/H

12. 18:
Had a bad dream, while dreaming patient proceeded to damage parents house. Refused doctor's medication, later attacked his siblings.

Schizophrenia T/H

13. 60:
Alcoholic insomniac, hears voices, separated from his second wife.

Alcoholic T/H

14. 26:
Strange behaviour T/H

15. 16:
Very disturbed and noisy

Post ganja psychosis T/H

16. 27:
Says he gets tense, agitated quickly, afraid he may kill someone. Everyone tells him he is mad. Often beats his girlfriend. Anxious type of personality. Complains of stomach pains. Has ideas of unworthiness, threatens to take his life.

Schizophrenia T/H
17. 47? Threatening and uncontrollable behaviour. Tried to kill his wife.
  ? Paranoid G/F

18. 17: Shows pressure of ideas, very restless and excitable.
  Hypomanic episode T/H

19. 34: Found wandering about. Feels that someone is affecting him in a spiritual way. Took lessons from a secret order, generally acting strange.
  Psychotic episode G/F

20. 32: Believes that colleagues at work are trying to move him by copying his signature. Doesn't trust anyone. Worried about his final law exams. Says he wants to kill himself.
  Depression T/H

21. 37: History of heavy drinking
  Alcoholic T/H

22. 23: Feels threatened by men with knives. Says his penis, heart, and head ache. Believes that a coolie-man, who he trusts from putting obeah on him.
  Acutely psychotic T/H

23. 28: Has a history of several hospitalisation in Canada.
  Schizophrenic T/H

### STATUS - FEMALE

24. 47: Believes that people are trying to kill her. A/V hallucinations, restless and agitated.
  ? Paranoid Psychosis G

25. 19: Says that doctors tried to kill her baby. Believes that boyfriend is having an affair with her sister.
  Post-partum Psychosis G
Paranoid Psychosis. G

27. 34: Refuses food, believes it contains poison, very aggressive. 
Paranoid Psychosis G

28. 45: Recently returned from Canada, very aggressive, smashes plates etc. Says she is going to kill someone. 
Psychotic G

29. 32: On remand for using indecent language. G

30. 48: Believes that her sister has returned to her home to do her harm. Believes someone is working obeah. 
Paranoid delusions G

31. 28: Complained of tightness in the head. Threw acid in boyfriend's eyes and stabbed him. Following this outburst has entered a catatonic phase. A/V hallucinations. 
Paranoid schizophrenia G

32. 69: A/V hallucinations. Said a member of her church put duppy dust in her seat. 
Paranoid delusions G

33. 29: A/V hallucinations. Doesn't like to see people whispering. Very aggressive. Burn boyfriend's clothes and damaged other property—then started crying. 
Psychothymic personality G

N.B. The reasons for admission, recorded in this appendix, were taken from the patients case notes.
APPENDIX VI

An Analysis Of Patient Care At Jenkins

The mental hospital is the main facility in the island for the treatment of the majority of psychiatric patients. Although great studies have been made in care and treatment, it still remains as a chronic institution, with cases being partly acute and partly psycho-geriatric. There is also a significant number of 'social cases' - patients who are suitable for discharge but have no home or relatives willing to look after them. Tables 1 and 2 show admission by age and length of stay for 1975 and 1976. Nearly two-thirds of all patients remain in hospital for less than six months and the largest single age group is 17 - 26 years. Although the number of patients in the hospital at the time of the study was said to be 633 (303 males and 300 females) the figures available for length of stay of the resident population on 31st December, 1976, referred to only 476 patients. The reason for this discrepancy could not be ascertained.

Table III gives an indication of Hospital Admissions and Discharges over the period 1971-1976. Table 4 gives a further breakdown by sex for the period 1975 and 1976.

<table>
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Admissions and Discharges - Mental Hospital 1971 - 1976

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<td>Total admissions</td>
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<td>934</td>
<td>864</td>
<td>846</td>
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<td>First admissions</td>
<td>275</td>
<td>256</td>
<td>294</td>
<td>225</td>
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<tr>
<td>Re-admissions</td>
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<td>278</td>
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<td>Weeks - 6 weeks</td>
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<td>35</td>
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<td>73</td>
<td>68</td>
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Table 1: Age Co-related with Length of Hospitalisation

1975 Admissions

Note: The table presents the distribution of age groups correlated with the length of hospitalisation. The data shows the number of admissions for different age groups across various length categories.
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AGE CORRELATED WITH LENGTH OF HOSPITALIZATION

1976 Admissions

TABLE II
All the tables in this section have been obtained from the Records Office of the Barbados Mental Hospital.

**Table IV**

**Male and Female Admissions - Mental Hospital 1975 and 1976**

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<th>Males</th>
<th>Females</th>
<th>Total</th>
<th>Males</th>
<th>Females</th>
<th>Total</th>
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<tbody>
<tr>
<td>First admissions</td>
<td>147</td>
<td>133</td>
<td>280</td>
<td>177</td>
<td>123</td>
<td>300</td>
</tr>
<tr>
<td>Re-admissions</td>
<td>277</td>
<td>303</td>
<td>580</td>
<td>335</td>
<td>295</td>
<td>630</td>
</tr>
<tr>
<td>Total admissions</td>
<td>424</td>
<td>436</td>
<td>860</td>
<td>512</td>
<td>418</td>
<td>930</td>
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</tbody>
</table>

Table shows deaths and discharges by cause of hospitalisation only for the year 1975. The classification numbers according to the International Classification of Diseases, 8th Revision (ICD - 8) are given in the left hand column. I could not obtain a diagnostic breakdown of admissions for 1975. These figures for discharges and deaths give some idea of the turnover of patients in 1975.

Schizophrenia is the largest single category. There are more than 5 of all patients for whom a psychiatric diagnosis was obtained. About two-thirds of them were psychotics, while neurotics and personality disorders made up less than 5 of the cases. Twenty four patients were mentally ill and would be better cared for in a separate institution. Table shows a diagnostic breakdown of admissions, with sex, for 1976.

Psychosis is the largest single category. Interestingly females indicate higher percentages than males where acute and general psychosis and neurosis are recorded.
### Table V

**Diagnostic Classification**

**Deaths and Discharges by Cause of Hospitalisation in 1975. ICD-8 Listing**

<table>
<thead>
<tr>
<th>Disease Category</th>
<th>No. of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 95 Schizophrenia</td>
<td>214</td>
</tr>
<tr>
<td>296 Affective psychosis</td>
<td>44</td>
</tr>
<tr>
<td>290,292-4,297-9 Other psychoses</td>
<td>122</td>
</tr>
<tr>
<td>291 Alcoholic psychoses</td>
<td>16</td>
</tr>
<tr>
<td>303 Alcoholism</td>
<td>55</td>
</tr>
<tr>
<td>300 Neuroses</td>
<td>64</td>
</tr>
<tr>
<td>301 Personality disorder (Psychopathic type)</td>
<td>12</td>
</tr>
<tr>
<td>301,302,304,309 Other non-mental disorders</td>
<td>63</td>
</tr>
<tr>
<td>310,315 Mental retardation</td>
<td>24</td>
</tr>
<tr>
<td>794 Senility without psychoses</td>
<td>12</td>
</tr>
</tbody>
</table>

Other medical (non-psychiatric) conditions, psychiatric diagnosis not given | 78
---

| Total | 866 |
### Table VI

**1976 Admissions**

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Male</th>
<th>Female</th>
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<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Acute psychosis</td>
<td>30</td>
<td>5.75%</td>
</tr>
<tr>
<td>Chronic psychosis</td>
<td>94</td>
<td>18.01%</td>
</tr>
<tr>
<td>Neurosis</td>
<td>11</td>
<td>2.11%</td>
</tr>
<tr>
<td>Alcoholism</td>
<td>83</td>
<td>15.90%</td>
</tr>
<tr>
<td>Mental retardation</td>
<td>26</td>
<td>4.98%</td>
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<tr>
<td>Epilepsy</td>
<td>7</td>
<td>1.34%</td>
</tr>
<tr>
<td>Senile dementia</td>
<td>8</td>
<td>1.53%</td>
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<tr>
<td>Psychopathy</td>
<td>9</td>
<td>1.72%</td>
</tr>
<tr>
<td>Marijuana addiction</td>
<td>5</td>
<td>.95%</td>
</tr>
<tr>
<td>Juvenile delinquency</td>
<td>2</td>
<td>.38%</td>
</tr>
<tr>
<td>No psychological illness</td>
<td>3</td>
<td>.57%</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
<td>1.72%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>287</td>
<td>54.98%</td>
</tr>
</tbody>
</table>
A figure of 11.68% for females in acute psychosis compared with 5.75% for males in the same classification. The difference between males and females for chronic psychosis is fairly even - for males 18.1% and for females 18.77%. This figure for females is higher than expected. Similarly the 2.11% figure for males suffering from neurosis, compared to 2.68% for females, is higher than generally expected.

The general diagnostic pattern among males and females population in other countries, reveals higher rates of psychosis among males than females and conversely, higher rates of neurosis among females than males. The 1976 admission figures reveal that mental illness (psychosis and neurosis) is fairly evenly distributed among men and women. However, in some areas sex differences are high-lighted.

Males with 15.9% dominate the area of alcoholism, when compared with a mere 1.77% for females.

Alcoholism is a very important causative factor in mental illness. The disease is frequently found, and predominates among males, in fact female intake of alcohol is much less than that of the male.

The attitudes prevailing in society concerning male and female standards of behaviour may be of particular relevance in understanding the difference between male and female intake of alcohol. Supporting the findings in Table 6, and Table 7 correlating age and sex with diagnosis for admission in 1976, identifies as the single most prevalent category. The largest single age group, 17-26 years is the most prevalent.

Thirty-three percent, thirty-five percent and forty-four percent of all persons suffering from acute psychosis, chronic neurosis and neurosis respectively, are found in the 17-26 age group. Table 7 further reveals that 75.1% of all persons admitted to the mental hospital in 1976 were diagnosed as suffering from neurosis and psychosis. The 17-24 age group is
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<th>7-12</th>
<th>13-18</th>
<th>19-24</th>
<th>25-29</th>
<th>30-34</th>
<th>35-39</th>
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<th>55-59</th>
<th>60-64</th>
<th>65-69</th>
<th>70+</th>
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<tbody>
<tr>
<td>1976 Total</td>
<td>164</td>
<td>114</td>
<td>105</td>
<td>94</td>
<td>82</td>
<td>70</td>
<td>65</td>
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<td>24</td>
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<tr>
<td>Age 60+</td>
<td>96</td>
<td>70</td>
<td>65</td>
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<td>54</td>
<td>49</td>
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<td>24</td>
<td>19</td>
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</table>

**Table VIII**

**1976 Admissions**

Age correlated with Diagnosis
the peak at which most psychotic and neurotic illnesses occur. From age 27-36 onwards there is a gradual incline. It noticeably occurs at age 27-36, reaching a peak at age 37-46 and persisting until quite late on in life - late sixties.

The occurrence of acute psychosis among teenagers - those under 16 years, is alarming, it is perhaps an indication of an increase in problems among teenagers. Many teenagers are referred to the mental hospital from school for behaviour and learning problems, while others are referred by the courts, on remand. There is no special facility for children with psychological problems. Children with such problems are usually sent to the mental hospital, where they are hospitalised in the same wards as other patients suffering from acute and chronic conditions.

In 1976, 930 patients were admitted to the mental hospital, 512 were male and 418 female. There were 177 male and 123 female first admissions, and 335 male and 295 female re-admissions. (See Table 4). An examination of the 1976 admission figures reveals a significant change in status of patients admitted. Of the 300 first admissions for 1976, there were 86 voluntary, 161 temporary, 43 remand and no certified patients. The male/female differences in status were not marked; 38 male and 45 female voluntary patients, 86 male and 81 female temporary patients. The only male/female difference occurred in the number admitted on remand, i.e. through the courts, 41 male and 3 female patients. The male figures are significantly higher than the female, as shown in the following data from the records department of the mental hospital for 1975-1976. (See Table 3).
Male offences ranged from indecent exposure and assault, to more serious offences like manslaughter. There was also a sizeable number of teenagers on remand who had a history of stealing and other anti-social acts, they are usually labelled as 'wild boys'.

The most significant finding, however, was the absence of any 'certified' patients among the first admissions for the year 1976 to July 1977. (See Tables 9 and 10).

These figures appear to indicate that persons suffering from mental ill health are much more willing now, than they were five years ago, to seek help voluntarily.

Overall there were more male than female first admissions, 177 male and 123 female. This difference might be due to easier recognition of mental ill-health among men. Men are more likely to come in frequent contact with the public than women, for example, through their jobs and social interaction.

Certified patients admitted in the years preceeding 1976, tend to stay in hospital linger than voluntary and temporary patients. Tables 11, 12, 13 and 14 give some idea of the number of patient days and average length of stay of certified patients, male and female respectively. Here we observed that female patients resident in the hospital at the end of 1976 spent 144,871 patient days, in comparison to 52,485 patient days and 4,414 patient days, for voluntary and temporary patients respectively. In comparison to this the
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First Admissions by Status and Sex 1976

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**First Admissions By Status And Sex 1977**

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*All rates per 1,000 population.
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<th>MONTH</th>
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<tr>
<td>JAN</td>
<td>1316</td>
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<td>FEB</td>
<td>918</td>
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<td>MAR</td>
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<td>APRIL</td>
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<td>OCT</td>
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<td>1464</td>
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<td>PATIENTS</td>
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<td>ADULT</td>
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male certified patients had spent 117,904 patient days.

Table 15 gives a further breakdown of the 1976 admission figures, by length of hospitalisation correlated with sex.

Interestingly, 36.89% of the male and 33.17% of the female patients admitted in 1976, stayed in hospital between less than 21 days and 6 weeks. This notable reduction in the length of hospitalisation must be due in some way to the extension of community psychiatric services and the new hospital policy of encouraging early discharge.

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<tr>
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<th>Male</th>
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<tr>
<td></td>
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<tr>
<td>21 days or less</td>
<td>143</td>
<td>22.70%</td>
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<td>3 - 6 weeks</td>
<td>102</td>
<td>16.19%</td>
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<tr>
<td>6 weeks - 3 months</td>
<td>44</td>
<td>6.95%</td>
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<td>6 months - 1 year</td>
<td>29</td>
<td>4.60%</td>
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<tr>
<td>Total</td>
<td>341</td>
<td>54.13%</td>
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* Certified patients are those under the jurisdiction of the hospital and can therefore be picked up at any time.

Despite improvements and extensions of the community psychiatric services, there is still a hard core of mentally ill persons who remain in hospital for more than a year.

Table 16 shows that more than 32.5% (or 155 patients) of the patient population resident in December 31st, 1976 were aged 67 and over; the majority of whom were suffering from chronic psychosis (67.4%) and senile dementia (26.7%). (See Table 17).
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**Table XVII**

*AGE CORRELATED WITH LENGTH OF HOSPITALIZATION*

Resident Population on December 31, 1976
|     | 69  | 70  | 69  | 68  | 67  | 66  | 65  | 64  | 63  | 62  | 51-55 | 46-50 | 41-45 | 36-40 | 31-35 | 26-30 | 21-25 | 16 & UNDER | 15 & OVER | TOTALS |
|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|------|------|------|------|------|------|-------|----------|---------|
| 5   | 0   | 0   | 2   | 1   | 0   | 1   | 0   |     |     |     |      |      |      |      |      |      |        |          |        |
| 12  | 7   | 4   | 0   | 1   | 0   | 0   | 0   |     |     |     |      |      |      |      |      |      |        |          |        |
| 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   |     |     |     |      |      |      |      |      |      |        |          |        |
| 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   |     |     |     |      |      |      |      |      |      |        |          |        |
| 7   | 0   | 2   | 2   | 0   | 2   | 1   | 0   |     |     |     |      |      |      |      |      |      |        |          |        |
| 95  | 0   | 10  | 0   | 0   | 0   | 0   | 0   |     |     |     |      |      |      |      |      |      |        |          |        |
| 12  | 9   | 6   | 2   | 7   | 2   | 1   | 1   |     |     |     |      |      |      |      |      |      |        |          |        |
| 96  | 7   | 3   | 6   | 6   | 12  | 15  | 11  |     |     |     |      |      |      |      |      |      |        |          |        |
| 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   |     |     |     |      |      |      |      |      |      |        |          |        |
| 89  | 73  | 73  | 77  | 31  | 15  | 8   | 0   |     |     |     |      |      |      |      |      |      |        |          |        |
| 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   |     |     |     |      |      |      |      |      |      |        |          |        |

Age Grouped with Diagnostic Resident Population on December 31, 1976

Table XVII
As shown in Tables 9 and 10, there were no certified admissions for 1976 and 1977. However, when I examined the data on total admissions by status and sex, it was discovered that 30 male and 29 female patients - certified patients - were admitted during 1976. (See Table ). The 69 certified admissions in 1976 were re-admissions and therefore in no way affected my earlier observations from Table 9. Table gives a breakdown of re-admissions by status and sex for 1976. The data in Table confirms that the 69 certified patients admitted in 1976 were re-admissions.

There is a marked difference in the number of male and female temporary and remand admissions during 1976. (See Table 18). There were 89 male and 185 female temporary admissions, and 79 male and 9 female remands. I am unable to give an explanation for these differences. Personnel in the records office of the mental hospital regard it as a freak year, when female admissions were exceptionally high and the courts remanded more people than they usually do.

Of all patients re-admitted in 1976, voluntary patients outnumbered all other status groupings. There were 319 voluntary admissions. (See Table 20). Admissions for 1976 by parish reveals that 63.5% of all patients came from St. Michael and Christ Church. Both parishes have the largest number of inhabitants - 88,000 and 36,000 respectively.

Re-admissions from both parishes were high - 300 patients from St. Michael and 123 from Christ Church (See Table 22).

The total admission figure of 161 patients, or 17.3% - for Christ Church is rather high; as Christ Church is one of the biggest tourist resorts. Most of the South Coast (including most of Christ Church) and much of the inland area is owned by white and black middle and upper classes. Mental illness carries a stigma in Barbados (as in many areas of the world), therefore it is unlikely that a member of the upper class would expose him/herself to ridicule by being
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TOTAL ADMISSIONS BY STATUS AND SEX 1976

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**TABLE IX**

TOTAL ADMISSIONS BY STATUS AND SEX 1977
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</table>

**TOTAL**

- **CERTIFIED**
- **TEMPORARY**
- **VOLUNTARY**
- **OTHER**
- **REMAND**

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**Re-Admissions by Status and Sex 1976**

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**Table XX**
|       | 66 | 67 | 68 | 69 | 70 | 71 | 72 | 73 | 74 | 75 | 76 | 77 | 78 | 79 | 80 | 81 | 82 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 90 | 91 |
|-------|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
|       |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|       |  4 |  3 |  0 |  0 |  1 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |
|       |  1 |  2 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |
|       |  1 |  1 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |
|       |  2 |  1 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |
|       |  1 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |
|       |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |
|       |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |
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|       |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |  0 |

Re-admissions by Status and Sex 1977

TABLE XXI
Table XXII

Admissions for 1976 by Parish

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<th>Re-admissions</th>
<th>Total</th>
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<td>123</td>
<td>161</td>
</tr>
<tr>
<td>St. Philips</td>
<td>17</td>
<td>38</td>
<td>55</td>
</tr>
<tr>
<td>St. George</td>
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<td>38</td>
<td>56</td>
</tr>
<tr>
<td>St. Thomas</td>
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<td>25</td>
</tr>
<tr>
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<td>54</td>
</tr>
<tr>
<td>St. Peter</td>
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<td>22</td>
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</tr>
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<td>St. Lucy</td>
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</table>

* Out of total of 11 new admissions there were 7 from overseas, 6 from the West Indies and 1 from England.
admitted to the public mental hospital. Similarly it is unlikely that a tourist, becoming ill would be admitted to the mental hospital when there are adequate private hospitals providing care. No logical explanation could be given for the high re-admission.

**Figures on Tables 16 and 17 contain the resident patient population at year ending December 1976. This therefore includes patients admitted before 1976. As stated earlier there were no certified first admissions for 1976 or 1977.**

Equally significant is the small number of patients, 92 (9.8%) of all patients admitted from St. Andrew, St. Lucy, St. John and St. Joseph; 38 first admissions and 54 re-admissions. These figures were influenced to a large extent by the success of the community psychiatric service in these parishes. A community psychiatric clinic was first set up in St. Andrew in 1971 and later extended to St. Lucy in 1972. The community clinics have reduced the number of admissions considerably, and re-admissions to the mental hospital also. For further information on referrals by parish see Table.

Of the 930 patients admitted in 1976, 947 patients were discharged. (See Tables 24 and 25). This indicates a very high turnover of patients. There were 53 deaths during 1976 – (See Tables 26 and 27) – 27 male and 26 female patients. The highest number of deaths –45 or 84.9% occurred in the 55 and over age group. (See Table 28)
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<th>AUGUST</th>
<th>JULY</th>
<th>JUNE</th>
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Table X

TOTAL DISCHARGES BY STATUS AND SEX - 1976
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- The table above represents the total number of discharges by status and sex for the year 1977.
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TABLE XXIII

DEATHS BY STATUS AND SEX - 1977
### Table XXVII

**Deaths by Age and Sex for 1976**

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Psychiatric Facilities In The Community

Psychiatry in Barbados faces a problem which is common to many developing countries: the tendency for the system to generate high rates of chronicity among the mentally ill.

The psychiatric services, like other areas of medical care are concentrated in the parish of St. Michael; in the case of psychiatry the mental hospital - Jenkins - serves the entire island.

Figures on the in-patient population of Jenkins for 1976, show that more than half the patients had been hospitalised for more than 10 years, and more than half were over 57 years. (See Table 16). This suggests that about half the population is geriatric or long-stay patients; the remainder of the beds are being fairly actively used.

The older patients suffer mainly from chronic psychosis (See Table 17), therefore it seems reasonable to consider either converting a section of the hospital into a geriatric hospital or transferring the elderly patients elsewhere with other geriatric patients.

The propensity for chronicity to appear among the mentally ill may be attributable to many factors, two major ones are:-

(1) The pessimistic attitude the society has towards mental illness, once mad always mad - and the lack of urgency and concern shown by the Ministry of Health about matters relating to mental health. Rarely are there any health education programmes about mental health, hence fear and ignorance about such matters flourish.

(2) The marked centralisation of care helps to create the isolation of many patients from their families and aggravates rehabilitation problems. There is
an acute shortage of medical staff; at the time of this research (September 1977) there were only 3 full time psychiatrists at the hospital, one of whom was the Medical Superintendent.

Some important developments have occurred in the last decade. The first significant was the establishment in 1965 of a chair of psychiatry at the University of the West Indies. Professor Michael Beaubrum, the first incumbent, is a strong advocate of community and general hospital management of psychiatric disorders. He immediately established an in-patient psychiatric service in the University College Hospital as well as a large out-patient clinic. A second important development was the beginning of the psychiatric services in the community.

The Community Psychiatric Nursing Services 1971-75

General Outline

The Psychiatric Nursing Service commenced in Barbados as a pilot project in the parish of ST. Andrew on September 2nd, 1971 with 44 patients. Clinic sessions were held every Monday at 2 p.m. at the St. Andrew out-patient clinic. In addition to attending these sessions the staff nurse assigned to the district from the mental hospital is required to visit each patient monthly, except in the case of a relapse patient. During these house visits, which usually last half-an-hour to two hours, time is spent educating the relatives on the many aspects of mental illness, in particular the type of illness their relative has; instructing the patient and relatives on the safe keeping and administering of drugs, assisting with the daily planning of activities for the patient, and when there are problems, discussing these and when necessary, seeking the assistance of appropriate agencies, e.g. National Assistance.
Patients are seen at the clinic by the Medical Officer once every three weeks. The patients are encouraged to speak freely about their problems they may have. This is usually a difficult experience for most patients, because of the traditional attitude of Barbadians, in keeping their personal problems to themselves. During these visits the doctor makes any necessary changes in medication.

The community nurse visits Jenkins weekly. During these visits a verbal report of his/her progress is made to the Medical Superintendent, the Principal Nursing Officer and the Sister of the out-patients department. These weekly visits also provide the nurse with an opportunity to attend seminars and lectures, which help to keep her abreast with the modern trends in treatment. The opportunity is also taken to collect medication from the hospital dispensary for the next clinic session.

The Psychiatric Nursing Service In St. Andrew

First Phase

As stated earlier, the St. Andrew community service started with 44 patients. Twelve of the 44 patients had between two and six previous admissions to the mental hospital. The other 32 patients had only one previous admission. During 1971, 12 new cases were added; 4 were admitted to the mental hospital, 3 of these were later discharged, the fourth remained in hospital until his death. The other 8 patients were treated in the district without hospitalisation.

The community nurse made 507 visits. Seventy-three of these were made late in the evening between the hours of 6.30p.m. and 7.30 p.m.; and one visit before 6 a.m. In each case the nurse was called by the patients relatives after he had suffered a relapse. In each case on-the-spot administration helped the patient and prevented certain hospitalisation. In such situations
the nurse has to make independent decisions, without the assistance of a Medical Officer, this means that the nurse must be experienced and have a sound knowledge of psychotrophic drugs.

Second Phase

In the period, September 1972 to August 1973, the number of patients attending the St. Andrew Clinic increased to 63. Of the 63 patients, 10 were admitted to the mental hospital, 3 were detained, even though their condition had improved - because of unfavourable conditions at home. Two of the three patients were employed in the mental hospital, one in the sheltered workshop, as a tailor and the other in the children's unit; the other 7 patients were discharged.
There were 612 home visits in this period.

Third Phase

During the year August 1973 to August 1974, the St. Lucy Community Service was launched with 64 patients. This service differed slightly from the one provided in St. Andrew. There is a doctor to keep clinic sessions in St. Lucy, as a result patients are escorted by the community nurse - from St. Lucy to the St. Andrew clinic, where they are seen by the District Medical Officer.
There were 898 home visits in St. Lucy, 162 were made in the late evening, and 10 emergency visits were recorded. By 1974 the number of patients (excluding those from St. Lucy) attending the clinic sessions in St. Andrew had increased to 74, the St. Andrew clinic was serving the mentally ill from St. Philips, St. John and St. Joseph.

As a result of dedicated work by the community nurse, the community in St. Andrew began to accept the nurse and no longer felt threatened by her presence. The community members now showed a greater willingness to help the mentally ill, and could be relied on to get in touch with the nurse in the case of an emergency.
Twenty-three new cases were referred to the clinic in 1974, 18 were referred by the District Medical Officer. All 23 patients were treated successfully in the community.

The psychiatric services in St. Lucy treated 77 patients in the period August 1974 to July 1975. There were two admissions to the mental hospital both were admitted on remand and were hospitalised for 177 days. There were only two new admissions in 1976; total attendances were 529 (See Tables and 32).

By September the St. Andrew clinic was in its fourth phase, and from all aspects seemed a great success. Some patients were made to feel independent of their relatives with the aid of welfare assistance and a few job placements. (See Tables 29 and 30)

Success could also be measured by the reduction in the number of admissions and in the length of stay in hospital.

In St. Andrew and St. Lucy the community nurses observed that the mentally ill person was no longer laughed at or teased, but often received assistance from members of the community; for example, a patient lives alone - a neighbour offers to keep and administer medication, or to call the nurse in the case of a relapse.

The psychiatric community service was further extended in 1974 - 75.

For at least two years previously patients from St Joseph attended the St. Andrew clinic. An increase in the number of mentally ill persons in the parish of St. Joseph proved too much for the limited facilities in St. Andrew's clinic, and too demanding for the one psychiatric nurse who covered the parishes of St. John and St. Joseph. As a result of this increased pressure on the community service, an additional nurse was assigned to St. Joseph during the month of November 1974.
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**TABLE XXX!**

**DISTRICT SERVICE 1976**

PARRISH OF ST. LUCY
| Month       | TOTAL PATIENTS | NEW PATIENTS | OLD PATIENTS | TOTAL ATTENDANCES | 1st VISITS PATIENTS VISITED | 1st VISITS PATIENTS VISTED | 1st VISITS | TOTAL HOME | 1st VISITS | ATM HOME | 1st VISITS | ATM HOME | 1st VISITS | ATM HOME | 1st VISITS | ATM HOME | 1st VISITS | ATM HOME | 1st VISITS | ATM HOME | 1st VISITS | ATM HOME | 1st VISITS | ATM HOME | 1st VISITS | ATM HOME | 1st VISITS | ATM HOME | 1st VISITS |
|-------------|----------------|--------------|--------------|-------------------|--------------------------|-----------------------------|-------------|------------|------------|----------|------------|----------|------------|----------|------------|----------|------------|----------|------------|----------|------------|----------|------------|----------|------------|----------|------------|
| January     | 96             | 0            | 0            | 0                 | 0                        | 0                           | 0           | 0          | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          |
| February    | 96             | 0            | 0            | 0                 | 0                        | 0                           | 0           | 0          | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          |
| March       | 96             | 0            | 0            | 0                 | 0                        | 0                           | 0           | 0          | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          |
| April       | 96             | 0            | 0            | 0                 | 0                        | 0                           | 0           | 0          | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          |
| May         | 96             | 0            | 0            | 0                 | 0                        | 0                           | 0           | 0          | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          |
| June        | 96             | 0            | 0            | 0                 | 0                        | 0                           | 0           | 0          | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          |
| July        | 96             | 0            | 0            | 0                 | 0                        | 0                           | 0           | 0          | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          |
| August      | 96             | 0            | 0            | 0                 | 0                        | 0                           | 0           | 0          | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          |
| September   | 96             | 0            | 0            | 0                 | 0                        | 0                           | 0           | 0          | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          |
| October     | 96             | 0            | 0            | 0                 | 0                        | 0                           | 0           | 0          | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          |
| November    | 96             | 0            | 0            | 0                 | 0                        | 0                           | 0           | 0          | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          |
| December    | 96             | 0            | 0            | 0                 | 0                        | 0                           | 0           | 0          | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          | 0        | 0          |
Fourth Phase

In St. Joseph clinic sessions were held every Wednesday from 2-4 p.m. at Horse Hill out-patients clinic.

The Medical Superintendent attends clinic every month, on the first Wednesday.
Sixty-six patients were treated in the district, 36 male and 30 female. Four patients were under 19 years, 50 patients were under 59 years, and 12 were 60 and over. (See Tables 33 and 34), for further information on the St. Joseph Clinic.

Fifth Phase

In January 1975 the district service was extended to St. Philip. The parish is divided into three areas; A, B, C, with a nurse assigned to each area. A joint out-patient clinic is held at Six Cross Roads Health Centre, which is easily reached by patients from all three areas. Clinic sessions are held every Wednesday between the hours 2-4 p.m. by the community nurses, and every third Wednesday by the Medical Superintendent.

During the year January-December 1975, 204 patients were seen by the psychiatrists and 604 by the nurses; 3,715 home visits were made. There were three admissions in area A, no admissions were reported in areas B and C.

In 1976, 29 new patients were seen and 2,363 home visits were made. (See Tables 35 and 36).

The psychiatric community services broke new ground in February 1975 when it was extended to the parishes of St. Michael, Christ Church, St. Thomas, St. George, St. James and St. Peter. The services provided to these parishes are different to that provided in the other parishes. Here, one nurse covers six parishes. The nurse is notified by the sister in charge of the Out-Patients Department at the mental hospital, of all 'drop-outs' - patients who have been treated with 'Fluphenazine' and who have not returned to the out-patients clinic within the past 12 months. Tables 39 and 40 shows a breakdown
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**Sessions**

**Re-Visits**

**Patients (patiens)**

**Attendance**

**Patients**

**New**

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TABLE XXXV

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TABLE XXXVII

Parish of St. Philip 1977
TABLE XXXVII

PARISHES OF ST. MICHAEL, CHRIST CHURCH, ST. GEORGE, ST. THOMAS, ST. JAMES, & ST. PETER. - 1977

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<th>Ist. VISITS FOR YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>JANUARY</td>
<td>73</td>
<td>85</td>
<td>73</td>
</tr>
<tr>
<td>FEBRUARY</td>
<td>71</td>
<td>79</td>
<td>9</td>
</tr>
<tr>
<td>MARCH</td>
<td>78</td>
<td>91</td>
<td>10</td>
</tr>
<tr>
<td>APRIL</td>
<td>75</td>
<td>85</td>
<td>10</td>
</tr>
<tr>
<td>MAY</td>
<td>79</td>
<td>83</td>
<td>9</td>
</tr>
<tr>
<td>JUNE</td>
<td>67</td>
<td>81</td>
<td>13</td>
</tr>
<tr>
<td>JULY</td>
<td>75</td>
<td>87</td>
<td>13</td>
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<td>AUGUST</td>
<td>81</td>
<td>96</td>
<td>14</td>
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<td>70</td>
<td>87</td>
<td>2</td>
</tr>
<tr>
<td>OCTOBER</td>
<td>85</td>
<td>92</td>
<td>15</td>
</tr>
<tr>
<td>NOVEMBER</td>
<td>85</td>
<td>94</td>
<td>6</td>
</tr>
<tr>
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<td>91</td>
<td>6</td>
</tr>
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<td>TOTAL</td>
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<td>1051</td>
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<tr>
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<td>Feb</td>
<td>Mar</td>
</tr>
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<td>-----</td>
<td>-----</td>
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</tr>
<tr>
<td>1976</td>
<td>506</td>
<td>71</td>
<td>93</td>
</tr>
<tr>
<td>1977</td>
<td>533</td>
<td>73</td>
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**Total Sessions:** 1977

**Total Patients Visited:** 1977

**Total Attendances:** 1977

**Total Patterns:** 1977
<table>
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<tr>
<th></th>
<th>1st Visit Patients</th>
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<th>Total Patients</th>
<th>New Patients</th>
<th>Old Patients</th>
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<tr>
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<td>M</td>
<td>F</td>
<td>M</td>
<td>F</td>
<td>M</td>
</tr>
<tr>
<td>1.</td>
<td>10</td>
<td>70</td>
<td>10</td>
<td>70</td>
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</tr>
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<td>10</td>
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<td>70</td>
<td>10</td>
</tr>
<tr>
<td>4.</td>
<td>10</td>
<td>70</td>
<td>10</td>
<td>70</td>
<td>10</td>
</tr>
<tr>
<td>5.</td>
<td>10</td>
<td>70</td>
<td>10</td>
<td>70</td>
<td>10</td>
</tr>
<tr>
<td>6.</td>
<td>10</td>
<td>70</td>
<td>10</td>
<td>70</td>
<td>10</td>
</tr>
<tr>
<td>TOTAL</td>
<td>M</td>
<td>F</td>
<td>M</td>
<td>F</td>
<td>M</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>70</td>
<td>10</td>
<td>70</td>
<td>10</td>
</tr>
</tbody>
</table>
of patient visits to the out-patient clinic. One nurse having to cover six parishes makes the job of providing an efficient community care extremely difficult. The area is too expensive, both in terms of the nurse properly serving the area and the patients receiving the maximum attention when attending crowded clinic sessions at the mental hospital, which is situated in St. Michael.

In April 1975, St. John became a separate unit with 48 patients. One of these patients had 20 previous admissions, 31 patients had 2 and 12 previous admissions, 10 had one admission and the other 6 were out-patients. During the year, 19 patients were referred, making a total of 67 patients. Clinic sessions are held every Wednesday from 2-4 p.m. at St. John's out-patient clinic. Tables 41 and 42 provide figures for 1976/77.

Summary

In addition to holding clinics, nurses visit patients at their homes, when necessary, to administer long-stay - phenothiazines drugs - to counsel relatives, to check up on clinic defectors and to deal with emergencies. There has been an increase in the number of patients handled by the service from 557 in 1975, to 825 in 1976. The increase has taken place in both the number attending the rural clinics and those visited at home by the nurses; though there has been a decrease in the actual number of home visits, (See Table 43).

This increase is attributed to attempts made to reduce travelling costs, as there was no special budget to meet such demands.

Although precise figures are not available to indicate to what extent re-admissions have been reduced in the district served, the view was expressed by senior hospital staff that a reduction in re-admissions had been achieved, even though the services had attracted new cases. Table 43 also shows that in 1976, the mental hospital out-patient clinic handled 1,368 patients,
<table>
<thead>
<tr>
<th>Year</th>
<th>26</th>
<th>27</th>
<th>28</th>
<th>29</th>
<th>30</th>
<th>31</th>
<th>32</th>
<th>33</th>
<th>34</th>
<th>35</th>
<th>36</th>
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<td>Cases</td>
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<td>15</td>
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<td>20</td>
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<td>0</td>
<td>15</td>
<td>10</td>
<td>0</td>
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**Table XI**

Parish of St. John 1976
<table>
<thead>
<tr>
<th>Year</th>
<th>Home Visits</th>
<th>Sessions</th>
<th>Home Visits (Patients Visited)</th>
<th>Old Visits (Patients Visited)</th>
<th>New Visits (Patients Visited)</th>
<th>Total Visits (Patients Visited)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1971</td>
<td>42</td>
<td>32</td>
<td>2</td>
<td>7</td>
<td>15</td>
<td>37</td>
</tr>
<tr>
<td>1972</td>
<td>29</td>
<td>22</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>17</td>
</tr>
<tr>
<td>1973</td>
<td>33</td>
<td>23</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<td>1974</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td>1975</td>
<td>31</td>
<td>22</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1976</td>
<td>34</td>
<td>23</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1977</td>
<td>35</td>
<td>22</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td></td>
<td>151</td>
<td>57</td>
<td>30</td>
<td>238</td>
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</table>
### Statistics Of The Out-Patients Service, Mental Hospital 1975 -1976

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<th>Mental Hospital</th>
<th>District Services</th>
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<tr>
<td><strong>Data</strong></td>
<td>1976</td>
<td>1975</td>
</tr>
<tr>
<td></td>
<td>1976</td>
<td>1975</td>
</tr>
<tr>
<td><strong>New visits (QEH)</strong></td>
<td>118</td>
<td>116</td>
</tr>
<tr>
<td></td>
<td>54</td>
<td>43</td>
</tr>
<tr>
<td><strong>Total patients treated</strong></td>
<td>1,368</td>
<td>1,435</td>
</tr>
<tr>
<td></td>
<td>294</td>
<td>186</td>
</tr>
<tr>
<td><strong>Total attendance</strong></td>
<td>10,744</td>
<td>10,286</td>
</tr>
<tr>
<td></td>
<td>1,951</td>
<td>1,508</td>
</tr>
<tr>
<td><strong>Home visits</strong></td>
<td>-</td>
<td>6,075</td>
</tr>
<tr>
<td></td>
<td>7,047</td>
<td></td>
</tr>
<tr>
<td><strong>Patients</strong></td>
<td>-</td>
<td>531</td>
</tr>
<tr>
<td></td>
<td>474</td>
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</tr>
<tr>
<td><strong>Average number of patient at clinic per month</strong></td>
<td>776</td>
<td>762</td>
</tr>
<tr>
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<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Average number of attendances per month</strong></td>
<td>42</td>
<td>40</td>
</tr>
<tr>
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</tr>
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</table>
a very creditable figure for such a small cadre of psychiatrists, registrars, social workers and nurses. In the district 294 patients were treated and 531 patients visited, 118 new patients were treated by out-patients clinic at the mental hospital; these patients came from St. Michael, St. George, St. Thomas, St. Peter, St. James and Christ Church. Total attendance was 10,744 (See Table 43).

Many of the patients were seen by nurses only. The figure of 1,368 patients treated does not include those sent the weekly out-patient psychiatric clinic at the Queen Elizabeth Hospital (QEH). The later clinic is also run by a psychiatrist from the staff of the mental hospital. The QEH clinic saw 118 new cases and registered 810 attendances; however, the total number of patients were not recorded. A diagnostic breakdown of the out-patient attendance was not available.
1. I hereby request you to receive as a temporary patient.

2. I am related to the said in the following manner:—

   I am not related to the said or

The reasons why this application is not made by a relative of the said and my connection with him, and the circumstances under which I make this application, are as follows:

3. Annexed hereto is a recommendation for the temporary treatment of the said

Signed by

Signed

Date

To the Medical Superintendent of the Mental Hospital.
ADMISSION AS A VOLUNTARY PATIENT UNDER
SECTION 12(1) MENTAL HEALTH ACT 1951.

I wish to be admitted to the Mental Hospital as a Voluntary patient for treatment. I understand that I can leave the Hospital by giving twenty-four (24) hours notice of my intention to do so.

-------------------------------------------
Signature

-------------------------------------------
Witness

-------------------------------
Date

I give my consent to undergoing physical treatment.

-------------------------------------------
Signature.
<table>
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<tr>
<th>Rank</th>
<th>Length of Stay (in weeks)</th>
<th>Occupation</th>
<th>Reaction to Depression</th>
<th>Diagnosis</th>
<th>Religion</th>
<th>Children</th>
<th>Age at Admission</th>
<th>No. of Readmissions</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>Baptist</td>
<td>Disturbed Behaviour</td>
<td>Carpenter</td>
<td>0</td>
<td>E</td>
<td>29 years</td>
<td>M</td>
</tr>
<tr>
<td>2</td>
<td>5</td>
<td>Unemployed</td>
<td>None</td>
<td>Labourer</td>
<td>0</td>
<td>E</td>
<td>17 years</td>
<td>S</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
<td>Labourer</td>
<td>Schizophrenia</td>
<td>Paranoic Schiz.</td>
<td>0</td>
<td>C</td>
<td>28 years</td>
<td>S</td>
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<tr>
<td>4</td>
<td>7</td>
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<td>R/C</td>
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<td>C</td>
<td>23 years</td>
<td>S</td>
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<td>R/C</td>
<td>Dep. with Hyp.</td>
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<td>C</td>
<td>20 years</td>
<td>S</td>
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<tr>
<td>7</td>
<td>24 weeks</td>
<td>Pentecostal</td>
<td>Reactive Depression</td>
<td>Carpenter</td>
<td>8</td>
<td>E</td>
<td>45 years</td>
<td>M</td>
</tr>
<tr>
<td>8</td>
<td>24 weeks</td>
<td>Pentecostal</td>
<td>Reactive Depression</td>
<td>Unemployed</td>
<td>8</td>
<td>E</td>
<td>49 years</td>
<td>M</td>
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<tr>
<td>9</td>
<td>1 day</td>
<td>C of E</td>
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<td>E</td>
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<td>10</td>
<td>8 weeks</td>
<td>Canteen</td>
<td>Schizophrenia</td>
<td>Schizophrenia</td>
<td>2</td>
<td>E</td>
<td>24 years</td>
<td>S</td>
</tr>
<tr>
<td>Status</td>
<td>Age at Admission</td>
<td>Diagnosis</td>
<td>Occupation</td>
<td>Religion</td>
<td>Children</td>
<td>Length of Stay</td>
<td>No. of Readmissions</td>
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<td>13 weeks</td>
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<td>33 years</td>
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<tr>
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<td>1 week</td>
<td>None</td>
<td>R/C</td>
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<td>C of B</td>
<td>3</td>
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<tr>
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<td>C of B</td>
<td>Husband builder</td>
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<td>61 years</td>
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<td>26 years</td>
<td>9 weeks</td>
<td>26 years</td>
<td>61 years</td>
</tr>
<tr>
<td>4</td>
<td>4 weeks</td>
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<td>Paroled State</td>
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<td>0</td>
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<td>61 years</td>
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<td>Length of Stay</td>
<td>No. of Admissions</td>
<td>Diagnosis</td>
<td>Occupation</td>
<td>Religion</td>
<td>Children</td>
<td>Education</td>
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<td>-----------</td>
</tr>
<tr>
<td>m</td>
<td>45 years</td>
<td>7 weeks</td>
<td>0</td>
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<td>Strichophrenia</td>
<td>Unemployed</td>
<td>Baptist</td>
<td>2 (in</td>
</tr>
<tr>
<td>Status</td>
<td>Age on Admission</td>
<td>Diagnosis</td>
<td>Admission</td>
<td>Length of Stay</td>
<td>No. of Readmissions</td>
<td></td>
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<td></td>
</tr>
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<td>47</td>
<td>Personality disorder with paranoid personality</td>
<td>Carpenter</td>
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<td></td>
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<td>24</td>
<td>Depression</td>
<td>Nurse</td>
<td>1 week</td>
<td>0</td>
<td></td>
<td></td>
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<td>Patient 3</td>
<td>56</td>
<td>Schizophrenia</td>
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<td>4 weeks</td>
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<td>Patient 4</td>
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<td>10 weeks</td>
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</tr>
<tr>
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<td>Labourer</td>
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<td>Patient 6</td>
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<td>Accountant</td>
<td>6 weeks</td>
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*Note: The table includes information about the patient's status, age at admission, diagnosis, admission method, length of stay, and number of readmissions.*
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<td></td>
<td>1.12.76</td>
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<td>1</td>
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<td>27.6.72</td>
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<td>20.10.72</td>
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<td>26.5.76</td>
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<td>24.8.76</td>
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<td>28.4.78</td>
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<td>26.6.78</td>
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<td>19.9.78</td>
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<td></td>
<td>29.9.78</td>
<td></td>
<td>30.11.78</td>
<td></td>
</tr>
<tr>
<td>3 &amp; 4</td>
<td>8 &amp; 1 dead</td>
<td>19.5.75</td>
<td>19.11.75</td>
<td>Patient now living in High Wycombe.</td>
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<tr>
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<td>11.8.77</td>
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<td>1.11.73</td>
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</tr>
<tr>
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<td>22.6.66</td>
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<td>22.2.71</td>
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<td>17.1.74</td>
<td></td>
<td>20.3.74</td>
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</tr>
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<td>31.10.75</td>
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<td>17.8.74</td>
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<td>2</td>
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<td>1.12.65</td>
<td>Patient returned (in Guyana)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>30.9.73</td>
<td>21.6.78</td>
<td>home</td>
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* Husband and Wife admitted at the same time.
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<tr>
<th>Patient</th>
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<th>Dates discharged</th>
<th>Comments</th>
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<td></td>
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<td>15.12.72</td>
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<td></td>
<td></td>
<td>21.11.76</td>
<td>7.7.78</td>
<td></td>
</tr>
<tr>
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<td>4</td>
<td>7.12.74</td>
<td>19.12.74</td>
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</tr>
<tr>
<td>13</td>
<td>-?</td>
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<td>20.9.74</td>
<td>Case notes says 'with children'</td>
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<tr>
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<td>3</td>
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<td>23.8.76</td>
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</tr>
<tr>
<td>15</td>
<td>nil</td>
<td>17.1.76</td>
<td>26.1.76</td>
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</tr>
<tr>
<td>16</td>
<td>4</td>
<td>7.4.75</td>
<td>8.7.75</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>28.9.77</td>
<td>27.10.77</td>
<td></td>
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<td></td>
<td></td>
<td>9.6.78</td>
<td>26.6.78</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>1</td>
<td>25.9.67</td>
<td>8.9.69</td>
<td>Patient has returned home</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7.1.70</td>
<td>1.1.75</td>
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</tr>
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<td>8.12.78</td>
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### JAMAICA

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<th>Comments</th>
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</thead>
<tbody>
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<td>Patient has possibly returned home.</td>
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<td></td>
<td></td>
<td>3.11.76</td>
<td>24.11.76</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>2 (in Jamaica)</td>
<td>5.5.75</td>
<td>6.6.75</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>25.7.77</td>
<td>16.9.77</td>
<td></td>
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<tr>
<td>4</td>
<td>2</td>
<td>29.7.66</td>
<td>13.9.66</td>
<td></td>
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<td></td>
<td></td>
<td>21.6.67</td>
<td>23.8.67</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>5.4.76</td>
<td>16.7.76</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>4.8.76</td>
<td>27.8.76</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>1.10.76</td>
<td>still in hospital</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>2 (in Jamaica)</td>
<td>5.7.74</td>
<td>16.8.74</td>
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### TRINIDAD

<table>
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<th>Dates discharged</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>2.2.74</td>
<td>3.2.74</td>
<td>Patient transferred to Littlemore, Oxford.</td>
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### MONTSERRAT

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<th>Patient</th>
<th>No. of children</th>
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<th>Dates discharged</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>5.10.75</td>
<td>9.11.75</td>
<td>Committed suicide 2.6.76</td>
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<td>Patient</td>
<td>No. of children</td>
<td>Dates admitted</td>
<td>Dates discharged</td>
<td>Comments</td>
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<td>------------------</td>
<td>----------</td>
</tr>
<tr>
<td>1</td>
<td>7 (6 in U.K., 1 in St. Vincent)</td>
<td>31.5.66, 5.9.74, 10.12.75, 3.2.76, 10.5.76</td>
<td>14.7.66, 23.9.74, 17.12.75, 1.4.76, 30.5.76</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>5</td>
<td>17.9.75</td>
<td>30.11.75</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>5</td>
<td>30.8.67, 29.2.68, 22.9.68, 9.12.68, 10.2.73, 13.11.73, 3.6.74, 14.1.75, 20.1.76, 22.10.77</td>
<td>23.9.67, 28.3.68, 4.10.68, 17.2.70, 22.6.73, 19.1.74, 27.9.74, 23.10.75, 10.10.77, 26.7.78</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>nil</td>
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<td>21.3.74</td>
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<td>5</td>
<td>5</td>
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<td>27.11.75, 16.12.75, 11.3.76, 30.7.76</td>
<td></td>
</tr>
</tbody>
</table>
Here are 5 accounts of informal interviews in which the respondents spoke freely about life, its problems and consequences. The names mentioned in the text are false, in order to respect confidentiality of the respondents. None of the respondents admitted being under medical care although individuals had previously had breakdowns. At the time of the interview they appeared to be functioning competently. The 5 'case studies' are classified into stressed/non-stressed, successful/unsuccessful, mentally healthy/disturbed individuals.

Stressed/unsuccessful, mentally disturbed.

Summary

(1) Mrs. Cox is a 48 years old woman who has lived in Reading with her husband and four children for the past 20 years. Both she and her husband are employed in Reading; the husband in a senior managerial job and Mrs. Cox a domestic at Battle Hospital. At the time of the interview (1977) her husband had left her for a younger West Indian woman. My arrival at Mrs. Cox's house provided her with a much needed opportunity to talk about her problems.

Researcher: How do you like it in England?
Respondent: Not a bit.
Researcher: Why?
Respondent: Since I came to this country, nothing has worked out for me. I came here to do nursing, and half through the course I had to give up because I got pregnant. Since then I have never had the chance to do it again. Then there wasn't one thing it was the next. When you have four children, you hardly have time for yourself.

Researcher: How did you manage?
Respondent: I stayed home most of the time. Sometime I used to do a little part-time job to help out with the bills. But since the children have grown up and can look after themselves I work full-time.
You visit me the wrong time.

Researcher: How is that?

Respondent: Look at the condition of the place, with hardly anything in it, as though a hurricane pass through it. Well my husband and I recently split up and I am going through a bad time. He is a real bastard. I gave up my career and spent most of my youthful life with him and then he went off with this young slut. The thing hit me so hard that I had a breakdown. I just didn't imagine that he would do a thing like that. Up till now I cannot believe it really happen. It's all right for you men to walk off because you can get another woman and start a family, but it's not that easy for a woman. Which man going to want a 48 years old woman with four children. The thing what really hurts me is that it smash up the whole family. It's only now that I am beginning to get back on my feet.

Researcher: Are you working?

Respondent: Yes, but not at the same job. You don't expect me to go back there, when everybody knows that I was in the hospital, 'they'll be washing their mouths all over me' (talking about).

Life can be something else. I never thought something like this could happen to me; never. I suppose I'll just have to pick up the pieces and try to make a go of life. I'll tell you one thing, I'll never trust another man as long as I live.

Stressed/successful mentally healthy individuals

Summary:
(2) This is a curious story, because the young man, of 25 years, was some one I knew at home. He lived on the same street as I did, and spent most of his childhood days, playing with my younger brothers. Meeting him was a pleasant, yet unpleasant accident.
His mother had immigrated to England many years ago (approx. 22 years), to escape the unpredictable psychotic behaviour of her husband Darcy (mentioned earlier in this text). She had subsequently sent for one of her sons, who is the subject of this discourse. Having expressed our surprise and pleasure of meeting each other we entered into the structured and informal interview. This young man had a long history of crimes and at present was on the run from the police. His main reason for visiting his mother, which was a dangerous exercise (because her house was frequently watched) was to see his little son. Despite his criminal activity and current escapades with the police, David appeared reasonably untroubled. I suppose, he had grown accustomed to such stress.

**Researcher:** What have you been doing with yourself since you have been in England?

**Respondent:** (smiled, paused and replied) A great deal man, probably too much.

**Researcher:** What do you mean?

**Respondent:** Well, I suppose you could say I have been a bad boy. I wasn't always like that, but somehow I got involved in crimes, and I just kept on, I guess.

**Researcher:** Have you been imprisoned?

**Respondent:** (Smile) I have done the lot, from detention to prison. At the moment I am on the run. By right I shouldn't be here, but I wanted to see my little boy before they catch up with me; I usually give them the slip.

**Researcher:** But David you just cannot go on like this. Don't you think that it is about time you stop. One of these days you wouldn't be able to see your little boy at all. If you say you love him as much as you do, then you ought to stay off crime and the 'nick' and spend some time with him, otherwise he might grow up and make all the mistakes you make.
Respondent: I guess you are right. The last time I did a job and was caught, I said it was the last, but here I am again. Oh I don't know.

Researcher: What fun is there in spending so much of your youth behind bars? I think it is a waste.

Respondent: I suppose you are right. My mum gets upset and I suppose she is a bit fed-up with me as well.

Stressed/unsuccessful mentally healthy individuals

Summary

(3) This case revolves around one of the 8 young unmarried females in my study, with whom I became acquainted. The stress experienced by this young lady could easily be reported for the other 7, all of whom experienced similar stressful life events. I selected this young lady because after the structured interview I discovered that we had both attended the same secondary church/school in Barbados. Miss Alleyne (lived on a council estate in Reading) emigrated to England about 18 years ago and lived with her mother in Reading. During her teens she became pregnant and subsequently moved to a council estate in Reading. Since living there, she had another child, for a different man. She now has two young children, is unemployed, possesses limited material resources, has an unreliable unstable relationship with a man who is not the father of her children, and laments her present social position and future prospects. However she has found a high degree of social support from her close association with several other young ladies who are in very similar situations. She receives a measure of support from her current boyfriend, but finds a more stable and reliable support from her female friends who are all supporting irrespective of her changing/changeable intimate relationships.

Researcher: After recalling mutual friends, I said to her, "It's really nice to see you again."
Respondent: It's nice seeing you too, but I am sorry you had to see me in this condition.

Researcher: What condition?

Respondent: Well, look at the place, then having two children for two different men. If my grandmother could see me she would turn in her grave.

Researcher: You are not the only person in such situation, so you shouldn't feel too badly.

Respondent: Sometimes I feel really down, I don't want to cook, nor wash the children, just couldn't be bothered. I mean it's not easy. I cannot work because the children are too small, although I suppose I could take them to the nursery. Anyway it is difficult to get a job. The few pounds I receive from Social Security is barely enough to manage on. I cannot afford to buy myself any nice clothes. The only break I get is the occasional party on a Saturday night, when Roger is going out. I cannot really rely on him, because he might come down this week and not the next week; he lives and works in London.

Researcher: What is he like?

Respondent: He is not bad. He is alright really. He shows some interest in the kids and he tries to help, but they are not his, so I should not expect too much. It is really difficult to find a good man. They are either dead or not born (smile). I haven't had much luck with men.

Researcher: How do you manage when you are 'down.'

Respondent: Well, Betty, Rosalindi and the others help out. We all help each other. Did you see Linda, the one who was lying on the chair, well she is having some problem with her parents because she is pregnant. She is staying with us until something is sorted out. My mum helps me as well. She occasionally buys clothes for the children, or she might give me something. My friends are really good, because sometimes things get on top of you; it happens to all of us, that's
when you need help. Had not for them I don't think I would cope.

(A broad smile) I suppose I would be in the hospital by now.

Non-stressed, successful mental healthy.

Summary

(4) This case study is about a middle age man who immigrated to England through a government sponsored scheme. He worked on the buses for sometime and later moved to Reading, where he subsequently combined working in the post office with an engineering course on evenings at the Institute for Further Education. He successfully completed the course and now has a degree in electrical engineering.

Researcher: How do you find life in England?

Respondent: I can't explain, I came here in 1960, lived in London, worked on the buses for about four years. I didn't have any hassles in London, I find it alright, only the place was a bit dirty. Then this friend of mine had an uncle living in Reading and he decided he would move up here. I used to visit him and got to like it here. For a start there was so many Bajans around, plus I later found out that I knew quite a few people out here; so I packed up my job and came to live here. I got a job in the post office and I realised that I had lots of time. After delivering the letters there was nothing else to do. It wasn't as hard as working on the buses either. So I decided to do electrical engineering. I was always interested in it. Luckily for me I passed and later went out to university. So I really have no complaints about England. I mean you know as well as I do that there is prejudice around, and occasionally some person tries to use it, but I don't take them on. So long as they don't hit me, they could talk till doomsday come. I know a lot of people who have had all sorts of hassles, but I suppose I am lucky. I haven't had any and that's the truth.
Summary

This case study concerns a middle age woman, age 40, who has been living in Reading for 18 years. She immigrated to England, stayed with relatives in Reading and later embarked on a nursing course. She had always wanted to be a nurse, but was unsuccessful in gaining admission to nursing school in Barbados. Not having the necessary qualifications to enter as a student nurse, Mrs. Allman, started out as a Pupil Nurse. Subsequently she successfully completed her State Registered Nursing (SRN) and also became a State Certified Midwife (SCM). Her nursing career was sandwiched between having three children and various domestic upheavals, e.g. threatened marital separation. The combination of domestic stress, intermittent childbirth and pursuing her nursing career, brought on a depressive illness, for which Mrs Allman was treated. She now appears reasonably well, although she admits feeling worried about her health.

Mrs Allman didn't want to talk about her domestic problems, but inadvertently let slip that she and her husband did not have the best of relations and it was this that caused her to have a "nervous breakdown." At the time of the interview Mrs Allman was an agency nurse at the Royal Berkshire.

Researcher: Why have you decided to do agency work?

Respondent: Who would look after the kids? I would love to work full-time but it is not possible. I don't get any help in the house; I have to do it all myself. (At this time her husband sent one of the children to ask her where she put his brown shirt). This angered Mrs. Allman who subsequently said, this blasted man could never find anything. He doesn't help in the house, all he wants to do is eat and dress and go out. I don't know why he doesn't stay out.
If he was any dammed good good I could at least do three nights a week instead of the occasional night. That really get me mad. After spending all of those years training then to come and spend most of my time at home, I think is a bloody waste of time. Excuse my language, but I am really angry, I have so much hassles with this man, I could write a book. Had not for him I would never have been sick. That put me back as well, because I lost a lot of confidence in myself.

From the time I was a little girl I always wanted to be a nurse, and look what happen. It's a bloody shame. Anyway I have got to be careful because I don't want this man to make me get sick again. The first thing he'll say is that I am mad.
<table>
<thead>
<tr>
<th>YEAR</th>
<th>STUDENT NURSES</th>
<th>PUPIL NURSES</th>
<th>HOSPITAL AUXILIARIES</th>
<th>B.T.C.</th>
<th>L.T.E.</th>
<th>CANTEEN WORKERS</th>
<th>DOMESTICS IN PRIVATE HOSPITALS</th>
<th>WEST RIDING AUTOMOBILE CO.</th>
<th>HOTEL WORKERS</th>
<th>L.C.C.</th>
<th>B.W.T. ARTISANS</th>
<th>COTTON WORKERS</th>
<th>LAUNDRY WORKERS</th>
<th>ENGINEERING &amp; COOPERS</th>
<th>BRITISH ARMY</th>
<th>LYONS TEA SHOP</th>
<th>CONDUCTORS (LONDON COUNTRY BUS SERVICE)</th>
<th>POLICE COLLEGE MAIDS</th>
<th>POLICE COLLEGE WAITRESSES</th>
<th>WALDHAM ABBEY APERATION</th>
<th>LONDON HILTON CALLENDER HANDS</th>
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<tr>
<td>Question</td>
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<td>Much More</td>
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<tr>
<td>1. How much have you eaten recently?</td>
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<td>3. How much time do you spend working?</td>
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<td>5. How much stress do you feel?</td>
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<td>6. How much do you drink alcohol?</td>
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**Appendix**

(60-117M Version)

**GENERAL HEALTH QUESTIONNAIRE**
<table>
<thead>
<tr>
<th>No.</th>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Do you often feel upset for no obvious reason?</td>
<td>2</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Do you have an unreasonable fear of being in enclosed spaces such as shops, lifts, etc?</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>3</td>
<td>Do people ever say you are too conscientious?</td>
<td>0</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Are you troubled by dizziness or shortness of breath?</td>
<td>Never</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Can you think as quickly as you used to?</td>
<td>0</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Are your opinions easily influenced?</td>
<td>2</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Have you felt as though you might faint?</td>
<td>Frequently</td>
<td>0</td>
<td>Occasionally</td>
</tr>
<tr>
<td>8</td>
<td>Do you find yourself worrying about getting some incurable illness?</td>
<td>Never</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Do you think that &quot;cleanliness is next to godliness&quot;?</td>
<td>No</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Do you often feel sick or have indigestion?</td>
<td>Yes</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>11</td>
<td>Do you feel that life is too much effort?</td>
<td>At times</td>
<td>1</td>
<td>Often</td>
</tr>
<tr>
<td>12</td>
<td>Have you, at any time in your life, enjoyed acting?</td>
<td>Yes</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>13</td>
<td>Do you feel uneasy and restless?</td>
<td>Frequently</td>
<td>0</td>
<td>Sometimes</td>
</tr>
<tr>
<td>14</td>
<td>Do you feel more relaxed indoors?</td>
<td>Definitely</td>
<td>2</td>
<td>Sometimes</td>
</tr>
</tbody>
</table>

### INSTRUCTIONS

The following questions are concerned with the way you feel or act. They are all simple. Please tick the answer that applies to you. Don't spend long on any one question.
thoughts keep recurring in your mind?

16. Do you sometimes feel tingling or pricking sensations in your body, arms or legs?

17. Do you regret much of your past behaviour?

18. Are you normally an excessively emotional person?

19. Do you sometimes feel really panicky?

20. Do you feel uneasy travelling on buses of the Under-round even if they are not crowded?

21. Are you happiest when you are working?

22. Has your appetite got less recently?

23. Do you wake unusually early in the morning?

24. Do you enjoy being the centre of attention?

25. Would you say you were a worrying person?

26. Do you dislike going out alone?

27. Are you a perfectionist?

28. Do you feel unduly tired and exhausted?

29. Do you experience long periods of sadness?

30. Do you find that you take advantage of circumstances for your own ends?

31. Do you often feel "strung-up" inside?

32. Do you worry unduly when relatives are late coming home?

33. Do you have to check things you do to an unnecessary extent?
34. Can you get off to sleep alright at the moment?

35. Do you have to make a special effort to face up to a crisis or difficulty?

36. Do you often spend a lot of money on clothes?

37. Have you every had the feeling you are "going to pieces"?

38. Are you scared of heights?

39. Does it irritate you if your normal routine is disturbed?

40. Do you often suffer from excessive sweating or fluttering of the heart?

41. Do you find yourself needing to cry?

42. Do you enjoy dramatic situations?

43. Do you have bad dreams which upset you when you wake up?

44. Do you feel panicky in crowds?

45. Do you find yourself worrying unreasonably about things that do not really matter?

46. Has your sexual interest altered?

47. Have you lost your ability to feel sympathy for other people?

48. Do you sometimes find yourself posing or pretending?