Economic and Social Review, Vol. 10, No. 4, July, 1979, pp. 301–320

Psychological Disturbance in Ireland, in England and in Irish Emigrants to England: A Comparative Study

RAYMOND COCHRANE
MARY STOPES-ROE*
University of Birmingham

Précis: A community survey involving 200 Irish emigrants to England, 200 natives of England and 200 residents of the Republic of Ireland was conducted to test a number of hypotheses drawn from mental hospital admission statistics. Contrary to the pattern revealed by these statistics, there was significantly less psychological disturbance amongst the immigrants than amongst the natives of England. It was also found that the Irish group had no more symptoms than the English. It is concluded that the high rate of mental hospital admissions among Irish immigrants is attributable to a small, separate group of deteriorated immigrants, rather than reflecting high levels of psychopathology throughout the community.

I INTRODUCTION

Starting from an observation of very high rates of mental illness among Irish-born residents of England, this paper looks at several hypotheses concerning the relationship between mental health and migration. A community survey involving 200 respondents in Ireland, 200 English natives and 200 Irish immigrants[1] was carried out, using as the central dependent variable standardised measures of psychological disturbance. Unexpectedly the immigrants had lower symptom scores than either the English group or the group interviewed in Ireland. Possible explanations for this finding are discussed and an examination made of social, personal and cultural variables which may affect immigrant adjustment.

Walsh (1971, p. 617) made a comparison of the number of patients

* The authors would like to thank the following people for assistance with various parts of this study: John Hanvey, Tom Simpson, Catriona Lleywellyn of Operations Research Centre; the staff of Irish Marketing Services, Dublin; M. A. Elliott, R. J. Eason and J. H. Falconer of the Department of Health and Social Security, UK; and all the people who kindly gave their time to complete the questionnaires. This work was supported by a grant from the SSRC.

1. Throughout this paper the terms "immigrant" and "emigrant" will be used alternatively according to the context and will refer to those born in the Republic of Ireland but resident in England; "Irish" will refer to those born in the Republic and resident there; and "English" will refer to those born in England and resident there.

resident in Irish psychiatric hospitals in 1963 with the numbers in similar institutions in England and Wales. He found that the Irish rate of residence was two or three times as high as the English rate, but found that much of this excess would be explained by reference to the different age and marital status structure of the population in the two countries. In particular, Ireland has a relatively high proportion of middle-aged and elderly single people who are particularly at risk for prolonged stays in mental hospitals.

Using a different index of mental hospitalisation (admissions to hospital rather than residence), Cochrane (1977, p. 25) found that Irish emigrants to England apparently also had very high rates of mental illness compared to natives and to most other groups of immigrants. Thus Irish immigrant rates were only exceeded by those of people from Ulster and were appreciably higher than those of Scots, West Indians, Pakistanis, Indians, Italians and Poles living in England. Adjusting rates for the marital status of the groups has little effect because 71 per cent of the Irish aged 15 and over in 1971 resident in England were married, compared to 67 per cent of the natives (Office of Population Census and Surveys, 1974).

By making certain adjustments to Irish figures published more recently by O'Hare and Walsh (1976) and putting these together with some unpublished English material, it is possible to make some direct comparisons of mental hospital admission rates of natives of England and Wales, Irish immigrants and rates in Ireland. Appendix I contains these figures and details of how they were assembled. It is clear from the comparisons that were possible that the two Irish groups have conspicuously higher rates than the native English group and that this is especially true for alcohol-related disorders where Irish rates are up to 10 times greater than English rates.

Of course, mental hospital admission statistics are not necessarily completely accurate indicators of mental illness rates. Other factors such as availability of beds, willingness to go to doctors, admissions policy of psychiatrists and availability of alternative forms of care will all influence hospital admission rates. It is also known that a marked cultural variation in the readiness of psychiatrists to make specific diagnoses exists. In addition, lack of comparability and lack of detail at the individual level make the testing of some interesting hypotheses very difficult, if not impossible.

This is one of a series of studies focusing particularly on migration as a major variable, but extending to comparisons of the sending and receiving groups. Although mental hospital admission rates were the starting point for the studies, psychological disturbance[2] measured by standardised instru-

2 The term "psychological disturbance" will be reserved for that aspect of psychic functioning measured by standardised indices of such disturbance which in fact consist of lists of the more common psychiatric symptoms. "Mental illness", on the other hand, will only be used in the context of a formal clinical diagnosis such as is presumed to occur prior to admission to a mental hospital.

ments became the central dependent variable. The reason for this was that it was possible to get an assessment of psychological disturbance in a community survey study which was continuous, ranging from an absence of symptoms to a great number of symptoms, without risking very high refusal rates which may have followed requests for detailed clinical interviews. Details of the questionnaires used are given in the next section, but it might be appropriate to consider here what it is that instruments of this kind measure. Clearly, they do not give an indication of whether or not a person is mentally ill in the clinical sense, so they are not likely to be valid as case identifiers. What they can do, however, is to give a fairly sensitive estimation of the extent to which an individual has psychological traits or symptoms which are characteristic of people diagnosed as mentally ill and very uncharacteristic of those not so diagnosed. In other words, the symptoms on the scales used occur with a much greater frequency in the mentally ill than in the normal population. They may not, however, be the defining characteristic of mental illness. In fact this is definitely not the case for psychotic states because the most bizarre and threatening symptoms (such as hallucinations and delusions) are not included on these symptom scales and yet may be very important in reaching a clinical diagnosis.

As the main focus of the study was on the relationship between social variables and psychological adjustment in Irish emigrants to England, this influenced several aspects of the larger study. The following general hypotheses were formulated:

1. Emigrants to England will show higher levels of psychological disturbance than English natives. The source of this hypothesis was the mental hospital admissions study to which reference has already been made. On the basis of the mental hospital residence statistics of Walsh (1971), it was further suspected that the Irish in Ireland would show more psychological disturbance than the English natives. This hypothesis assumes that there is some continuity between psychological disturbance, as measured by symptom inventories, and mental illness.

2. Emigrants will differ from the remaining Irish population in important psychological and social areas. On one variable at least – decision to move to England – the two Irish groups differed significantly and it could well be that other factors which might be related to this decision could also show differences between the two groups. Thus it was suspected that potential migrants to England would have been geographically and socially mobile prior to their migration and that the move to England was a continuation of this pattern of mobility. They may also have had more psychological problems which predisposed them to migrate than the non-migratory population.

3. Immigrants will also differ substantially from the native English population in ways other than psychological disturbance. We expected Irish immigrants to be more socially mobile (both upwards and downwards), both as a cause and effect of their migration, than the English natives. It was also suspected that family cohesion would be lower because of the disrupting effects of migration and because living conditions might be poorer and employment history less stable amongst immigrants than amongst natives.
4. The success of immigrants' psychological adjustment will be related to certain social and motivational variables. More specifically, it was hypothesised that those immigrants who remained oriented to Ireland rather than acculturating to their new surroundings would have more problems. Similarly those who lacked close contact with their family after migration would be more at risk. Obviously these two variables (cultural orientation and family contact) might themselves be related.

Paradoxically, it was also hypothesised that those for whom the circumstances of migration had involved most difficulty would show better adjustment than those people for whom relocation had been relatively free of stresses. The reason for this hypothesis was that it had previously been suggested (Cochrane, 1977) that where migration is easy this route may be taken to attempt to escape from problems which are in fact purely personal and perhaps transported with the person rather than being left behind. We expected that rural to urban immigrants would be better adjusted than urban to urban immigrants because there could be a greater tendency for self-selection of the stable individuals and because a greater improvement in living standards would be experienced.

Finally, it was predicted that immigrants experiencing housing, employment and other personal difficulties would show psychological symptomatology.

II METHOD

(i) Sample

As the group of prime interest was Irish emigrants to England, this group was defined in terms of known characteristics and the other groups matched to them. On the basis of the 1971 Census of Great Britain, the age and sex distribution of Irish-born residents of England was determined and a sample of immigrants in London, Birmingham, Coventry and Manchester chosen to match these parameters. These towns were chosen because of the relatively high concentration of Irish-born residents.

Sampling within these towns was done by the "random walk" technique. Obviously, the preferred sampling method would produce a true random

sample from which the required quotas could be filled as it is important that every member of the defined quotas should have an equal chance of inclusion in the sample. The use of standard sampling frames, such as the electoral register, was ruled out because of the impossibility of identifying Irish-born migrants and also because a population which is by definition migratory may be missed from official lists. A second valid random technique is a private census of an area believed to contain a high proportion of the group required. When the census is completed, a sample of individuals therein can be taken and interviewed. This method is expensive and time-consuming since it involves an extra fieldwork step in the large-scale compiling of lists of people, most of whom will not be contacted or interviewed.

The "random walk" technique is considerably cheaper and with well-briefed and competent interviewers is almost as good a method of avoiding bias and ensuring equal probability of selection as either of the two true random techniques. In brief, the method involves a random selection of dwellings rather than individuals by having the interviewer follow a pre-designated random walk. The interviewer starts at the beginning of a randomly selected street and calls at every home on one side of the street until an interview is obtained. A specified number of addresses is then missed before another call is made. Left and right turns are made alternately and detailed instructions given for dealing with culs-de-sac, non-residential premises and for dealing with multiple dwelling units, flats over shops, etc. This method has the advantage of taking away from the interviewer the initiative in selecting potential respondents, while remaining almost as cheap as ordinary quota sampling. The choice of particular residential areas within the towns chosen from which to draw the samples was also determined by the high concentration of Irish-born residents. It is recognised that any sampling technique based on private dwellings will risk missing the itinerant and the institutionalised section of the population. This problem is returned to later.

The native-born English sample was selected from the same towns as the immigrants and matched to them on the variables of age, sex and type of residential area. The Irish were also matched to the immigrant group and selected from 17 districts of Dublin. This city was chosen to add an extra control for living in a large urban area. Both the English and Irish comparison groups were selected by the same random walk method as the immigrant group.

(ii) Questionnaires

The questionnaires used consisted of three main parts. The central dependent variable – psychological symptoms – was assessed by two previously developed scales, the Symptom Rating Test (SRT) (Kellner and

Sheffield, 1973) and the Twenty-two Item Scale of Distress (Langner, 1962). These will subsequently be referred to as the SRT and Langner Scales. Both scales have been previously validated in England by the criterion groups method and the Langner Scale has been specifically validated for use in immigration studies (Cochrane, Hashmi and Stopes-Roe, 1977). Both scales have also received thorough psychometric evaluation and have been shown to be reliable (Cochrane, 1979). Apart from their demonstrable validity as measures of psychological symptoms, the scales were chosen because they are brief (30 and 22 items, respectively), easily administered and understood, and do not contain any very disturbing questions.

The SRT yields a total score and sub-scale scores measuring Anxiety (8 items – e.g., nervous, scared or frightened); Depression (8 items – e.g., feeling guilty or feeling that there was no hope); Somatic (7 items – e.g., feeling numb or tingling, chest pains or breathing difficulty); and Inadequacy (7 items – e.g., feeling that people look down on you or difficulty in thinking clearly). It should be noted that this division of items was an *ad hoc* arrangement and has not been unambiguously supported since (Cochrane, 1979). In the form used here respondents were asked to say whether they had experienced the symptoms on the scale in the past few months or so "never", "sometimes" or "often". These response alternatives were weighted 0, 1 and 2, respectively, in computing scale scores.

The Langner scale consists of twenty-two items, each scored as present or absent (0 or 1), although for some items three alternative answers are provided for respondents. Examples of items are "Do you have periods of such great restlessness that you cannot sit still very long?", "Do you feel somewhat apart even among friends?" and "Do you find that you sometimes cannot help wondering if anything is worthwhile any more?" Only a total scale score is available from this measure which has been shown to have no significant sub-factor structure, apart from a large single factor running through all items (Cochrane, 1979).

The second part of the questionnaire contained questions relating to several indices that were constructed to test various hypotheses. A *Family Contact Index* was computed from questions relating to frequency of contact and proximity of close family members. A *Social Isolation Index* measured the basic contact of the respondent with other people in the normal routine of life. It was formed by taking responses to questions concerning marital status, number of children, number of cohabitants and occupational status. (Details of the construction of these indices can be obtained from the authors on request.) A *Migration Difficulty Index* was composed of questions concerning the circumstances of migration (financial help, travelling alone, job waiting, joining relatives, accommodation problems, etc.). Finally, an *Acculturation Index* was derived from questions

relating to ties with Ireland, integration at work, social integration, visits to Ireland and intention to return permanently to Ireland. The latter two indices were relevant only to the immigrant group. The items forming these four indices are presented in Appendix II.

The other section of the questionnaire contained questions on demographic, social mobility, housing and employment variables.

(iii) Procedure

The field work for this study was carried out by Opinion Research Centre in England and Irish Marketing Services in Dublin. Briefing of interviewers was done under the supervision of the authors. The survey was presented to respondents as a study of the kind of problems different groups of people have, how they cope with them, and how they are affected by such problems. Each potential respondent was given a letter describing the rationale for the study in detail and stressing his right to refuse to be interviewed or to terminate the interview at any time. The confidentiality of responses was also emphasised. Interviews were conducted in the respondent's home at a time convenient to him or her and all questions were read out by the interviewer in order to prevent differential treatment of the non-literate, if any.

III RESULTS

Table 1 contains a description of the samples obtained and some data on response rates. Although the groups were matched on the variables of age and sex, other characteristics were free to vary. It should be emphasised that only the immigrant group is representative of the population from which it was drawn; the other two groups were matched to the immigrant group and were not, therefore, representative of the total English or Irish population.

Refusal rates ranged from 13 to 19 per cent which is typical for a survey of this sort and, although they do not give cause for concern, the possibility nevertheless exists that perhaps the more unstable individuals declined to be interviewed. However, even if this did occur, it should not introduce any systematic bias since the refusal rates are quite similar in the three groups being compared.

The three groups were broadly similar on several of the demographic variables examined. They differed appreciably only on religion which is to be expected; on social class, with a higher proportion of Irish respondents being in the UK Registrar General's classes I and II (i.e., professionals, managers and proprietors); and on origin, with far fewer of the immigrants being born in urban areas than either of the other groups. The English group were also

somewhat less likely to own their houses and somewhat more likely to be council tenants than either the Irish or the immigrant group.

Table 1: *Characteristics of survey respondents*

	Immigrants	*Irish*	*English*
Variable			
Refusals (%)	16.6	18.7	13.4
Number of respondents	200	200	200
Males (%)	49	49	49
Mean age (years)	40	39	40
Married (%)	86	77	84
Mean no. children	2.5	2.8	2.1
Mean years of education	11	12	11
Males unemployed[a] (%)	11.2	13.3	13.3
Social class – I and II[b] (%)	8	30	17
– III (%)	60	54	59
– IV and V (%)	32	16	24
Religion – R.C. (%)	98	95	18
– C. of E. (%)	2	2	62
– Other (%)	0	1	12
– None (%)	0	2	8
Origin – Urban (%)	19	70	70
– Small town (%)	15	8	20
– Rural (%)	76	22	10
Owner occupier[c] (%)	71	76	50
Council housing (%)	11	14	31
Mean years resident in England	19	–	–

a Not including retired and student categories.

b Married women living with their husband classified by his occupation. UK Registrar General's scheme used.

c Owned by respondent or spouse of respondent.

Turning now to psychological symptoms, a somewhat unexpected pattern emerged. On the SRT the immigrant group obtained the lowest score followed by the Irish with the English having the highest score. Individual comparisons revealed that the immigrant group scored significantly lower than either of the other groups which were not significantly different from each other. As is usually found with scales of this sort, females obtained higher scores than males and the old scored somewhat higher than the young. None of the interactions between group, sex and age were significant. It might be noted here that the obtained F ratios indicate a substantial, as well

Table 2: *Psychological symptom scale scores in three groups: means and analysis of variance results*

Scale	*Irish*			*Immigrants*			*English*			*F Ratios*[a]		
	Male	*Female*	*Total*	*Male*	*Female*	*Total*	*Male*	*Female*	*Total*	*Group*	*Sex*	*Age*
N =	*98*	*102*	*200*	*98*	*102*	*200*	*98*	*102*	*200*			
SRT – Total	6.92	9.29	8.15	2.41	6.41	4.45	8.88	12.52	10.74	27.9***	23.6***	2.6
SRT– Somatic	1.12	1.32	1.23	0.55	1.15	0.85	1.64	2.23	1.94	15.8***	8.7**	13.8***
SRT – Depression	1.62	2.44	2.04	0.62	1.59	1.12	2.30	2.99	2.65	20.7***	17.8***	2.8
SRT – Anxiety	2.27	2.88	2.58	0.60	2.00	1.31	2.68	4.06	3.38	24.4***	21.4***	3.9
SRT – Inadequacy	1.91	2.65	2.29	0.63	1.68	1.17	2.25	3.21	2.75	29.5***	28.6***	0.3
Langner	2.32	3.27	2.81	1.54	2.94	2.25	3.06	4.63	3.86	12.8***	25.1***	6.2*

a No interactions were significant.

* $p < 0.05$

** $p < 0.01$

*** $p < 0.001$

as a statistically significant, difference between the three groups of respondents. For example, the F value found for the comparison of the three groups on the SRT total scale (27.9) is equivalent to a correlation of +0.48 which means that almost 23 per cent of the variance in SRT scores is accounted for by group differences (Friedman, 1968). This is a very large proportion of the variance, compared to that explained in other psychological studies (Cochrane and Duffy, 1974).

Table 3: *Correlations between psychological symptoms (SRT) and other variables*

	Irish		*Immigrants*		*English*	
	Male	*Female*	*Male*	*Female*	*Male*	*Female*
N =	*98*	*102*	*98*	*102*	*98*	*102*
Social class	.13	.07	.16*	.05	.05	.08
Years of education	−.17*	−.15	−.05	−.19*	−.06	−.18*
Social mobility	.07	.01	.05	−.02	.05	.03
Pre/post-migration social mobility	—	—	.00	.12	—	—
Post-migration social mobility	—	—	.02	.14	—	—
Crowding index	.05	.09	−.07	−.04	−.03	−.15
Years lived in England	—	—	.05	.23*	—	—
Acculturation index	—	—	.20*	.13	—	—
Migration difficulty	—	—	−.01	.07	—	—
Age at migration	—	—	.09	−.24**	—	—
Family contact index	−.12	−.10	−.07	−.04	−.05	−.12
Social isolation index	.32***	.13	.17*	.22**	.08	.29**

* $p < 0.05$
** $p < 0.01$
*** $p < 0.001$

Similar complete analyses were carried out for each of the sub-scales of the SRT and the Langner scale with very similar results. All of these results have been condensed into Table 2 to conserve space. In none of the comparisons made were any of the interactions significant.

The most striking feature of these data is the very low scores recorded by the immigrant males on the SRT scales. Indeed as a group they scored significantly lower than the English and Irish groups on the total scale and on all four sub-scales. The Irish males' scores were not distinguishable from the English scores. Although females scored higher on all scales than males, there were fewer differences between female groups. Immigrant females scored lower than English females on all scales, but were only significantly lower than female Irish residents on the inadequacy subscale. As the Langner

scale and SRT total scale scores correlated so highly (Irish group r = 0.85, immigrants r = 0.86 and English r = 0.85) and yielded similar results, only SRT scores will be presented in future tables.

The correlations found between psychological disturbance (SRT total score) and several other variables are presented in Table 3. A word of explanation is required for some of the variables listed in this table. Social class was classified by the UK Registrar General's scheme and ranges from 1 (professional) to 6 (unskilled manual); thus a positive correlation means higher scores in the lower social classes. Social mobility refers to differences between the respondent's occupation (or husband's occupation for a married woman) and father's occupation. The scale values are: 1 (upwardly mobile), 2 (stationary), and 3 (downwardly mobile). The pre/post-migration index refers to social mobility associated with the migration, and the post-migration index refers to social mobility since migration. These latter two indices are scored in the same way as the general social mobility index, but are appropriate for immigrants only. The crowding index was derived simply by dividing the number of occupants of a dwelling unit by the number of rooms it contained. A higher score on the acculturation index indicates a more positive orientation to living in England and, conversely, a lower score means a greater orientation to the country of origin. A higher score on the social isolation index indicates a greater degree of social isolation.

Table 4: *A comparison of social variables in three groups*

	Irish	*Immigrants*	*English*	*Significance of difference between groups*
Family contact index (range 0 – 30)	18.60	19.07	19.07	NS[a]
Household crowding (range 0.2 – 4.0)	1.08	1.05	0.87	$p < .000$[a]
Social isolation index (range 0 – 5)	1.20	0.85	1.74	$p < .000$[a]
Males unemployed at anytime in past year (%)	15.3	15.3	17.3	NS[b]
Social Mobility				
upwards (%)	33.3	19.5	27.6	$p < .01$[b]
downwards (%)	32.2	54.7	26.5	

a Based on analysis of variance.
b Based on Chi square.

The final data to be considered are a comparison of the three groups on several of the social indices, employment status and social mobility. Table 4 contains these data. The three groups do not differ on the Family Contact Index, household crowding nor the extent of recent unemployment. However, the immigrant group is slightly less socially isolated than either of the other groups, somewhat more likely to be downwardly socially mobile, and correspondingly less likely to be upwardly mobile.

IV DISCUSSION

It is proposed to discuss these results in the context of the general hypotheses put forward in the introductory section.

1. The first hypothesis was clearly not supported. Irish emigrants to England did not show elevated levels of psychological disturbance; in fact, the very opposite was true. This result flatly contradicts the expectations generated by an inspection of the mental hospital admission data (see Appendix I for details). The resolution of this paradox could lie in any of three aspects of the two sets of data. First, the measure of psychological disturbance used may not relate to mental illness as reflected in mental hospital admission. Although a complete isomorphism is not expected, this is thought unlikely to explain the entire discrepancy because these scales were validated by a comparison of the hospitalised mentally ill and normal groups. However, the scales may very well fail to detect some aspects of mental illness, such as alcoholism, which is a category where Irish admissions are extremely high.

   A related explanation is that the apparently low symptom levels of the immigrant group is in fact due to this group's distrust of revealing what might be considered as socially undesirable or even incriminating information to outsiders. Members of this particular group might be inclined to reticence, both because of being Irish and living in England and also because of their predominantly rural backgrounds. In another context Hart (1971, p. 30) has shown that a sample of Dublin male voters obtained scores on several psychological tests which were anomalously low by international standards. Arguing against this being a complete explanation of the low symptom scores of the immigrant group is a recent study in the USA by Gove, McCorkel, Fain and Hughes (1976) which specifically examined the possibility of systematic bias influencing the results of community surveys of mental health based on scales like the Langner 22-Item index. These authors concluded that although there was some evidence that response bias variables such as naysaying, perceived trait desirability and need for social approval did influence scores on the Langner scale,

> the three forms of response bias did not act as a form of systematic bias that invalidated the pattern of the observed relationships, but instead as random noise. This suggests that these forms of response bias may not pose a serious problem in psychiatric surveys (Gove *et al.*, 1976, p. 501).

Second, it could be that the measures of mental illness are valid, but that at similar, or even lower, symptom levels the Irish (both in Ireland and in England) are more likely to be admitted to mental hospitals than the English. Apart from being an inherently unlikely explanation for such vast discrepancies in mental hospitalisation rates, other evidence of migrant illness behaviour shows that migrants tend to under-utilise, rather than over-utilise, facilities (Cochrane, 1977, and Morgan and Andrushko, 1977). It is also likely that any tendency to over-utilise psychiatric facilities would be confined to the less severe diagnostic categories (such as neuroses). This is clearly not the case as even the most psychotic categories show an enormous Irish excess (e.g., schizophrenia and depressive psychoses).

Third, and most likely, is the hypothesis that the mental hospital admission data and the survey data refer to only marginally overlapping populations. In other words, it might very well be that because the homeless, hostel and institution residents and the chronically inebriated have a very low probability of falling into a survey sample based on households, they are under-represented and yet account for much of the excessive Irish rate of mental hospitalisation. If this were true, it would mean that the difference in psychological disturbance between English and Irish groups is not uniformly spread throughout the population, but rather confined to an excessively deviant tail of a possibly otherwise normal distribution of mental states in the Irish and immigrant groups. Indeed, as has been pointed out, the symptom level in the "normal" population is lower among the Irish than the English. This seems to be particularly true for male Irish emigrants to England. On the one hand, there is a minority who have high rates of mental illness (over 10 times as high as English rates for alcoholism) while, on the other hand, the residentially stable, employed, "respectable" group of male immigrants have extraordinarily low rates of symptom formation. It is as though there are either two distinct groups of immigrants or that the Irish deviant drops out of the normal scene entirely much more readily than his English counterpart and so does not figure at all in the samples taken for surveys, whereas an English sample contains a more representative cross-section. It is thought that the former is more likely – that there are two distinct groups of immigrants. If this were not the case, then from what is known of the gradual onset of illnesses such as depression and neuroses, higher symptom levels should be picked up even in the settled community. These higher scores would derive from those who were destined to become hospital-

ised. This was clearly not the case here, so we are led to the conclusion that a certain small proportion of Irish migrants to England never settle into the local Irish (or English) communities, and are in fact probably disturbed prior to migration. Although there is a dearth of hard evidence at present, it is a common impression that the Irish in England are over-represented in the itinerant and hostel population and that a high proportion of mental hospital admissions come from these sources. In their study of two hostels for alcoholics in London, Otto and Orford (1978) found that 18 per cent of the residents were from the Republic of Ireland which is a far higher proportion than would be found in the non-hostel population.

2. Again, there is absolutely no evidence from this survey that immigrants are more unstable psychologically than the non-migrant Irish. If anything the position is reversed. Immigrants scored significantly lower on the symptom scales than did the Irish at home. (Because many comparisons are made, the more stringent 0.01 level of probability is used when making comparisons of pairs of groups.) Male immigrants score significantly lower on the SRT overall than Irish males, as they do on each of the sub-scales. Female emigrants to England are not distinguishable from residents of Ireland, except on Inadequacy.

   In terms of social mobility the migrant group appears to be more downwardly mobile when compared with their fathers than either of the non-migrating groups (Table 4). This in part is explained by the fairly large proportion of immigrants whose fathers owned and farmed their own land in rural Ireland and this occupation (unlike that of farm labourer) has a high social status. Thus a man who is himself a clerk or welder and whose father was a land-owning farmer will be counted as downwardly socially mobile compared to his father. Further, if we examine the social mobility patterns of the immigrants since migration – that is, comparing the status of the first job they had on arrival in Britain with their current job – a very different pattern emerges. Over 43 per cent of the males and 32 per cent of the females have moved upwards, compared to 6.8 and 8.2 per cent moving downwards, since migration. Thus a common pattern seems to be of a person who is potentially downwardly socially mobile because of structural factors in his home country (e.g., primogeniture in the inheritance of land) avoiding the full impact of this by migrating and progressing upwards in a new status structure.

3. As regards differences between immigrants and natives, the same strictures that applied to the discussion of the social mobility comparisons of the immigrants and Irish groups also apply when the immigrants and native-born English group are compared. There appears to be more inter-generational downward social mobility in the immigrant group, but this is definitely not the case if only the period since migration is considered.

Although data are not available for a comparable period for the native group, it is doubtful whether they would have been so successful socially as the immigrants have been.

Irish emigrants to England appear no more likely to be unemployed or to have recently experienced unemployment than do the English. Neither do they have any less contact with their families. Although it was predicted that this would be the case, it seems that the long average period of residence in England means that most immigrants have managed to assemble their family about them there. In terms of social isolation in general, the immigrant group is in fact less isolated than either the Irish or English groups which again conflicts directly with our expectations.

4. It is clear from Table 3 that few of the background and social factors included significantly affect the psychological adjustment of Irish emigrants to England. In addition to those included in this table, social mobility, urban/rural origin, marital status and employment status were examined for effects on psychological symptoms. None of these variables manifested a significant relationship to symptom levels, except for a marginally significant tendency for those in employment to have lower symptom scores than those not in employment, this being true of the Irish and English groups also.

Although the correlations between social variables and symptom levels are low for the immigrant group, it is perhaps worth commenting on one or two of these. Irish immigrant males of lower social class status have higher symptom scores where this is not true for any other group. Even here the SRT score of the lowest social class group among the immigrants is still lower than the scores of the highest social classes in the Irish and English group. On the acculturation index, however, there is a distinct tendency for those more oriented to life in England and less towards life in their country of origin to have higher symptom scores. This, of course, is exactly the opposite of what was predicted by the initial hypothesis. It appears that for males at least, maintaining strong ties with the home country is associated with psychological stability. The direction of a causal link, if indeed there is one, cannot, of course, be gauged from a correlation coefficient. Orientation towards life in England is also strongly related to length of residence there ($r = 0.69$, $p < 0.001$).

For immigrant women the longer they have lived in England, the higher their symptom scores, but both of these variables are related to age at migration. Women who were younger when they migrated have higher levels of symptoms and have been in England longer.

For both males and females the extent of social isolation is related to psychological distress, but this is not unique to the immigrant group. It

appears consistently and not, perhaps, unexpectedly to be the case that the more socially isolated people are, the more symptoms they admit to.

V CONCLUSION

Most of the hypotheses set up before this study began were suggested by an examination of mental hospital admission statistics in England and Ireland. These hypotheses, especially as they apply to Irish emigrants to England, have by and large not been substantiated or have actually been refuted. The group of Irish immigrants sampled in this study were psychologically stable and showed no evidence at all of self-selection for migration on the basis of personal or social inadequacy. On many variables the reverse was true – while the Irish and native English groups were similar, the immigrants were distinguished by their superior adjustment. Given that the measures used were valid, it can only be concluded that another group of Irish immigrants living in England, but not readily accessible to sample surveys, accounts almost entirely for the high level of psychopathology recorded in official statistics.

Finally, figures for Irish emigrants to England and Wales include those who gave their birth place as the "Republic of Ireland" or as "Ireland". As this convention is followed for both the patient and the population figures, it is unlikely to introduce any appreciable bias.

APPENDIX I

Mental Hospital Admissions

Table A.1 contains a comparison of rates of admission to mental hospitals in three groups in 1971: Irish-born residents of England and Wales, native-born residents of England and Wales, and residents of Ireland. All residents of Ireland are included in this last category, not just the native-born, but as the proportion of foreign-born residents living in Ireland in 1971 was only 4.5 per cent of the total (Central Statistical Office, Dublin, 1974), this will make only a marginal difference either way. The year 1971 was chosen for a comparison because it was a census year in both countries and so reliable population estimates are available.

The Irish data are taken from O'Hare and Walsh (1976, p. 30), but restandardised for age on the basis of 1971 population figures (O'Hare and Walsh used 1966 figures) and confined to patients and persons aged 15 years and over in 1971.

Because of the idiosyncratic way in which the British Department of Health and Social Security assembles diagnostic categories, it only proved

possible to make diagnostic specific comparisons for schizophrenia, depressive psychoses and alcohol-related disorders. These are defined as International Classification of Disease (8th revision) codes 295 + 297, 296, and 291 + 303, respectively. Other diagnostic categories do not permit comparison of English and Irish data. The diagnosis-specific rates are not age-standardised because sufficient detailed data were not available for standardisation.

The figures presented for "all diagnoses" exclude admissions for mental handicap, but are age-standardised on the total population of England and Wales aged 15 years and over in 1971. In fact the effect of this age-standardising exercise on the Irish data is minimal; first admission rates for males changed from 393 per 100,000 unstandardised to 395 standardised and for females from 346 to 358 per 100,000.

The two sets of figures pertaining to residents of England and Wales include a proportion of patients whose place of birth was not recorded on admission to mental hospital, but who were allocated to the various groups included in the study. The reallocation was achieved by assigning patients whose place of birth was unknown to native and immigrant groups in proportion to the best estimate of the origin of a sample of such patients at one mental hospital who were investigated individually. This method has been described in more detail in Cochrane (1977).

Table A.1: *Rates of admission to mental hospitals per 100,000 population aged 14 years and over, 1971*

	First admissions			*All admissions*		
	Ireland[a]	*England and Wales*[b]		*Ireland*	*England and Wales*[c]	
		Native	*Irish*		*Native*	*Irish*
A. Males						
Schizophrenia	88	16	31	298	87	183
Depressive psychoses	58	13	17	170	45	69
Alcohol-related	121	9	81	296	28	265
All diagnoses[d]	395	157	312	1,069	434	1,065
B. Females						
Schizophrenia	68	17	45	232	87	254
Depressive psychoses	90	22	40	285	92	174
Alcohol-related	25	2	11	58	8	54
All diagnoses[d]	358	195	330	1,003	551	1,153

a Recalculated from figures in O'Hare and Walsh (1976, p. 30).

b Recalculated from figures supplied by the Department of Health and Social Service (UK).

c Source: Cochrane (1977, p. 30).

d Excludes mental handicap. Age-standardised on total population of England and Wales.

APPENDIX II

The Composition of the Indices Used in the Study

(a) *Family Contact Index.* A score derived from a weighted combination of responses to the following questions:

1. Where does your father live?
2. In general, how often do you see your father?
3. Where does your mother live?
4. In general, how often do you see your mother?
5. Where does your husband/wife live?
6. In general, how often do you see your husband/wife?
7. How many children do you have?
8. How many of your children are living at home with you?

(b) *Social Isolation Index.* A score derived from a combination of responses to the following questions:

1. Are you married, single, widowed, divorced, separated, or cohabiting?
2. How often do you attend church or place of worship?
3. How many people are there living in this household, excluding yourself?
4. Are you in employment, self-employed or not employed?
5. How many of your children are living at home with you?

(c) *Migration Difficulty Index.* For immigrants only a score was derived from responses to the following questions:

1. Was it very expensive to come here?
2. Did you have any financial assistance from the State or Government?
3. Did you have any financial help from family or friends?
4. Did you come with anybody or did you come alone?
5. Was there someone in England to receive you when you arrived?
6. Did you have somewhere to live waiting for you when you arrived?

(d) *Acculturation Index.* For immigrants only a weighted score was derived from responses to the following questions:

1. Do you regularly correspond (once a month or more) with anyone in Ireland?
2. Do you own, or partly own, any property in Ireland (such as a shop/farm/house/business)?
3. Do you plan ever to return permanently to Ireland; if so, when?
4. Where would you prefer your children lived their lives?
5. How long have you lived in England?

6. How many times have you returned to Ireland since you first moved to England?
7. Whereabouts is your present employment located?
8. What nationality is your employer?
9. What nationality is your most immediate supervisor?
10. What nationality is the person with whom you work most closely?
11. What nationality are most of the people with whom you work?
12. What nationality are your closest neighbours on both sides?
13. What nationality are your closest friends?
14. Do you have any English friends?
15. Do you belong to any Irish clubs or organisations?
16. What nationality are the people you are most likely to go to the pub with?

Further details of the construction, use and scoring of these indices are contained in a series of working papers available from the authors.

REFERENCES

CENTRAL STATISTICS OFFICE, 1974. *Census of Population of Ireland, 1971, Bulletin No. 38,* Dublin: The Stationery Office.

COCHRANE, RAYMOND, 1977. "Mental illness in immigrants to England and Wales: An analysis of mental hospital admissions, 1971", *Social Psychiatry,* Vol. 12, pp. 25-35.

COCHRANE, RAYMOND, 1979. "A comparative evaluation of the Symptom Rating Test and the Langner 22-Item Index for use in epidemiological surveys", University of Birmingham, unpublished.

COCHRANE, RAYMOND and JOHN DUFFY, 1974. "Psychology and scientific method", *Bulletin of the British Psychological Society,* Vol. 27, pp. 117-121.

COCHRANE, RAYMOND, FARUK HASHMI and MARY STOPES-ROE, 1977. "Measuring psychological disturbance in Asian immigrants to Britain", *Social Science and Medicine,* Vol. 11, pp. 157-164.

COCHRANE, RAYMOND and MARY STOPES-ROE, 1977. "Psychological and social adjustment of Asian immigrants to Britain: a community survey", *Social Psychiatry,* Vol. 12, pp. 195-207.

FRIEDMAN, HERBERT, 1968. "Magnitude of experimental effect and a table for its rapid estimation", *Psychological Bulletin,* Vol. 70, pp. 245-251.

GOVE, WALTER R., JAMES McCORKEL, TERRY FAIN and MICHAEL D. HUGHES, 1976. "Response bias in community surveys of mental health: systematic bias or random noise?", *Social Science and Medicine,* Vol. 10, pp. 497-502.

HART, IAN, 1971. "Scores of Irish Groups on the Cattell Culture Fair Test of Intelligence and the California Psychological Inventory", *The Irish Journal of Psychology,* Vol. 1, pp. 30-35.

KELLNER, ROBERT and BRIAN F. SHEFFIELD, 1973. "A self-rating scale of distress", *Psychological Medicine,* Vol. 3, pp. 88-100.

LANGNER, THOMAS S., 1962. "A twenty-two item screening score of psychiatric symptoms indicating impairment", *Journal of Health and Social Behaviour*, Vol. 3, pp. 269-275.

MORGAN, PETER and ELIZABETH ANDRUSHKO, 1977. "The use of diagnosis-specific rates of mental hospitalization to estimate underutilization by immigrants", *Social Science and Medicine*, Vol. 11, pp. 611-618.

OFFICE OF POPULATION CENSUS AND SURVEYS, 1974. *Census of Great Britain, 1971: Country of Birth Tables*, London: Her Majesty's Stationery Office.

O'HARE, AILEEN and DERMOT WALSH, 1976. *Activities of Irish Psychiatric Hospitals and Units, 1971 and 1972*, Dublin: The Medico-Social Research Board.

OTTO, SHIRLEY and JIM ORFORD, 1978. *Not Quite Like Home: Small Hostels for Alcoholics and Others*, Chichester: John Wiley and Sons.

WALSH, DERMOT, 1971. "Patients in Irish psychiatric hospitals in 1963 – a comparison with England and Wales", *British Journal of Psychiatry*, Vol. 118, pp. 617-620.