A STUDY OF THE HEALTH OF IRISH BORN PEOPLE IN LONDON: THE RELEVANCE OF SOCIAL AND ECONOMIC FACTORS, HEALTH BELIEFS AND BEHAVIOUR.

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Abstract

This thesis argues that the health of Irish people in London is influenced by factors arising in both Ireland and Britain. Using different qualitative methods, the perceptions and experiences of Irish born people in London and professionals working with the Irish community were elicited. High levels of social distress, poor health and disability were evident and related to the experience of being Irish in London. Psychosocial factors associated with low income, poor housing and living in deprived localities added to the effects of discrimination and low socio-economic position. The insidiousness and specificity of anti-Irish racism evoked persistent feelings of insecurity, impacted on identity, access to health care and influenced ways of coping.

Factors relating to earlier life in Ireland may also account for poor health. Resentment about unfairness which compelled interviewees to leave Ireland, and failure to acknowledge their remittances persisted long after the experience of culture shock and homesickness. Aspects of childhood, schooling and Irish society, abuse in institutions or by family were clearly linked to physical or mental ill-health by interviewees. Factors from both countries influenced health beliefs and behaviour. Smoking and alcohol were culturally acceptable strategies for coping with life's difficulties and although harmful, afforded dignity and control in a hostile environment. Religious or spiritual beliefs and practices, contact with Ireland and a sense of belonging in both countries were associated with better health and greater service uptake. Contrary to expectations there was considerable willingness to discuss painful, emotional issues and engage with culturally sensitive services.

The pathways by which negative experiences impact upon health are not totally clear but the data highlight the relevance of psychosocial explanations. The thesis demonstrates a relationship between being Irish in London and ill-health but reveals the relevance of childhood experiences and factors associated with Ireland in understanding the complexity of the Irish health experience.

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I would like to dedicate this work to Geraldine, an interviewee whose courage and tenacity in her difficult life were and still are a great inspiration. She touched my life in both a personal and professional way before her untimely death from cancer in her early fifties.

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1.0. Chapter one : Introduction and background

Since the early 1980s there has been evidence that the physical and mental health of Irish people in Britain is considerably poorer than that of the population in general and of other ethnic minorities. The data demonstrate that the overall mortality rates of Irish born people exceed that of other people living in England and Wales by about 30% for men and 20% for women. Despite significant problems related to the classification of Irish people in census data, there is evidence that the health of Irish-born people in the United Kingdom is poor by comparison with the indigenous population and most other minority groups and is also consistently worse than the Irish in Ireland. Excess mortality is evident in most diagnostic categories and in all the target areas of the government policy document *Our Healthier Nation.* Studies show that these excesses are also evident in the second and third generations, a phenomenon which is highly unusual in migrant mortality studies.

Yet despite the evidence of distinct health disadvantage, the Irish remain relatively invisible in contemporary health policies. From the mid 1990s an increasing body of research emerged, documenting patterns of ill-health among the Irish in Britain and identifying some causal relationships. However there was little attempt to explain health disadvantage or to examine the explanations, experiences or consequences of ill-health from the point of view of Irish people. Given the concentration of Irish people in parts of the UK, and the concern of government to tackle inequalities in minority ethnic health, there is an urgent need to understand the structural determinants of poor health for Irish people.

1.1 AIMS AND RESEARCH QUESTIONS

1.1.1 The aims of the investigation

The study aims to identify factors contributing to the poor health of Irish people living in London, exploring how health inequalities are generated and maintained, examining the interaction between structural, lifestyle, cultural factors and health and considering individual and institutional barriers to health care. In particular the study sets out to explore the factors which Irish people perceive to impact on their health, how they maintain it and manage illness or disability.

1.1.2 The research questions

The investigation focuses on four distinct but interrelated research questions.

1. What is the experience of migration and settlement, and how might this impact on health and health related behaviour?

2. What is the relationship between the psycho-social effects of relative deprivation, discrimination and the generation and maintenance health inequalities?

3. What is the interaction between structural, cultural and lifestyle factors and health beliefs, behaviour and coping?

4. What are the individual, cultural and institutional factors which serve as barriers to good health and health care?

The research is underpinned by a number of theoretical perspectives which are discussed in chapter two. It is influenced by research on migration, discrimination and minority ethnic health. It is informed by the concept of relative deprivation and examines the relationship between the experience of disadvantage, feeling different relative to others and poor health. In this vein it examines the interaction between structural, lifestyle, cultural factors and health and access to health care. The investigation draws upon bodies of knowledge relating to health beliefs, behaviour and self-efficacy and explores factors which Irish people perceive to impact on their health, how they maintain it and manage illness or disability. In order to minimise the effects of migration, the study is limited to Irish-born people who have spent at least ten years in England. The study is confined to London for practical reasons and because of its high Irish population. A qualitative approach is adopted and involves a combination of key informant focus groups, lay focus groups and individual interviews.

The chapter begins by highlighting the relative invisibility of the Irish community in academic and race relations debates in Britain. It goes on to consider ways in which the Irish community are constructed as a racialised group, and the tensions wherein they are both invisible in policy yet highly visible in racialised discourses. The chapter then

paints a backdrop of Irish migration to Britain since the Great Famine, noting specific differences in citizenship status differentiating Irish people from other minority ethnic groups. It then considers the evidence of discrimination against Irish people before outlining the profile of Irish people in London. In the absence of a large body of research on the health of Irish people in London, the health of the Irish in Britain is discussed, highlighting the gaps in evidence to be addressed.

1.2 CHANGING DISCOURSES OF THE IRISH IN BRITAIN

1.2.1 Invisibility in academic and race relations discourses

According to Miles (1982) and Hickman and Walter (1997), the invisibility of the Irish in Britain in academic discourse, originates in the way in which British and Irish historians and sociologists deal with the topic of migration from Ireland. They argue that historians mainly address the process of assimilation, whereby Irish people appear to dilute their own culture, becoming more oriented to an English way of life and absorbed into British society. While not denying the disadvantage and hostility experienced in the nineteenth century, historians assumed that later discrimination was located in the class position of the Irish in Britain, and therefore not explicable within a paradigm of racism (Hickman and Walter 1995). The emphasis on assimilation neglected the diversity of Irish experience and geographical, temporal, gender and socio-economic differences influencing the acceptance of Irish people and their descendants into British society at different times.

With the exception of Jackson (1963), Walter (1980, 1984), Miles (1982) and Holmes (1978) there was little attention to the Irish in Britain from the social sciences until fairly recently. Miles (1982, 1993) was critical of race relations discourses which neglected the history of migration, the relevance of migrant labour to capitalist development, migration which predated 1945, and focused on skin colour as a marker of "race". He was particularly critical of the neglect of Irish migrant labour in the industrial development of England and Scotland (Miles 1982). Holmes too, (1978) criticised suggestions that the inclusion of Irish people within the boundaries of British nationality and their absorption into British society reflected greater tolerance towards them than to their Black and Asian counterparts. On the contrary, he argued that they were still exposed to hostility on the basis of labour market competition and perceived

responsible for various social problems. Walter (1984, 1995) demonstrated that Irish settlement in two different parts of England (Bolton and Luton) had to be seen in the context of labour migration, but that it also related to cultural characteristics associated with feelings of belonging with other Irish people.

Hickman and Walter (1995) suggest that in adopting the prevailing paradigm of skin colour in Britain, the sociology of race relations assumes White homogeneity. This neglects consideration of racist discourses affecting White minority ethnic communities and therefore excludes concern about the Irish as victims of racism. The black/white binary restricts analysis of the position of Irish people and constructs a framework for the conceptualisation of ethnicity which excludes them further. The classification of Irish people within the White category suggests a homogeneity which does not exist, and in equating "whiteness" with dominance, the experience of hostility and discrimination is neglected. "Whiteness" according to Frankenberg (1993), is not fixed and immutable but changes over time and space and is a product of local, regional, national and global relations. As demonstrated by hostility towards and discrimination against Jews and Gypsies, it is influenced by the racism of the time and society. Cohen (1988) argues that racism has never confined itself to body images and that all kinds of behaviour, customs and cultural practices are used to signify difference and inferiority. Similarly Brah (1996) and Anthias and Yuval Davis (1992) argue that groups are racialised differently on the basis of differing signifiers of "difference". Hickman and Walter (1995) support this and argue that colonial racism and the construction of the Irish (Catholic) as significant "other" of the English (Protestant) frames the experience of Irish people in Britain. Jews, despite their fair skin, have at various times been victims of racism both as "outsiders" and as non-Christians (Miles 1993, Anthias and Yuval Davis1992). The anti-Irish racism and anti- Catholicism experienced by Irish people mirrors to an extent the Jewish experience. Although there is recognition by some academics that being white does not necessarily protect the Irish in Britain against racism, ideas of White homogeneity appear to deny it at policy level.

Walter (2000) argues that sometimes the parameters of "whiteness" include the Irish, but at times construct them as the "other". The notion of the "British Isles" and terms like "Mainland Britain" or the "Celtic Fringe" suggest geographical inclusion which do

not necessarily exist. Walter (2000) argues that in Britain, Irish women are constructed simultaneously as priviledged and subordinate in relation to other women. Brah (1996) suggests that Irish women are constructed as a dominant group compared to Black women despite being subjected to anti-Irish racism themselves. While they may be protected from some of the racism experienced by Black women, they are not immune to racialisation on other axes of difference, such as class, education and labour group differences. Although both Walter (2000) and Brah (1996) refer to the situation of Irish women, there is much resonance with the experience of Irish men described by Hickman and Walter (1997). While skin colour may preclude official recognition of racism against Irish people, it does not stop them experiencing it and there is substantial evidence of discrimination in many areas of life and health (Hickman and Walter 1997, Harding and Balarajan 1996). Although data on racist abuse of Irish people are limited, there is evidence that different forms of anti-Irish racism such as jokes and stereotypes have persisted well into the 1990s (Hickman and Walter 1997), despite being prohibited by the 1976 Race Relations Act.

1.2.2 The racialisation of the Irish

Despite apparent invisibility at one level, Hickman and Walter (1997) show that the social problems of Irish people are similar to those of other minority ethnic groups in Britain and that the Irish in Britain are a racialised community. Although a number of differences exist, there are clear parallels between the experience of Irish people and Jewish, African-Caribbean and Asian migrants (Anthias and Yuval Davis 1992). The Irish are often represented as the "same", sharing skin colour, language and other attributes with English people (Walter 2000), but there is also a history of racialisation as the "other" over several centuries. According to Curtis (1984), the Irish have long been constructed as the backward "other". She argues that scientific racism played an important part in the construction of the stereotype of Irish people in Victorian Britain. This stereotype attributed characteristics of ignorance, laziness, primitiveness, childishness and emotional instability to Irish people. Stereotypes are socially constructed and are therefore dynamic and changing, but while the nature of assumptions and their expression change over time, stigmatisation, inferiorisation and exclusion of the Irish community still persist at the end of the twentieth century (Hickman and Walter 1997).

Miles (1982), focusing on the racialisation of the Irish in nineteenth century England and Scotland, argues that the situation of Irish people relate more to a political economy of labour migration than racism. He challenges the application of the concept of racism only to those distinguishable by skin colour, citing the presence of anti-Irish racism long before any substantial numbers of dark skinned immigrants arrived in Britain. He demonstrates that biological, cultural or social characteristics were attributed to groups like the Irish, differentiating and excluding them from the majority British community. He describes a number of ideological forces articulating with political and economic factors to locate populations in specific and subordinate class locations. He highlights the significance of large numbers of migrants in any particular area, and their impact on labour markets, not just in urban areas but in rural economies. The overcrowded and unsanitary conditions they were forced to live in, meant that the Irish "race" were constructed as having negative social and cultural characteristics. This led to fears of social disorder, contamination, violence and robbery and anti-Irish sentiment was whipped up in newspapers, pamphlets, and public pronouncements of the time.

Miles (1982, 1993) also suggests that exclusionary attitudes and practices did not necessarily use "race" as a marker of difference, but focussed on religious adherence, and cited widespread evidence of anti-Catholicism. Hickman later proposes that anti-Catholicism contributed to the manufacture of negative stereotypes, since being largely Catholic, Irish people were additionally constructed as inferior to the English Protestant (Hickman 1995). The tradition of anti-Catholicism in England predating the Reformation was based on concerns about idolatry, superstition and moral corruption, as well as fears that allegiance to the Pope would be subversive towards the state. The Irish Catholic was portrayed as problematic by English Catholics, despite the expansion of the English Catholic Church by large numbers of working class Irish people in the late 19th and early 20th centuries. This related in part to concerns about the allegiance to Rome, but also about the transformation of the social class profile of the English Church. Concerns about " ignorant, sensual and revolutionary infidels"(Royal Commission 1848 p55) were such, that demands for separate schools for the education of Irish working class children led to the introduction of state funded grant aid for Catholic Schools in the nineteenth century. The aim was less to do with providing Irish

children with opportunities for social mobility than avoiding the risk of contaminating other pupils by mixing them in interdenominational schools (Hickman 1995). In addition, Hickman (1995) argues that the agenda of the Catholic Church in England from the nineteenth century onwards was the incorporation and denationalisation of Irish people. The ethos of Catholic schools, which most Irish children attended, aimed to weaken Irish identity by strengthening Catholic identity. "Becoming English" was not based on an inevitable process of cultural assimilation, but on acquiring a perception of the inferiority of Irishness as opposed to Englishness.

In popular discourse and parliamentary debates in the first half of the twentieth century, the Irish were portrayed as dirty, fighting and social security fraudsters (Holmes 1978). Despite the need for migrant labour in the post war period, many MPs expressed their concerns that the Southern Irish were a social liability (Glynn 1981). Hansard reports of parliamentary debates (cited in Hickman and Walter 1997: 10) blamed the Irish for problems such as increasing levels of tuberculosis in the 1960s. They were seen to place greater demands on health and housing services than other Commonwealth immigrants. It was even argued that stopping immigration controls on Commonwealth subjects would have little effect on health, housing or criminal justice provision, since the problems of the Irish were greater than the former (Hickman and Walter 1997).

From the late sixties, Irish people in Britain were exposed to hostility resulting from the political situation in Northern Ireland and paramilitary activity in English cities (Hickman and Walter 1997). While some British politicians and commentators sympathised with Catholic community demands for civil rights in Northern Ireland, they behaved as though this situation had nothing to do with Britain (Curtis 1984). British authorities, aided by the media presented an image of Northern Ireland which played down atrocities committed by British forces while depicting the situation as one of persistent acts of violence perpetrated by Republicans. After the Birmingham pub bombings in 1974, the Prevention of Terrorism Act (PTA) was rushed through Parliament despite adequate existing legislation to deal with terrorist activity in Britain. The draconian powers of this act legitimated surveillance and targeting of Irish people by the police and appeared also to sanction hostility and harassment by the public (PTAWRA 1987). The PTA according to Hillyard (1993) justified labelling of the

whole of the Irish community as a "suspect community".

In another insidious but frequently dismissed way, the Irish have been racialised by persistent offensive negative stereotyping in the media, jokes and cartoons. Curtis (1984) documents derogatory images of Irish people in cartoons and in publications like Punch and Harper's Weekly from as early as the eighteenth century. While it is argued that jokes and banter are merely sources of fun, Curtis (1984) suggests that the persistence of anti-Irish jokes perpetuates the association of Irish people with negative characteristics like stupidity, drunkenness and terrorism. While the problems in Northern Ireland from the 1970s provided a fertile ground for satirists and cartoonists, it also allowed the anti-Irish joke to flourish on stage and on television, reinforcing negative images of Irish people.

1.2.3 Invisibility and visibility – a tense relationship

The term "invisible" is widely used in the literature about Irish people in Britain but masks an ambiguity in which they are both invisible and highly visible in different discourses. The conceptualisation of ethnicity in terms of skin colour has served to "over-racialise" groups like African-Caribbean and Asian while de-racialising white minority ethnic communities like Jews and Irish (Mac an Ghaill 2001). Such models emphasise the problems of visible minorities but fail to explain anti-Semitism, anti-Traveller sentiment or the marginalisation of groups on the basis of religious beliefs or lifestyle choices. The adoption of a skin colour paradigm in race relations discourse means Irish people are largely invisible from policy debates and their disadvantage is generally unrecognised. Unlike some other minority ethnic groups, the failure to collect ethnicity data and reliance on figures for country of birth leads to gross under-enumeration of the second and subsequent generations of Irish people. Thus there is limited evidence through which comparisons can be made between Irish people, the population in general or other minority ethnic groups. In the absence of data there is limited or no evidence of need, and there is little, if any commitment to addressing the deficits in information. Even where data such as the high mortality rates of Irish born people in England and Wales exist, there is scant endeavour to explore further, let alone tackle the problem. In the past there was little pressure from Irish people or

organisations in Britain to deal with the disadvantage evident in many parts of the Irish community.

The invisibility of the Irish in Britain is not the consequence of an inevitable process of assimilation. Despite being relatively invisible in policy, the Irish in Britain were highly visible in discourses of "otherness", and seen in parliamentary debates as a drain on resources and blamed for a range of social ills. Spinley (1953) and Kerr (1958) describe official reports and social scientists' accounts of Irish "slums"in British cities in the 1950s (Walter 2000:23). The term "dirty Irish" was used in the nineteenth century to describe the Irish settlements believed to be the root of ill-health and social decay. Hickman and Walter (1997) report that it was still used openly in the verbal abuse of Irish people a century later in the 1990s, almost thirty years after the Race Relations Act 1976. Stereotypes of scroungers in parliamentary debates about welfare in the 1930s impacted on the ability of Irish people to access services and benefits that were legitimately their right in Britain right into the late twentieth century. Although the Irish had been afforded the rights of British citizens in 1948 and entitled to housing, benefits and welfare services, they were differentially treated by social security and housing agencies. Curtis (1984) argued that anti-Irish stereotypes and humour had reinforced and made acceptable chauvinistic attitudes to the Irish and their political objectives. She goes so far to suggest that stereotypes, anti-Irish racist jokes and banter may even have had a role in legitimating Britain's continuing presence in Northern Ireland with all the injustices that followed.

Connor (1987) and Mac an Ghaill (2001) argue that because of the tendency of the majority to opt for a kind of invisibility outside the home and to appear to merge into the host community, that there was limited pressure to be recognised as a distinct community until the 1980s. Irish community groups formed in the 1950s were mainly Catholic Church organisations espousing assimilationist ideas and encouraging the adoption of a low public profile by the Irish community. While church based organisations responded to welfare need among needy Irish people, with few exceptions they were reluctant to raise issues relating to inequality or injustice until the late 1970s. The majority of Irish organisations had constitutional clauses prohibiting "political" activity. This reflected the reluctance of the Catholic Church to engage in politics, as

well as unwillingness to draw attention to themselves and a fear of being drawn into debates about Northern Ireland (around which many community concerns emerged).

Hostility resulting from the political situation in Northern Ireland, paramilitary activity in English cities and the Prevention of Terrorism Act (1974) led many Irish people to keep a low profile in Britain from the late sixties onwards. While many individuals and families kept their heads down, sections of the community were politically active around internment, hunger strikes, the Prevention of Terrorism Act, and miscarriages of justice from the mid 1970s onwards. Spurred on by questions of civil rights and social justice, Irish born activists, second generation Irish and other concerned individuals began to challenge the status quo.

Professional workers who were predominantly Irish or of Irish origin drew attention to increasing evidence of disadvantage, poor housing, health and unequal access to welfare benefits. They began to question the invisibility of the Irish community, to seek minority ethnic group status and they were cognisant of the policy frameworks through which inequities could be addressed. There was increasing recognition within the community of its own internal diversity and in the spirit of the times, a growing awareness of gender and sexuality issues. There were concerns for the specific and differing experiences of Northern Irish Protestants, the Travelling community, second generation Irish and gay men and lesbians. The change in London was facilitated by the ethos and provision of funding by the Greater London Council. In the 1980s, organisations like the Federation of Irish Societies, London Irish Women's Centre, the Irish in Britain Representation Group and Action Group for Irish Youth began to actively campaign on Irish issues. There were differences across organisations with some taking a conservative line and others being much more radical. All were united however on the need for the inclusion of an Irish census category in the national census and in local monitoring data in order to address disadvantage.

However while organisations recognised the need to research and to address disadvantage, many people who identified as Irish were uncomfortable drawing attention to themselves in a society they found hostile. According to Hillyard (1993), the police made little distinction between being Irish and being involved in terrorist

activity, reinforcing the reluctance of people to expose themselves to surveillance, having their homes and businesses raided, or being stop-searched and arrested. They were also unwilling to identify with the way in which both Irishness and minority ethnic status had been constructed in British society over time. The pervasiveness of negative stereotypes and media images of Irishness made Irish people reluctant to identify their culture outside an Irish or otherwise safe environment. At an individual level challenging a "Paddy" joke risked being regarded as lacking a sense of humour, akin to a Black person being accused of having a "chip on the shoulder". At a collective level efforts to challenge discrimination or negative media images by Irish groups attracted further sarcasm and derision by suggesting that a group so similar to the English could be victims of racism. Even the publication of the CRE report *Discrimination and the Irish Community in Britain* by Hickman and Walter (1997) was greeted with mirth and sarcasm by the tabloid newspapers. Although many recognised the disadvantage experienced by Irish people, the 1980s backlash against the anti-racist strategies of the so called "Looney Left" authorities where many Irish people lived, did little to encourage Irish people to sign up to being members of a minority ethnic group.

So while at political level the Irish were both invisible and highly visible, the factors generating those tensions led to a vicious circle of circumstances. Challenging inequalities required the Irish community to provide data which were neither available nor any commitment to obtaining them evident. In drawing attention to needs, Irish organisations risked confirming existing stereotypes or at best locating the root of problems within the community. They also risked hostility from within their own community, from those who had been successful or who had assimilated into a British way of life. Those with difficulties did not necessarily welcome being identified as having problems in an individualist culture which invariably blamed the victim. Anecdotal accounts of Irish professionals who attempted to raise issues relating to discrimination against Irish people cite hostile responses from other minority ethnic groups who did not distinguish the Irish from the dominant culture. Black and Asian groups were angry with a "white" group trying to access the concessions they had struggled to achieve. The reluctance among individuals and groups to raise issues of concern was a product of the relationship between Irish people and British society and therefore took skill, energy and persistence before any change began to emerge.

1.3 THE IRISH IN BRITAIN

The 1991 census showed that there were some 837,500 Irish born people in Britain and they formed 1.5% of the population. It was estimated by Hickman & Walter (1997) that had second and third generation Irish been counted, there would be around 2.5 million Irish people in Britain. A long and successful campaign by the Federation of Irish Societies from the early 1980s led to the inclusion of an Irish ethnicity category in the 2001 census and these data began to be released in 2003. The absence of data on second and subsequent generations is not a problem for this study but the study is limited by the reliance mainly on 1991 census figures now largely out of date.

1.3.1 Irish migration to Britain.

Irish people have migrated in small numbers to Britain for centuries but they left Ireland in great waves of emigration since the Great Famine of the 1840s. It is difficult to estimate the numbers of people who left Ireland before 1987 since no records of those leaving were kept. Changes in the Republic of Ireland population at five year census intervals provide a crude estimate based on flows in and out of Ireland but they underestimate the movement of people and tell nothing of the profile of those who left.

1.3.2 Patterns of net migration

Table 1 demonstrates migration patterns showing large fluctuations following the first wave of emigration associated with the Great Famine in the mid to late nineteenth century (Walter et al 2002). The "second wave" occurred in the post war period in the late 1950s with the "third wave" in the late 1980s. Tables 1 and 2 show the destination of emigrants to the UK, US and other parts of the world at different times. In the 1970s inward migration to Ireland increased a population depleted by reducing birth rates and emigration for the first time in one hundred and fifty years (Table 3). In the late 1990s inward migration saw not only the return of many Irish families from Britain and the US, but a significant group of immigrants from different parts of the world.

Table 1. Estimated Gross Migratory Outflows from Ireland 1901 –1990

(000s)

Period	Destination UK	Destination USA	Destination other	Gross outflow
1901-1911	14	240	12	266
1911-1922	9	97	10	16
1926-1931	-	104	15	-
1931-1936	-	2	2	-
1939-1941	-	3	2	-
1941-1946	173	-	-	173
1946-1951	-	17	8	-
1951-1961	-	----------68----------		-
1961-1971	-	----------49----------		-
1971-1981	155	----------21----------		-
1981-1990	245	----------113----------		358

(- information not available)

Source : Economic and Social Implications of Emigration. National Economic and Social Council March 1991. Cited in Mac Laughlin J., 1994. Historical and recent Irish Emigration : A critique of core-periphery models. University of North London Press.

Patterns of net migration from Northern Ireland follow a similar cycle although the outflow in the 1950s was less than from the Republic. The 1970s saw a reverse situation with massive emigration due to the violent situation in the North. The 1990s showed similar rates of emigration to that from the Republic with net gains in the early part of the decade levelling off by the end.

Table 2. Destination of Emigrants from the Irish Republic 1987- 2001

Percentage of all emigrants

Year	UK	Rest of EU	USA	Rest of World
1987	54.2	7.7	24.6	13.4
1988	70.0	4.6	12.9	16.7
1989	68.3	5.5	11.6	14.2
1990	63.6	9.1	13.7	13.5
1991	65.2	8.8	13.4	12.5
1992	49.9	22.1	10.8	17.2
1993	45.9	20.1	14.9	18.1
1994	42.9	16.1	26.3	14.5
1995	40.3	14.4	26.3	19.2
1996	45.2	16.3	16.7	21.8
1997	44.5	14.1	14.1	27.2
1998	40.1	20.3	20.3	19.3
1999	35.2	15.5	18.6	30.7
2000	28.3	19.3	14.3	38.1
2001	26.6	20.6	11.6	40.7

Source : CSO Dublin 1987- 2001 (cited in B. Walter with B. Gray, L.Almeida Dowling, S. Morgan (2002) A Study of the existing sources of information and analysis about Irish emigrants and Irish communities abroad. Dublin. Department of Foreign Affairs

1.3.3 Age of emigrants

What is significant about the migrants throughout the decades and especially in the post war period, is the young age of the migrants. The greatest losses have been in the 15-24 age group and in times of heaviest migration this has extended to the 25- 34 age band and in the 1950s into the 35-64 group. Even during periods of net immigration losses in the youngest age bands continue. Approximately 80% of emigrants who left Ireland

from the 1950s to the 1980s came to Britain, falling dramatically from the late 1980s onwards but with increases to Europe and America. This related to higher levels of education, language skills and easier entry to the US. The largest group of Irish migrants currently living in the UK are those who came in the 1950s and in the 1980s. According to Walter et al (2002), the numbers of Irish-born migrants in Britain are lower than at any time in the post-war period.

Table 3 Net migration classified by age for Intercensal Periods between 1946-1996 (000s)

Age	1946-51	1951-61	1961-71	1971-81	1981-86	1986-91	1991-98
0-14	-4.4	-22.9	+23.1	+47.4	-6.3	-8.1	+20.1
15-24	-66.3	-146.9	-90.8	-10.2	-48.5	-87.8	-48.9
25-34	-43.6	-140.0	-64.7	-1.1	-19.1	-47.7	+9.0
35-44	-8.1	-44.5	+8.1	+39.6	-1.6	-6.1	+12.0
45-64	-3.7	-54.3	-15.8	+9.8	-2.9	-3.1	+10.1
65+	+9.6	+11.5	+7.3	+18.2	+6.5	+7.2	+5.9

(- emigration, + immigration)

Sources : Census of Populations of Ireland 1966, 1981, 1996 . Cited in B. Walter with B. Gray, L.Almeida Dowling, S. Morgan (2002) A Study of the existing sources of information and analysis about Irish emigrants and Irish communities abroad. Dublin. Department of Foreign Affairs

1.3.4 Gender and migration

The profile of those who emigrated over the decades shows that at different times women left Ireland in greater numbers than did their male counterparts.

Table 4 Net Migration by Sex 1871- 1986

Intercensal Period	Annual average (000)			Females per 1000 males
	Males	Females	Persons	
1871-1881	-24,958	-25,314	-50,172	1,010
1881-1890	-19,275	-30,476	-59,733	1042
1891-1901	-20,315	-19,327	-39,642	951
1901-1911	-11,764	-14,390	-26,154	1,223
1911-1926	-13,934	-13, 068	27,002	938
1926-1936	-7255	-9420	-16,675	1,298
1939-1946	-11,258	-7,453	-18,711	662
1946-1951	-10,309	-14,075	-24,384	1,365
1951-1961	-21,786	-19,091	-40,877	876
1961-1971	-6,236	-7,215	-13,451	1,157
1971-1981	+5,806	+4,583	+10,389	789
1981-1986	-8,283	-6,094	-14,377	736
1986-1991	-14,865	-11,969	-26,834	805
1991-1995	+311	+1,336	+1,647	+4,296

(- emigration, + immigration)

Sources : (1) Commission on Emigration Reports (1954) (2) Censuses of Population 1946, 1951, 1986, 1996. Cited in B. Walter with B. Gray, L.Almeida Dowling, S. Morgan (2002) A Study of the existing sources of information and analysis about Irish emigrants and Irish communities abroad. Dublin. Department of Foreign Affairs

1.3.5 Push and pull factors in Irish migration

Although migration from Ireland is similar in many ways to that of other former British colonies, a number of differences make it distinctive. As in other colonised countries the under-development of much of the economy through the colonial relationship with Britain meant that Ireland at the end of 19th century had nothing to offer particular

sections of the community and they were forced to emigrate (Crotty 1986). The need to pay cash rent to landowners meant that families were required to produce grain or cattle whilst subsisting on a small section of land for their own use. Customs arising out of colonisation, prevented the division of land into small units, and meant that only one family member (usually the eldest son) could inherit, so other children had little choice but to emigrate. In addition, changes in the forces of production in both Ireland and England all contributed to emigration in the nineteenth century. The mechanisation of agricultural production in Ireland reduced the need for manpower and competition from the British textiles as mechanised industry lowered prices for cotton goods and destroyed the Irish domestic economy associated with hand-weaving (Miles 1982). The absence of industrialisation except in the north-east, reduced need for labour, the division of land, and subsistent rural economies in the first half of the twentieth century, meant that for many young people there was little hope of earning a decent living.

MacLaughlin (1997) however, argues that large- scale emigration from Ireland from the late 19th century and well into the 20th century had its roots in the interface between Ireland and the international economy, with Ireland in a central position in the labour market. While the "push" factor of a deprived economy was central to Irish migration, many young Irish people saw emigration as an opportunity not to be missed (Ryan 1990). Emigration was not the response of a panic stricken young population, but a rational response to opportunities in an international economy (MacLaughlin 1997). This "pull" factor was fuelled by letters from abroad, citing high wages, abundant work opportunities, and frequently enclosed the cost of the fare (Brody 1973). The effect was magnified by the loneliness and isolation experienced by young people whose friends had gone away leaving them with few opportunities for youthful social activity.

High rates of emigration by women from the Irish Republic is unusual amongst European migration patterns, with one in three women leaving between 1946 and 1971(Walter 2000). In the first half of the twentieth century this resulted from a land inheritance system favouring their male siblings. It also reflected greater opportunities afforded them abroad, by the higher levels of education they had received in Ireland compared to men. Those with secondary level education or above were recruited to nursing, teaching and social work. Nursing was particularly attractive as it provided

accommodation, meals, uniform and laundry. Women with basic levels of education found employment in personal services, cleaning and catering jobs which often offered board and lodging. It is also argued, that at different times across the last hundred years, many women left Ireland to get away from repressive attitudes to marriage, sexuality and reproduction (Beale 1986, Walter 2000).

Although the contribution of those who migrated tends to be forgotten, records indicate that emigration was essential for the survival of the family at home and a substantial part of the Irish economy in general (Brody 1973). Making remittances to the family, coupled with low pay or intermittent employment, left many Irish women and men abroad with little income for their own use or to provide for themselves in the future (Brody 1973). Although it is clear that many achieved success they could never have hoped for in Ireland, Ryan (1990) argues that the exodus of large numbers increased opportunities for those who remained. Conversely, it is argued that the contribution of Irish men and women to politics and trades unionism in America and England (Walter 2000, Ignatiev 1995) suggests that forces for change and potential leaders in Ireland might have been lost through emigration.

1.3.6 The changing profile of emigration in the late 20th century

For most emigrants at the beginning of the 20th century, the place of choice was America, but the cost was prohibitive, the 1930s depression and immigration controls at other times meant that migration to the USA was restricted. The only alternative for most was Britain and emigrants generally went there reluctantly. Despite the opportunities it appeared to offer, emigration was not a choice taken lightly by the majority of men and women. This was evident by the slow pace of migration and large numbers returning to Ireland in the boom years of the 1970s (Greenslade et al 1991), shown in Table 3. But the pattern of migration changed in the 1980s, with emigrants predominantly educated to degree level, or with professional qualifications and skilled trades. However despite this contrast, smaller numbers of unskilled young men and women with low levels of education continued to leave Ireland for England. The late 1990s again saw a reduction in emigration with a large increase in return migration to different sectors of the booming "Celtic Tiger " economy.

Table 5. Irish Immigrants to the UK by year of entry and highest qualification

(Percentages)

Qualification	**Pre 1955**	**1955-64**	**1965-74**	**1975-79**	**1980-83**	**1984+**
Degree	2.3	4.6	5.0	9.2	20.3	7.9
Higher, Nursing, Education	6.6	6.2	7.7	9.7	6.2	-
GCE A Level / Leaving Cert	13.1	14.4	14.3	23.2	28.1	18.7
GCE O level / Inter Cert	4.7	6.5	10.3	8.6	6.1	18.7
CSE (below Inter Cert)	1.9	0.8	1.8	3.7	-	-
Other	12.6	11.2	10.0	8.7	14.2	25.1
No qualifications	58.9	54.1	48.0	34.5	25.1	32.8

Source UK. Labour Force Survey 1988. Cited in Hazelkorn E (1990) Irish immigrants today : A socio-economic profile of contemporary Irish emigrants and immigrants in the UK. London. Polytechnic of North London Press.

1.3.7 Regional destination in the UK

The Irish in England are strongly clustered by regions of settlement reflecting the availability of demand for labour in different industries at differing times, with over half living in the London and the Southeast. (Table 6)

Table 6. Irish immigration to the UK by year of entry and destination

(Percentages)

Destination	Pre 1955	1955-1964-	1965-1974	1975-1979	1980-1983	1984+	Total
Southeast	47.2	49.2	60.1	66.2	66.3	64.9	52.5
SE (exc GLC)	15.3	15.0	17.6	7.6	19.0	8.2	15.7
GLC	31.9	34.3	42.5	48.6	47.3	56.8	37.0
Elsewhere UK	52.8	51.8	39.9	33.8	33.7	36.1	47.5

Adapted from : UK LFS 1988 cited in Hazelkorn E (1990) Irish Immigrants Today : A socio-economic profile of contemporary Irish Emigrants and Immigrants in the UK. London. PNL Press.

1.4 SIMILARITIES AND DIFFERENCES

1.4.1 Citizenship status and Irish people in Britain.

People from the Irish Republic are in a unique position compared to other immigrants by virtue of the 1948 Nationality Act. This act afforded rights to people from British colonies and Commonwealth countries as British subjects or Commonwealth citizens. Following partition, in 1922, the Irish Free State was accorded status of a dominion of the Commonwealth. Six counties with the largest Unionist populations in Northern Ireland remained under British jurisdiction (Sales 1997). In 1948, Ireland withdrew from the Commonwealth and in 1949 the Irish Republic was inaugurated. The government of the time was forced to make special provisions for Irish people under the 1948 Nationality Act. The need for migrant labour, the significance of security in the post-war period, and the continuing presence of Britain in Northern Ireland meant that citizens of the Irish Republic were afforded the same rights as British subjects (Hickman and Walter 1997). In 1962, because of the difficulties in imposing immigration controls from Ireland, the government reluctantly excluded Irish people from the terms of the Commonwealth Immigration Bill which posed restrictions on

other immigrants. Although there was acquiescence by the British Government in relation to immigrant status, debates in Parliament reflected those of the 1930s when the Irish were portrayed as a source of social contamination and a drain on the public purse (Hickman and Walter 1997). For pragmatic reasons, the Irish could not be seen as "immigrants" in the same way as people from the New Commonwealth, but were still exposed to the same negative assumptions and discrimination. Excluding the Irish from nationality and immigration controls since World War Two has often been interpreted as acceptance and tolerance of the Irish in comparison with other black communities. However in 1988, Holmes saw this as over optimistic, as the first major study of discrimination and the Irish community in Britain would testify almost ten years later (Hickman and Walter 1997).

1.4.2 Discrimination and the Irish community in Britain – from anecdote to evidence

Despite some methodological problems, there had been substantial evidence of multiple disadvantage among the Irish community in Britain for many years (Burke 1976, Marmot et al 1984b, Connor 1987). Individuals and organisations had cited cases of discrimination and widespread disadvantage among sections of the Irish community. In 1994 following pressure from the organised Irish community, the Commission for Racial Equality (CRE) commissioned a study to examine discrimination against Irish people in Britain. The study by Hickman and Walter (1997) incorporated statistical analyses of socio-demographic data, a survey of ethnic monitoring of Irish people among local authorities and housing associations, a survey of community groups and individual in-depth interviews investigating the experience of discrimination and harassment. The findings confirmed the previously anecdotal evidence of Irish people and reports from Irish agencies citing abuse, harassment and discriminatory practices from neighbours, employers and the police. The report demonstrated material and social deprivation and that Irish people were subjected to widespread discrimination and disadvantage in health, housing, employment, education and training. The findings in particular showed that Irish people were subject to harassment in wider society and especially by the police and criminal justice system (Hickman and Walter 1997). However it appeared that these factors were not monitored consistently by statutory authorities, and even when disadvantage was recorded, no targets for improvement were

set and unlike some other minority ethnic groups Irish people were excluded from funding to address disadvantage.

1.5 A PROFILE OF IRISH PEOPLE IN LONDON

The situation of Irish people in London reflects the broad picture throughout Britain, but with some differences relating to age, marital status and occupational profile. There are also differences between inner and outer London and within different London Boroughs.

1.5.1. Size and age structure

The absence of data on the children and grandchildren of people born in Ireland is generally a problem for researchers, though not for this study which focuses only on Irish born people. Irish people in London as elsewhere are diversified by gender, socio-economic group, birthplace, religious background and era of migration.

Census data for London must be used with caution since it is estimated that there was severe under-enumeration of the population as a whole in the 1991 census. This related to the introduction of the community charge or "poll tax", placing an individual tax on all adults rather than a single charge rated on the value of the property. Irish people and young people in particular were heavily concentrated in multiple occupancy accommodation in inner cities where census returns were lowest, so it is probable that there is a significant undercount (Storkey 1994). In addition, data on other minority ethnic groups which include all generations make the size of the Irish community appear much smaller than it really is.

The 1991 census showed that the largest concentrations of Irish born lived in London and the South East with clustering in particular London boroughs and even in specific wards in those boroughs (Walter 1997). Table 7 demonstrates the size of the Irish born and second generation Irish population in London relative to other minority ethnic communities.

Table 7 Relative size of the Irish community in London in 1991 Census

Group	Size	Percentage
White non-Irish-born	5,077,110	76.0
Irish born	256,470	3.8
1st and 2nd generation	641,175	9.6
Indian	347,091	5.2
Black Caribbean	290,969	4.4
Black African	163,635	2.4
Pakistani	87,816	1.3
Bangladeshi	85,738	1.3
Black other	80,613	1.2
Chinese	56,579	0.8
Asian other	112,807	1.7
Other other	120,872	1.8
Total	6,679,699	100

Source : AGIY (1995) Census Briefings

Patterns of settlement in London are complex and differentiated by age, gender, and era of migration. London has always attracted Irish immigrants in large numbers and the 1991 census provided evidence that 32.5 % of the Irish born in England, lived in London (Walter 1997). The age structure in London reflects large waves of migration in the 1930s, 1950s, 1960s and 1980s and the return migration of the 1970s. There is evidence of clustering of Irish born people to the west of London and its adjoining boroughs (Walter 1997). The age structure of the Irish born population in London is younger than that of the Irish born population in Britain as a whole. Those in the 16-24 and 25-44 age bands are more numerous and make up 43% of the Republic born and 57% of those born in Northern Ireland. This pattern relates to the availability of work, makes London attractive to young new arrivals of both sexes from both parts of Ireland and reflects the rejuvenation of the Irish born population in the 1980s (Walter 1997).

Greater numbers of young people are found in traditional areas of Irish settlement but numbers are increasing in adjoining boroughs where past settlement of Irish people had been low. This may reflect the availability of affordable rented accommodation in these areas and greater earning capacity which affords higher rents. It might also reflect greater confidence, a wish to detach from older traditional communities and willingness to engage with multicultural London.

Table 8 demonstrates how the numbers of Irish-born people in the 25-44 age group declined between 1981 and 1991 reflecting the return migration of families in the 1970s. However in the late 1980s the numbers of men and women in these groups grew again as jobs in the financial sector expanded. Numbers in the 45-64 group changed little during the 1980s and suggests fairly stable family patterns settled in London.

Table 8 Changes in the Irish born population in London by age group 1981-1991 (Percentage change)

Age group	Women	Men
0-14	+105.6	+79.9
15-24	+81.5	+65.4
25-44	-8.9	-0.8
45-64	+1.5	-0.2
65+	+32.5	+22.2
Total	+8.6	+8.8

Source Connor 1987 ; 1991 Census, Ethnic Groups and Country of Birth. From Walter B. (1997) in J Mac Laughlin. Location and dislocation in contemporary Irish Society. Cork. Cork University Press.

Table 9 highlights a distinctive feature of Irish settlement in London which is the greater number of women than men recorded in almost every decade. This could reflect the demand for skills as clerical and personal services workers which women are more likely to have on arrival. Conversely it could be a feature of the way in which Irish women are forced into a particular ethnic labour market niche.

Table 9 Profile of the Irish born population in London by age and gender 1991

Age group	Men	Women
0-14	4188	4127
15-24	11060	15107
25-44	42644	43941
45-64	43298	46933
65+	18393	26779
Total	1119583	136887

Source AGIY (1995) Census Briefings – Demography . London Action Group for Irish Youth.

Although the age structure of the Irish born population in London is younger than the Irish born population in Britain, the mean age profile of the Irish population is older than that of the population of London as a whole (Table 10). This reflects large numbers of Irish born people who arrived in the 1950s and 1960s, and who have since settled. Although there are high concentrations of older people in some inner London boroughs, suburbanisation and social mobility has led large numbers to reside in outer London boroughs with low Irish-born populations in the past.

Table 10 Irish -born and Total Populations in London and Britain by age (Percentages)

Age band	London			Britain		
	Irish Republic	Northern Ireland	Total population	Irish Republic	Northern Ireland	Total population
16-24	9.9	12.6	16.6	6.2	10.5	15.9
25-44	33.1	44.7	40.5	27.8	37.9	36.5
35-44	11.6	11.9	8.0	18.3	13.5	13.7
45-64	38.2	27.3	25.6	42.1	32.2	27.4
65+	18.6	15.4	17.9	24.0	19.4	20.1
Total	99.8	100.0	100.6	100.1	100.0	99.9
N	206,868	40,776	5,375,652	573,131	231,804	43,865,121

Source : 1991 Census. Ethnic group and country of birth. From Walter B (1997) in J Mac Laughlin. Location and dislocation in contemporary Irish Society. Cork. Cork University Press.

Another distinctive characteristic of the Irish population in London illustrated in Table 11 is the higher number of unmarried people in most age bands compared to the population as a whole.

Table 11 Percentage of Never - Married People in London Irish born and Total Population, in 1991 census

Age band	Women			Men		
	Irish Republic	Northern Ireland	Total population	Irish Republic	Northern Ireland	Total population
16-19	96.8	97.6	97.8	100.0	98.9	99.3
20-24	88.0	88.5	76.8	93.0	93.4	88.9
25-34	46.7	39.6	28.9	57.1	50.1	41.7
35-44	11.6	11.9	8.0	18.3	13.5	13.7
45-54	7.1	4.8	5.1	13.0	8.4	8.7
60-64	8.6	7.7	6.0	14.3	10.1	8.1
65-74	11.1	9.0	7.3	11.3	5.7	7.5
75+	14.0	8.7	10.6	11.7	9.3	6.5
N	1179	730	418,011	1318	671	131,124

Source : 1991 Census 2% Sample of Anonymised Records . From Walter B (1997) in J Mac Laughlin. Location and dislocation in contemporary Irish Society. Cork. Cork University Press.

This relates to a number of different factors and has implications for housing as well as the availability of support to people who may be disabled or in poor health.

1.5.2 Occupational status

The occupational profile of Irish born people in London is somewhat different from that of the Irish in Britain as a whole. There is evidence of greater numbers of younger men and women represented in professional administrative and managerial occupations in London than the national average (Walter 1997). Nurses account for a large proportion of this group and explain the high representation of women at these levels, but the proportion of men is significantly higher than in the population as a whole. Even if nursing, the traditional niche occupation for Irish women were excluded, there would still be a substantially greater concentration of Irish people in higher level managerial, administrative and professional work than the population in general. This pattern reflects the high demand for professional, technical and managerial employees in London throughout the 1980s, and the availability of suitably qualified Irish migrants meeting these requirements.

However alongside this, the continued need for unskilled labour in London has meant that other Irish people remained in manual causal and unskilled work with the proportions in these categories increasing with age. Although there are considerable numbers of younger men in the personal services categories, middle-aged men are still concentrated in traditional niches of industrial and general labour. Irish women continue to be concentrated in nursing and but there are fewer in domestic service jobs than in the past. Although comparisons with the White category is problematic, the 1991 census suggests that Irish men are more likely to be unemployed than the White population but less likely than most other minority ethnic groups. Likewise, the economic activity rates of Irish women are similar to that of the White population.

While labour patterns for Irish people have changed since the 1980s, there are still continuities with traditional occupational groupings. Nursing is still an important occupation for women and the availability of educated young women from Ireland has met many of the NHS demands for nurses since the 1980's. Social and personal services also attract a similar group of both men and women who have little hope of finding acceptable work in Ireland. However the economic booms of the 1970s and 1990s in Ireland means that unlike the earlier generations people are able to return home with new skills and enhanced experience.

Although construction work remains a niche occupation for older men the demise of the building industry from the 1980s left many without employment. The nature of manual labour in this sector means that declining vigour or ill-health makes it difficult for many to find work. Aspinall (2001) demonstrated a high level of economic inactivity among Irish men, related to permanent ill-health and often associated with occupational injury. Gaffney (1997) argues that ill-health and redundancy means that men with twenty to thirty years of low paid work are faced with a choice of moving into areas where they have no skills, or facing long-term unemployment, while manual jobs go to the younger fitter men.

1.5.3 Housing status

Irish people are less likely than the UK population as a whole, to be owner occupiers and are more likely than the White population and some minority groups to be living in private and public rented sectors of the housing market (Hickman and Walter 1997). They are significantly more likely to be in poor quality, overcrowded accommodation, sharing amenities, without central heating (AGIY 1995) and without the consumer durables the rest of the White population enjoy (Owen 1995). These patterns are replicated in London (AGIY 1995). The 1991 census shows that Irish people are over represented in communal establishments such as nurses' homes, residential homes and hostels, reflecting the nature of the work they engage in (OPCS 1993). They are also excessively represented in multiple occupancy establishments and hostels for homeless people (Hickman and Walter 1997). The limited data available from the 1991 census show that Irish people are substantially over represented in figures for "rough sleepers". In the absence of empirical data, there is anecdotal evidence that a significant number of people accessing night shelters and services for street homeless people are Irish. Young women in particular are forced to move frequently to change jobs, as shared arrangements break down or because they experience various types of harassment (Egan and Tilki 1995). There are a number of concerns about older workers who because of illness, redundancy or retirement are evicted from tied accommodation. The high level of long- term illness and disability in the Irish community suggests that many are likely to be living in accommodation inappropriate for their needs (Tilki 1996).

1.5.4 Health Status

Despite the substantial size of the Irish population in London there has been limited attention to the health status or health needs of this community. Neither the *London Health Strategy* or the *Mental Health Strategy for London* pay attention to the high incidence of poor physical and mental health and limiting long- term illness among Irish people in the capital. However there are a number of indicators that the health of Irish people in London reflects the broader pattern in Britain. Local studies and data from Irish organisations in London provide evidence that Irish people have problems with physical and mental health, compounded by poor housing low income and unequal access to health services. The report of the Race, Health and Social Exclusion Commission *Sick of Being Excluded* identified the poor health and problems of access experienced by the Irish community in London (ALG 2000). Where research specific on London exists, it will be referred to in the discussion of the health of Irish people in Britain.

1.6 HEALTH PROFILE OF THE IRISH IN BRITAIN

1.6.1 Health disadvantage – the existing evidence

Despite the absence of data on second or subsequent generations, evidence since the early 1980s demonstrates clearly that the health of Irish born people in Britain is poor by comparison with the indigenous population and most other minority groups. (Marmot et al 1984b, Adelstein et al 1986, Balarajan and Bulusu 1990). While differences in data mean that clear comparisons are not always possible, there is some evidence that the health of Irish people is consistently worse than that of the Irish in Ireland (Marmot et al 1984b, Kelleher and Hillier 1996). Unlike trends reported in minority ethnic groups in the United States, this ill health persists into the second generation (Raftery et al 1990, Harding and Balarajan 1996) and as recently demonstrated, into the third generation (Harding and Balarajan 2001).

Although there is a socio-economic variation in health status, when a range of related variables are controlled, Irish health is still poorer than that of the majority population and a significant number of minority ethnic groups (Harding and Balarajan 1996, 2001). Analysis of mortality data shows that Irish men have the highest all-cause standardised mortality ratios of all country of birth groups in Britain (Harding and Maxwell 1997).

Similarly Irish women have the third highest all cause standardised mortality ratios of all country of birth groups in Britain. Mortality statistics at different times have shown that Irish people living in Britain have significantly higher mortality rates for heart, respiratory, gastrointestinal disorder, cancer and accidents than the population in general (Balarajan and Bulusu 1990, Harding and Maxwell 1997). ONS Longitudinal Study data demonstrate over time that this pattern persists into the second generation (Raftery et al 1990, Harding and Balarajan 1996) and third generation (Harding and Balarajan 2001). Irish men in particular demonstrate considerable evidence of premature mortality for all diagnoses and a significant proportion die up to ten years earlier than their fellow countrymen who remained in Ireland (Marmot et al 1984b). Aspinall (2001) showed variations in Irish men's health in comparison with other men in areas of the South East and London.

At present it is evident from Office of Census and Population Studies cancer statistics, that unlike other minority ethnic groups who have low levels of cancer, the Irish have excess mortality rates for all cancers (Harding and Allen 1996). Significant mortality excess is evident for men of working age and for women over 60 (Harding and Balarajan 1996). Research on the incidence of cancer points to excess mortality in most types of cancer in Irish born people but particularly lung, lip mouth and pharynx malignancies (Harding & Balarajan 1996). Harding and Allen (1996) indicate significantly increased mortality from lung cancer for both sexes but particularly for Irish women in comparison with the England and Wales population. Excesses exist for liver cancer in men and with smaller increases in gall bladder cancers for both men and women. Despite evidence of significant excesses for all cancers, the failure by service providers to use an Irish category in ethnic monitoring, means an absence of data on uptake of screening, access to specialist treatment or the outcome of cancer therapy for Irish people.

1.6.2 Limiting long-term illness

There is limited evidence of the generic health status of Irish people in England and Wales but the 1991 census showed higher rates of limiting long-term illness among Irish people of all ages compared to the population as a whole. The 1999 Health Survey for England (Erens et al 2001) which included the Irish for the first time, shows that

levels of longstanding illness are highest for Irish men and second highest for women in comparison with all other groups in the population. This study which used a combination of interviews and screening tests shows that self-accounts of general health among Irish people in manual groups are more likely to report bad or very bad health than those in higher social groups (Erens et al 2001). However the survey does not identify specific causes of longstanding illness. Although the Irish population in Britain is an ageing one, age alone does not explain the high levels of long- term illness experienced by Irish people at all stages of the life span (Owen 1995). Aspinall (1999a) shows that Irish born people are more likely to be unable to work because of long term sickness and disability and that men in early adulthood to retirement age are particularly disadvantaged.

There is limited information about the causes of chronic illness in Irish people but mortality, hospital admissions and service utilisation data exist give some clues to the causes of ill-health. Chronic obstructive airways diseases such as chronic bronchitis, asthma and emphysema are significantly higher in Irish people (Balarajan and Bulusu 1990) and probably account for some of the long-term illness figures. High mortality from cardio-vascular disorders may be linked to heart disease of a chronic nature and account for some of the disabling illness experienced by the Irish in England. The absence of data on service use by Irish people makes it difficult to compare utilisation of services with other groups. However where place of birth is recorded there is evidence of high consultation rates for circulatory, musculo-skeletal and nervous system disorders, injuries and poisonings among Irish born people (Harding 1998b, Haskey 1996). Hypertension and stroke are higher among Irish born people than in the white population (Erens et al 2001) and may lead to ill-health and disability. Mental disorders are common reasons for seeking medical help (Wild and McKeigue 1997) and although the information is somewhat dated (Cochrane and Bal 1989), elevated admission rates for mental illness suggest that mental ill-health may be a cause of disability.

1.6.3 Occupation related ill-health

The health of Irish men is a particular cause of concern. Mortality data show that rates from accidents are raised for Irish men compared to the population as a whole (Harding and Maxwell 1997). Irish community organisations report a high level of occupational

injury among construction workers (Kowarzik 2000,2001). Analysis of 1991 census data by Owen (1995) showed that a higher proportion than average of Irish men who were economically inactive were permanently sick. Although this might reflect older men moving from long-term unemployment to sickness benefit (Owen 1995) it is equally likely to reflect the high incidence of industrial injuries. Evidence from front line Irish agencies suggests that disability in Irish men is manifest at an earlier age than would normally be expected, with men experiencing musculo-skeletal disorders like rheumatism and arthritis in their early to late forties (Kowarzik 2000,2001. This fits with the elevated rates of long-term sickness in men from adulthood to retirement found in Aspinall's analysis of local authority variations in long-term illness and permanent sickness (Aspinall 1999a). Although there is an absence of adequate statistical evidence, Irish community organisations have specific concerns about the long-term effects of a lifetime in the building trade. In addition to degenerative disorders and the effects of accidental injury, community workers describe a number of occupational injuries leading to different levels and types of incapacity. Common problems include a necrotic bone condition affecting former tunnel workers, vascular damage caused by vibrating machinery and known as "white finger" and deafness caused by noise damage. These disorders are not confined to Irish people, but with the high preponderance of Irish men in the construction business they may account for considerable levels of preventable disability in this community.

1.6.4 Mental ill-health

People from minority ethnic groups in Britain and elsewhere experience high levels of mental illness (Nazroo 1997). There is an urgent need for more up to date information on mental health among Irish people (Bracken et al 1998). Dated evidence showed Irish people living in Britain to be more than twice as likely as the UK population to be admitted to hospital with all classifications of mental illness. In most diagnostic categories figures were higher than in other minority groups (Cochrane 1977, Cochrane and Bal 1989). Rates of admission for depression are higher for women than men, but both exceed rates for the host population and other ethnic groups. The incidence of schizophrenia is also high, as are anxiety states and to a lesser extent personality disorders (Raleigh and Balarajan 1992). Walls (1996), in an analysis of in-patient records in a London hospital showed that levels of alcohol-related mental illness were

high and that Irish people are more likely to be given a secondary diagnosis of alcohol problems in addition to their primary condition. The relationship between mental health and alcohol has not been investigated despite a huge risk of misdiagnosis and inappropriate treatment (Foster 2003). Mortality from suicide is some twenty to thirty percent higher in Irish people at all points in the lifespan but particularly in the 20-49 age bands (Raleigh and Balarajan 1992) with suicides in Irish men excessively high (Neeleman at al 1997, Leavey 1999).

1.6.5 Access to primary care

Although research on access to health services is limited and inconsistent, morbidity statistics from general practice (McCormick and Rosenbaum1990) and a survey of men in a north London borough (Aspinall 2001) point to a high utilisation of acute services among Irish people. Studies of GP consultation patterns (Gillam et al 1989, McCormick and Rosenbaum 1990) show that Irish people appear to consult about musculo-skeletal problems, urinary and ill-defined conditions and respiratory disorders. Irish people make fewer visits to GPs than the general population, but when they do it is for more serious conditions. They are less likely to be given a follow-up appointment or to be visited at home (Gillam et al 1989, Mc Cormick and Rosenbaum 1990). The evidence by Aspinall (2001), that Irish people are more likely to use Accident and Emergency departments, local pharmacists, social workers or advice agencies suggests that they may be reluctant to access healthcare until health has deteriorated, or that they are dissatisfied with the services on offer.

1.6.6 Health related behaviour

Apart from the Health Survey For England 1999 (Erens et al 2001), there is little research on smoking and alcohol use and other lifestyle factors. This study points to excessive smoking and risky patterns of alcohol use in sections of the Irish community, but there is no attention to the part cultural and structural factors play in the patterning of ill health for Irish people. However literature on minority ethnic health challenges the tendency to attribute illness, poverty and health behaviour to cultural factors alone (Nazroo 1997) and has much resonance with the Irish in Britain. Irish people share many similarities and experiences with people from minority ethnic groups and like others, their beliefs are borne out of a complex web of knowledge linked with the social

context of their lives (Calnan 1987, Cornwell 1984, Marks et al 2000). Foster (2003) argues that that there is an urgent need to investigate the relationship between alcohol use, mental health and wider social factors for Irish people in Britain

1.6.7 Gaps in the evidence

From the mid 1990s, a body of knowledge about Irish health began to accumulate, but the evidence was largely based on mortality data, hospital admission figures and longitudinal studies describing patterns of ill-health. While quantitative data identified mortality rates, the incidence of poor health, risk factors and some possible causal relationships, they left many questions unanswered. Statistical data confirms links between socio-economic status and health, but they are inadequate in explaining the possible pathways through which poor health is mediated. Although Irish people share many similarities with other disadvantaged groups, their experiences as Irish migrants, and having white skin differentiate them in other ways. It is not clear whether or how migration and settlement or the experience of racism impacts on health. Material disadvantage and socio-economic status do not adequately explain the poor health profile. There is limited evidence about cultural and lifestyle factors, health behaviour and confusing data about service access. Given the high levels of long-term illness and disability there is little attention to the way in which Irish people cope with ill-health or the availability of family or community networks to help them. Poor health cannot be disentangled from the wider social setting from which Irish people have migrated or from the situation within which they live in London. There is therefore a need to address gaps and limitations in existing research and to do so in a way which accounts for personal experiences, perceptions and meanings within the social context of being Irish in London.

1.7 THE STRUCTURE OF THE THESIS

This chapter has introduced the background to the study and highlighted the social and research contexts within which it is undertaken. Chapter two discusses the rationale, highlighting the gaps and weaknesses in the literature it aims to address and outlines the conceptual ideas underpinning the investigation. It considers conventional explanations for the poor health of Irish people and examines the potential of research into ethnic health, health inequalities and health beliefs and behaviour to overcome the limitations

of existing theories. Drawing upon these key ideas, chapter three examines the appropriateness of qualitative methodology and in particular interpretative approaches for addressing the research questions. The value of combining key informant focus groups, lay focus groups and semi-structured interviews is considered and the chapter ends with a reflection on the methodology. Chapter four begins with a brief overview of the study findings and deals in particular with issues of migration, ethnic identity and perceptions of belonging. It recounts specific factors associated with migration from Ireland and being Irish in London which impact on ethnic identity. It discusses the importance of belonging and the way in which feeling comfortable in Ireland and England relate to the health and well-being of participants. Chapter five focuses on discrimination, disadvantage and relative deprivation and the psychosocial stress they generate. Beyond the direct effects of low income and poor housing the data point to the meaning of poverty, poor quality housing, living in deprived areas and their potential impact on health. They highlight the changing nature of anti-Irish racism and the subtle ways in which it undermines confidence, induces negative emotions and evokes particular coping mechanisms. In particular this chapter focuses on the impact of conflict in Northern Ireland and the effects of the Prevention of Terrorism Act on individuals and the Irish community collectively. Chapter six describes the poor health profile of the interviewee sample, comparing their understanding with those of the key informants. It considers the complex relationship between health beliefs, health behaviours and socio-economic circumstances. The evidence of extreme hardship throughout life, experiences of abuse and the impact of religious socialisation on the health of informants is discussed. The relationship between material deprivation, social circumstances, everyday stresses, illness or disability and smoking or alcohol use are considered, as is the significance of smoking, alcohol and the pub for Irish people in London. Chapter seven tackles the issue of access to health care suggesting that insensitivity, stereotyping and racism are as significant barriers to health care as stigma or the inability to express emotions. The data demonstrate the willingness of people in distress to use services which are caring, non-judgmental and culturally sensitive. The importance of spirituality, religious beliefs and self-reliant ways of coping with ill-health and maintaining dignity in an alienating system are discussed. Chapter eight draws together the various findings and considers the ways in which they extend the

body of knowledge on the health of Irish people. It reflects on the limitations of the study and highlights issues raises for research policy and practice.

2.0 Chapter two : Conceptual issues and rationale

The study is motivated by evidence of poor health and high premature mortality among Irish people in Britain, an issue which is not adequately addressed by either statutory bodies or researchers. Throughout the 1990s an increasing body of research on Irish health emerged, but because of a focus on mortality and admissions data is limited in what was covered and how poor health was explained. Hickman and Walter (1997) provided evidence of socio-economic disadvantage, racial discrimination and harassment and information about lifestyle and health behaviour was revealed by Erens et al (2001). This evidence suggests no single explanation for the poor health profile of Irish people, and the assumption underlying this study is that different factors interact with each other or operate cumulatively to damage health.

Despite the relative invisibility of the Irish community in research discussed in chapter one, various theories have been offered at different times to explain poor health among the Irish in Britain. Health disadvantage has been explained as hereditary, the result of selection effects, migration, class or cultural or lifestyle differences. Other explanations located mental ill-health in the Irish community in the colonial relationship between Britain and Ireland (Greenslade 1992) or in a pathological aspect of Irish society (Scheper-Hughes 1979, Cochrane and Bal 1987). Williams (1992), challenged these explanations describing a "minority environment" which he believed contributed to Irish ill-health. More recently there is an interest in the relationship between ethnic identity and health (Greenslade 1994, Hickman 1995, Kelleher 2001, Kelleher and Hillier 1996, Cahill and Kelleher 1999).

Although there is no single explanation for poor health profile of Irish people in Britain, a number of theories go some way towards understanding it, but still leave many questions unanswered. This chapter examines explanations for the poor health profile of Irish people in Britain, considers their strengths and limitations and the gaps in research to be addressed. It explores the relevance of three mainstream bodies of literature which although failing to address the Irish, have the potential to enhance understanding. Firstly the minority ethnic health literature is explored, drawing upon research on migration stress, the effects of racialisation on identity, settlement and belonging and factors which influence access to services. Secondly, the health

inequalities literature is examined, focussing on socio-economic disadvantage and in particular the psychosocial effects of relative deprivation. The relationship between social inequality and social cohesion is considered and the particular problems experienced by Irish people in London discussed. Finally, the literature on health beliefs and behaviour is reviewed and the relationship between lay definitions and expectations of health and health related behaviour considered. The chapter goes on to consider the interaction between perceptions of personal control and wider social circumstances before and after migration. The role of smoking and alcohol as coping strategies is considered and attention paid to their social meaning for Irish people in London.

2.1 EXISTING EXPLANATIONS FOR THE HEALTH OF IRISH PEOPLE IN BRITAIN

2.1.1 Genetics/ heredity

There are inherited health problems in all populations which have a clear genetic link and are transmitted from one generation to the next. It is unclear however, to what extent health or illness is transmitted through the genes, or through culture, environment or a combination of both. The medical sociologist Rory Williams, analysed Irish and Scottish historical documents and demonstrated that high mortality rates in 19th century Glasgow were blamed on Irish migrants who it was assumed brought disease (Williams 1992). He argued on the contrary that evidence from Irish records showed that excepting the period of the Great Famine, Ireland had similar or even lower mortality rates than Britain (Williams 1992). Various sources of data showed that poverty, overcrowding, inadequate nutrition and sanitation were linked to the health of Irish migrants in 19th century Glasgow and that these were related to the expansion of capitalism. This increased the demand for cheap labour, and the ensuing low wages were not attractive to local people, but were significantly better than what was available in Ireland. Williams argues that it was not an inherent predisposition to illness among the Irish, but poverty, malnutrition and overcrowding which fuelled the infectious diseases and the subsequent premature mortality of the time. However, denial of the social and industrial factors involved in the health of Irish people and the focus on genetic inheritance was not just influential at the end of the 19th century. According to Williams it remained part of the medical and social policy understanding of the health

problems of Irish people well into the 20th century (Williams 1992).

Using Office of Population and Census Studies evidence from the 1970s, Williams argued that high mortality rates among Irish people in Britain could not have been explained by genetics and heredity unmodified by the environment (Williams 1992). Evidence at the time showed that male mortality rates in Ireland and England were practically identical, yet Irish men living in England had a 14% higher standardised mortality ratio than English men. The pattern for women was similar but with 9% excess. Cochrane (1983) noting high rates of mental hospital admission for Irish people in England, suggested that this corresponded with high rates in Ireland and reflected genetic or cultural factors. Ní Nualláin et al (1987) and Williams (1992) argued that this was not so, but a reflection of different patterns of hospitalisation, readmission and retention of people who were no longer symptomatic. Hospital admissions in Ireland were a reflection of rural communities depopulated by emigration, with low levels of marriage and therefore fewer relatives to support those who were ill. However despite this consideration, it is still difficult to challenge the idea of genetic/hereditary causes for many health problems because of the absence of comparable data from both countries. In particular it is complicated by problems of separating heredity from cultural and environmental factors owing to a lack of information about economic and cultural differences (Williams 1992).

It might be expected that in the absence of a genetic factor, differences in health patterning for Irish people in Britain would diminish by the second generation. However, the persistence of high mortality rates for several disorders into the second generation in the late 20th century still raises questions of heredity in Irish people (Harding and Balarajan 1996). Harding and Balarajan (2001) argue that although mortality improved across the generations, health disadvantage still persists into the third generation. They go on to propose that heredity cannot be separated from the environment within which Irish people in Britain live and that although socio-economic factors play a part, they do not fully explain the causes of excess mortality in this group. However they may explain lifestyles, health behaviours, occupational exposure or structural factors persisting across generations, therefore giving the impression of heredity. Wild and Mc Keigue (1997) argue that Africans and Afro-Caribbeans in the

UK have a genetic predisposition to particular illnesses, but that socio-economic conditions and access to health care significantly influence mortality rates (Wild and Mc Keigue (1997). There is no research which substantiates a genetic link for the main causes of mortality among Irish people, but there is evidence that disadvantage persists across generations for sections of the Irish community. The suggestion that health patterning results from racial heredity neglects the poverty, working and living conditions to which Irish people like their Black peers are exposed in Britain.

2.1.2 Health selection

Health selection has been proposed as an explanation for Irish ill-health in Britain by Marmot et al (1984) and Adelstein et al (1986). Positive health selection suggests that only the healthiest, most resourceful and financially secure migrate. This might explain migration from parts of the world where only the fittest, economically independent and resourceful are granted entry to Britain. Negative selection however suggests that when people are ill and unable to work, their economic position declines and they are forced to migrate. By virtue of differences in citizenship status, the Irish had fewer barriers to entry compared with people from other countries and therefore the less fit could easily migrate to Britain. This suggestion, while plausible, is simplistic and neglects the real effort and considerable resourcefulness involved in migrating to a new country, even one which is geographically close. Even if negative selection could account for some of the difference between the first generation Irish and the UK population in general, it is not convincing for second and subsequent generations (Wild and Mc Keigue 1997). Should this be the explanation, the expectation would be that, as with migrants to the USA, over time mortality would return to a common level in England and Ireland. However this is not shown by studies into second and third generation Irish people (Raftery et al 1990, Harding and Balarajan 1996, 2001). Greenslade (1997) argues that that negative and positive selection mechanisms explain the health status of different Irish people, with some leaving because of ill-health while others leave because of their skills and motivation to succeed. It is possible that the education and occupational qualifications of Irish women, assimilation and exogamous marriage afford them more rapid social mobility than Irish men (Hornsby-Smith and Lee 1979, Hornsby-Smith 1987). This greater mobility may explain lower mortality in women whose mother alone is Irish (Harding and Balarajan 1996) but does not explain the high mortality rates

of men born in exogamous marriages or excessive female mortality where both parents are Irish (Raftery et al 1990).

While both positive and negative selection mechanisms may be involved in the patterning of ill-health in the Irish in Britain, they still leave questions unanswered. It is probable that over the years, people left Ireland because of ill-health, low educational achievement, family or other problems. However many fit, intelligent young people left rural communities to find work in the 1950s and most had low levels of education which were the norm of the time. The fact that a significant number were able to improve their social situation in Britain questions the idea that their sojourn was related solely to poor health, individual weakness or flawed character.

In the 1980s the pattern of emigration changed and people were generally educated, well qualified and able to use these skills to the full in their new country (Mac Laughlin 1997). It is clear that at different times people left Ireland to get away from oppressive attitudes and traditional social mores and this might reflect positive selection at work. Although work was the main reason for young people leaving in both 1950s and 1980s, the impact of structural inequalities in Ireland might have been significant in shaping who left or who stayed. In addressing the link between migration and health the study is not confined to experiences after migration but explores factors in Ireland which may have impacted on health.

2.1.3 Culture

From the middle of the 19th century evidence from the Royal Commission (1835), and other historical documents suggested that the poor state of health of the Irish in Britain was attributed to their cultural inheritance (Williams 1992). There were clear associations with poverty overcrowding and inadequate diet in Glasgow, but it was presumed that Irish people had no desire for what other people considered comforts and were content with "an animal existence"(Royal Commission 1835 p xi). Health behaviour will be discussed in a subsequent section, but it is not easy to separate lifestyle and behaviour from culture. Morals and habits originating in Irish culture and in particular the use of alcohol by Irish people were linked with disease and mortality in the middle of the 19th century. 150 years later, Adelstein et al (1986) concluded that

many of the major causes of death among Irish people had a link to alcohol and smoking.

Anthropological explanations for mental ill-health in Ireland suggest problems originate in pathogenic aspects of Irish culture. Scheper-Hughes (1979) in a study in rural Kerry two decades ago, suggested that factors such as late marriage, repressed sexuality, guilt induced by Catholicism and social isolation in rural communities contributed to high rates of schizophrenia in Ireland. Ní Nuallain et al (1987) however questions this arguing that high admission rates in Ireland relate to patterns of in-patient stay and the absence of services rather than to aspects of Irish life.

Mc Cluskey's (1989) health and lifestyle study in Ireland, shows that a significant proportion of Irish people believe health is largely a matter of external control rather than something they can influence. He argues that this is a learned experience originating in the Catholic Church in a traditional unquestioning society. Although only addressing the Irish in Ireland, the study is potentially applicable to those living elsewhere. Stoicism resulting from accepting attitudes developed within Irish culture might contribute to reluctance to admit illness and the high tolerance of pain reported in the US by Zborowski (1952) and Zola (1973). According to Bandura (1986), belief in the ability to succeed is learned through personal successes and failures, observation of others and the assessment of abilities communicate to the individual by others. Kenny (1990) argues that disciplinarian childrearing practices in Ireland encourage helplessness, passivity and negative self-regard. Biographical, popular fiction and anecdotal accounts of early life in Ireland point to aspects of Irish social or family life which might influence health and health behaviour before migration. Cruelty and authoritarian discipline was common in both the school (Coldrey 1996) and the family (Kenny 1990). Accusations of abuse of children by clergy (Moore 1995), family members (Leonard 1993), in orphanages, industrial schools and other institutions (Raftery and O Sullivan 1999), emerged and eventually began to be investigated in the early 1990s. Given the importance of parenting and schooling in psychological development (Sarafino 1990), the possibility of a relationship between cruelty in early life and poor health in adulthood is explored.

However even if socialisation affords a plausible explanation for the generation who left in the 1905s and 1960s, it is less convincing for the assertive and confident people who left Ireland in the 1980s. Arguably a proportion of those leaving in both waves of emigration did so to get away from the closeness and constraints of a traditional society, believing they could take control of their lives. Focussing on socialisation in Ireland, however, neglects factors in England which might invoke or accentuate passivity or low self-esteem. It is possible that at least some Irish people learn in the family, school and society that they have no control over their lives and that this is reinforced on moving to the UK. Rather than make assumptions about an inherent Irish tendency to fatalism or presume that it is generated in Ireland, there is a need for a much wider examination. The study therefore examines the extent to which Irish people feel in control of their lives and explores social circumstances in Ireland and England which influence perceptions of autonomy and ability for self-determination.

2.1.4 Class position

The poorer health of Irish people has been explained to some extent by class position (Marmot et al (1984), Adelstein et al (1986) Cochrane and Bal (1987), suggesting that high rates of illness are to be expected of such a group and that poorer economic circumstances, and working conditions are contributory factors. Mortality data from the Longitudinal Study of the Office of Censuses and Population Studies shows that socio-economic status is not the only explanation for high mortality rates in second generation Irish people (Harding and Balarajan 1996, Haskey 1996.) Abbotts et al (2001) studying the Irish in the West of Scotland suggest that although socio-economic position is related to ill-health, it does not explain why mortality rates are still higher among Irish people even when class is controlled for.

Since class position alone does not fully explain the poor health profile of Irish people, this study explores aspects of socio-economic status impacting on health. Modood et al (1997) suggest that even when classified in the same socio-economic, occupational group or housing tenure, people from minority ethnic groups, are in lower income bands, with worse employment conditions and less affluent housing than the White population. The high incidence of self-employed, small construction businesses owned by Irish men masks the fact that they invariably operate alone in manual jobs which are

strenuous and often dangerous. The literature on job control and psychosocial factors at work (Karasek 1979 and Marmot et al 1991), demonstrates that the organisation and nature of work impacts on health.

There is clear evidence that poverty, working conditions and environment impact on the health of Irish people in England (Harding and Balarajan 1996, Aspinall 2001). However there is also a need to consider the possibility of a reverse relationship where socio-economic disadvantage is the result of ill-health. This seems particularly pertinent to men who have spent a lifetime in the construction industry. Evidence from Irish organisations testifies to physical ill-health caused by wear and tear, occupational injuries and accidents (Kowarzik 2000, 2001). They highlight psychological distress caused by recession in the construction industry, and mental illness following redundancy or economic inactivity due to ill-health. Unemployment and ill-health are clearly related to homelessness and this study focuses on the psychosocial importance of having a place to call home in maintaining health or recovering from illness. There is widespread evidence of poor housing, dampness and lack of amenities (Hickman and Walter 1997). Although these can damage health directly, the quality of accommodation, where it is situated and having a place of one's own can be as important as the structure and facilities (Macintyre et al 2000). Inaccessible and poorly designed housing impairs independence, while the fear of harassment or crime in the area can lead to social isolation. The incidence of insecure housing and homelessness is high among Irish people and although hostels and staying with others afford a roof over their heads for some, they invariably lack something they could call a "home"(Cope 2001). The study explores aspects of work, housing and area of residence which may explain poor health.

2.1.5 Behaviour and lifestyle

The limitations of class based explanations for ill-health suggest that some other factor is involved and in the absence of a clear genetic link the focus is on lifestyle and behaviour (Adelstein et al 1986). The incidence of smoking and alcohol consumption has long been blamed for ill-health in the Irish community (Wild and Mc Keigue 1997, Cruickshank 1996) However Abbotts et al (1999a,b) using data from West of Scotland "Twenty –07" Study at the Medical Research Council in Glasgow, show that in

Scotland at least, the reputation of the Irish as heavy drinkers is undeserved. They demonstrate that although smoking is a factors in the health of the very oldest cohort, there is no relationship in the case of younger groups. Studies in England show that although there are class based differences, intake of alcohol and tobacco are high among Irish people and the likelihood of cessation is less than in the general population (Erens et al 2001).

While these may partly explain poor health, there is limited attention to structural factors which affect Irish people and influence health behaviour. Graham (1993a,b) and Lupton (1994) show a clear link between class position and health behaviour in the general population. Despite an increasing volume of research since the late 1990s, analyses of why Irish people engage in health harming behaviours is limited. Lack of knowledge may be a contributory factor, but difficult circumstances also lead people to take risks with their health. Harrison and Carr-Hill (1992) demonstrate that low income, sporadic employment, poor housing and are all implicated in alcohol-related health problems experienced by Irish people after arrival in Britain. This study is concerned with the ways in which Irish people make decisions affecting their health, how they justify them and the link between these choices and wider structural and cultural factors.

2.1. 6 Irish identity

A number of authors have alluded to problems among Irish people in forming and maintaining a positive identity in England (Hickman 1995, Ullah 1885, Kelleher and Hillier 1996, Walsh and Mc Grath 2000). Kelleher and Hillier (1996) suggest that the behaviour of Irish people both in Ireland and England is shaped by the history of Ireland and its relationship with England. According to Ryan (1990) and Greenslade (1994), many Irish people experience feelings of inferiority in Ireland but are protected until they emigrate to the land of the oppressor where they are confronted by images of themselves as inferior. This sense of inferiority leaves them ambivalent to their Irishness and in contrast to those who went to America, where being Irish is seen as more positive, they are often reluctant to be identified as Irish (Walsh and Mc Grath 2000). While perceptions of inferiority might relate to being Irish in Britain, not all Irish people feel inferior and the study explores experiences which contribute to such feelings.

The relationship between the experience of being Irish in England, the effects of racism and the role of ethnic identity all have the potential to impact on the health of Irish people. According to Berry and Kim (1988), ethnic identity is an integral part of an individual's self-concept and a central aspect of the acculturation process. A number of writers suggest a link between these and the health of Irish people in Britain (Greenslade (1994), Kelleher and Hillier (1996), Cahill and Kelleher (1999). Being Irish in Britain has not always been easy and pressure to assimilate, the prevalence of negativity around "outsiders" and the natural desire to be accepted are all possible sources of tension involved in the production of poor health. Lacking confidence in being Irish or at times feeling the need to reject one's Irishness, are all stressful. People adopt a range of strategies to cope with difficult situations and there is evidence that at times Irish people play down or deny their Irish origins (Hickman and Walter 1997). As with other minority groups there is pressure to assimilate and adapt to the British way of doing things, even to the extent of being scornful of those who maintain their own culture and traditions. Conversely Irish people also take great pride in their Irishness and go to great lengths to transmit Irish culture to their children and maintain links with home (Walter 2001). There is limited attention to how Irish people choose one course rather than the other, or the circumstances in which they feel confident and proud of being Irish. There is a link between positive self-esteem and health (Sarafino1990) and it is likely that confidence and positive self-regard are important in enabling Irish people to manage these tensions and to protect them from the worst effects of a hostile environment. The impact of the troubles in Northern Ireland will be discussed in a subsequent chapter, but there is evidence that Irish people lead double lives, being proud to express their Irishness in safe circumstances but keeping their heads down in others (Walter 2001). The study explores the issue of identity and the potential health effects of being on guard or having to gauge the safety of a group of unfamiliar people or uncertain environments.

2.1.7 Minority environment

The most comprehensive explanation for the poor health of Irish people at the beginning of the last decade was Rory Williams' idea of a "minority environment"(Williams 1992). He described an environment where hostility,

stereotyping, frank racism and economic disadvantage impacted on the health of the Irish. This theory drew a number of causal elements together and recognised the significance of factors external to the person and community. Drawing upon historical and contemporary sources, it challenged explanations based on the effects of heredity, selection, migration stress and social class. Williams identified continuities across almost two hundred years emphasising the social construction of Irish disadvantage through stereotyping, prejudice and outright discrimination. This reflected the knowledge of Irish organisations in Britain in the early 1990s, which was later confirmed by the Commission for Racial Equality research (Hickman and Walter 1997). This study provided ample evidence of the persistent harassment experienced by Irish people, with the potential to impact on health independently or in addition to material deprivation.

While Williams acknowledged that many questions remained unanswered, the work did suggest possible routes to ill health in need of further investigation. It is evident that there is a link between acculturation stress, positive identity, health behaviour, and the "minority environment" in which Irish people live. Any one of these aspects can in itself be health damaging, but the findings of Hickman and Walter (1997) suggest that people are rarely exposed to one single disadvantage, so the possibility of a cumulative effect on individuals needs consideration. Discrimination has a directly damaging effect on health as well as operating through the behaviours that people adopt as coping strategies in persistently hostile environments. Perceptions or experiences of unfairness invoke anger which may or may not be expressed, and the struggle to succeed in the face of discrimination is invariably stressful and erodes confidence in the longer term. Institutional forms of racism make life unpredictable, anxiety provoking and discourage people from expressing their cultures or from seeking professional help when in difficulty. Negative stereotypes and hostile behaviour are real sources of anger but also damage self-esteem and ethnic identity and influence attitudes to help seeking. Internalising blame for poor health or other social disadvantage may impact on the willingness of Irish people to access care and treatment, causing them to rely on harmful ways of coping. The study focuses on the psychosocial effects of prejudice, discrimination and disadvantage on Irish people in London. It also explores aspects of early life in Ireland which have either exposed people to risk or protected them from ill-

health or health harming behaviour.

2.2 BRIDGING THE GAPS – MAINSTREAM RESEARCH

In the absence of sufficient specific research on the health of Irish people, the generic research literature is considered. There is much to be learned from other bodies of knowledge, even though they do not address the Irish or do so in a limited way. Greenslade (1992), Kelleher (2001), Kelleher and Hillier (1996), and Cahill and Kelleher (1999) have already drawn upon wider sources and have begun to pull the debate about Irish health into a broader arena. Theoretical developments within the sociology of health and illness and the psychology of health from the mid 1990s, challenge conventional explanations of illness and focus on social and psychological factors (Ogden 1997). Although generally neglecting the Irish, these bodies of knowledge offer ways of looking at the Irish in Britain which might elicit more comprehensive explanations of health than focussing on the Irish alone.

The Irish in Britain are clearly a minority ethnic population who share experiences of migration, discrimination and racist hostility with other communities. They experience socio-economic disadvantage and are concentrated in poor housing and sectors of the labour market which expose them to the risk of poor health. Lifestyle, health behaviours and patterns of service uptake are also potential factors in the generation of ill-health. The research literature on ethnic health, health inequalities and health beliefs and behaviour offers potential explanations and suggests some answers not hitherto developed by those researching Irish health. The ethnic health research points to factors accounting for health disadvantage among minority ethnic groups which are not unique to Black and Asian communities. The health inequalities literature provides explanations for health variation in the wider population which are largely applicable to Irish people. These bodies of knowledge consistently show a relationship between social environment and health, the importance of feeling unequal relative to others and the interaction between disadvantage, psychosocial stress, and health. The health beliefs and behaviour literature highlight the relationship between the social environment and beliefs, behaviour and lifestyle and provides insights into the ways in which people in general cope with life, health and illness.

2.2.1 Ethnic health

With the exception of a few authors such as Smaje (1995), Kelleher and Hillier (1996), Harding and Balarajan (1996) and Acheson (1998), research on ethnic health has largely neglected the Irish people in Britain. The term minority ethnic group is complex and is constructed by members of a group and by the society they inhabit. An ethnic group broadly refers to a self-conscious group whose members feel bound together by common origins, a shared sense of history, language and culture and by their position within society (Castles and Miller 1993). The "minority" element refers to the way in certain groups are defined by others as subordinate and attributed with undesirable characteristics or assigned to inferior positions in society. While the extent of self and other definitions vary, the concept of ethnic minority invariably implies marginalisation or exclusion (Castles and Miller 1993).

Researchers and policy makers tend to assume homogeneity, group solidarity and cohesion and neglect the diversity of background and experience within any group (Papadopoulos et al 1998). Additionally in popular usage, the term ethnic minority usually means non-western, non-white and in the UK particularly, non-British. Ethnicity is an equally complex term, but contains elements of subjective identification, cultural and religious affiliation, as well as ascribed attributes which distinguish an individual from others (Modood et al 1997). Ethnicity is not an entity in itself but achieves its significance within a social context. Nazroo (1999) highlights diverse patterns of disadvantage across different cultural groups and in particular the relationship between ethnicity and socio-economic status, mortality and morbidity.

The ethnic health literature in recent years is critical of the absence of ethnic monitoring data by health service providers (Aspinall 1995). Despite this, as discussed in chapter one, there is clear evidence of a range of health problems, high mortality rates, poor self-reported health and differential patterns of service access and hospital admission among minority ethnic groups. Where data are kept they are often based on crude definitions of ethnicity used without attention to differences within broadly generalised categories such as "Asian". Recent literature highlights differences between and within minority ethnic groups and research using sensitive indicators of ethnicity demonstrates significant health variations across groups with not all minorities being equally at risk

of premature mortality or poor health (Nazroo 1997). Some groups have relatively good health while others suffer excessively from major causes of ill-health in the population such as coronary heart disease, hypertension, stroke, and diabetes. Outcomes for specific health problems such as respiratory disease and cancer show that some minority ethnic groups are significantly better off than others or the majority community. However, particular ethnic groups are disadvantaged by certain diseases such as the high rates of stroke and hypertension in the Caribbean community and heart disease on South Asians. Data demonstrate socio-economic inequalities in health within groups and show structural differences contribute to ethnic variations in health. (Nazroo1999)

Ahmad (1996), Lambert and Sevak (1996) Nazroo (1998) and others, challenge the tendency among health researchers to presume that "ethnic/race" variables represent true and fixed genetic and cultural differences between groups which lead to differences in health. They argue that the focus on ethnicity fails to make explicit causal pathways to illness and pathologises minority ethnic status itself. In doing so there is an over-emphasis on cultural difference, underplaying socio-economic and material conditions and ignoring variations in socio-economic status which exist within minority ethnic populations. According to Rudat (1994), structural and cultural factors are more significant than heredity or selection, and impact on health through lifestyle and health behaviour. However migration stress, culture shock and the experience of acculturation all have a part to play (Furnham and Bockner 1986, Berry and Kim 1988, Berry et al 1992).

Although not addressing the Irish, an extensive psychological literature on migration stress exists and shows considerable potential for culture shock on migration especially when the new country is dissimilar from the home country (Furnham and Bockner 1986, Berry and Kim 1988, Berry et al 1992). Furnham and Bockner (1986) demonstrate that enforced migration and subsequent culture shock are major sources of migration stress. While the stress of migration may in part explain poor health in the first few years after migration, it does not explain the health profile of Irish people years after they have left home. The literature on migration and acculturation from the US, Canada and Australia largely neglect the experiences of Irish people, but the wider

literature on acculturative stress suggests avenues worth exploring. Acculturation is the change experienced by an individual as a result of contact with other cultures and the stress associated with acculturation is known to affect health (Berry et al 1992). Acculturative stress contributes to lower mental health status, alienation and marginality (Berry and Kim 1988, Berry et al 1992) and may explain the poor mental health of people from minority ethnic groups.

There has some attention to the migration and settlement experiences of Irish people, and these accounts throw some light on the challenges faced by Irish women (Lennon et al 1988, O Carroll 1990). Popular fiction based on real life accounts by Mac Amhlaidh (1985), McCarthy (1990a,b,) and Keane (1993) record the experiences of men in the construction industry. Irish people continue to experience difficulties long after arrival from Ireland and being largely unpredictable, they are invariably stressful (Hickman and Walter 1997). There is evidence that prolonged exposure to low level stress has a cumulative effect on health and that this augments the impact of material disadvantage (Elstad 1998). The effects of prolonged acculturative stress might go some way to explaining the poor health profile of Irish people and the behaviours they engage in to deal with it.

An important issue to be explored in this study is the fact that like many other migrant workers, most Irish people intend to return home after a particular time. The closeness of Ireland affords a significant difference by comparison with other minorities who come from faraway places. The ease with which Irish people can go home, might mean that unlike those who go to America, they never make a complete break with Ireland. It is possible that making frequent visits to Ireland and the anticipation of returning home after a given period might stop them establishing roots in Britain. Although continuity with Ireland and close links with home and family may be psychologically protective, it might also be unsettling if people never feel completely Irish or English. The study explores factors which influence a sense of belonging for Irish people in London and whether retaining an idea of Ireland as home is protective or damaging to health.

Nazroo (1999) highlights the significance of social structure in the manufacture of ethnic health inequality and stresses the importance of exploring inter-relationships

between ethnicity, class and health. Socio-economic differences make an important contribution to the production of ethnic health variation, but do not alone explain them. Conventional indicators of socio-economic status can be misleading and neglect the actual material conditions in which people from minority ethnic groups live. There is evidence that even in the same socio-economic band, income levels are often lower, employment and housing conditions poorer for people from minority ethnic groups than for the White majority (Karlsen and Nazroo 2002). Although more sensitive indicators of socio-economic status are now used, they still do not account for the poor health of Irish people (Abbotts et al 1999a,b). The study explores experiences of hardship and perceptions of exclusion across socio-economic groups.

Having white skin does not protect Irish people from racism (Hickman and Walter 1997) and it is probable that this impacts on health for Irish people in distinct but overlapping ways. Structural discrimination leads to lower socio-economic status, low income, poor housing and all have the capacity to damage health (Acheson 1998). Feeling disadvantaged relative to others because of discrimination is a potential factor generating psychosocial stress and in turn ill-health. The experience of relative deprivation will be considered in the following section because like other migrants, Irish people left home to better themselves. There is therefore pressure to progress, get promotion and earn money but if these are not forthcoming it is invariably distressing. Failure to measure up to personal or family expectations, or those of British society, may influence the health of Irish people. In a society valuing success, homeownership and self-reliance, those unable to achieve these attributes are regularly confronted by their disadvantage relative to others. The study explores the factors which Irish people believe contribute to their social situation and health.

Since ethnic health variation is multifactorial in origin, explaining it requires an understanding of the experience of people from minority ethnic groups, their health behaviours and access to health care. Nazroo (1999) argues that racism is a common feature of the minority ethnic experience and that although it impacts directly on health through socio-economic position, it operates in two other significant ways. Firstly, people from minority ethnic groups have a clear recognition of the relative disadvantage they face as a result of discrimination and racism. This sense of what Wilkinson(1996)

calls relative deprivation", will be addressed in the next section. Secondly, the experience of racism and harassment has a direct effect on health. Despite a paucity of research into the non-economic effects of racial discrimination on health in minority groups in general, there is evidence that emotional stress, suppressed anger and degree of control are important risk factors in high blood pressure and other cardiovascular disease (Syme et al 1974). Krieger's (1990) study of Black people in the USA demonstrates that being subject to demeaning and stressful situations is potentially damaging and leads to high blood pressure. She postulates that the experience of being made feel inferior, verbally or physically abused or harassed, provokes feelings of anger and self-doubt contributing to ill-health in the long term. The negative effects of internalised anger are increased in those who tolerate it rather than reporting it (Krieger 2000). Cahill and Kelleher (1999) found that Irish people felt slighted and offended by stereotypes, anti-Irish humour and argue that the negative emotions induced might increase susceptibility to ill-health through elevated neuro-hormonal activity.

Although the history and migration experiences of Irish people are similar to those from other minority groups, there are differences which may have added significance for health. Berry and Kim (1988) and Berry et al (1992) argue that alienation and marginality are not inevitable for any group but depend on a number of variables in the individual and in the new society. It might be expected that the ability to speak English, a fair skin and familiarity with a western lifestyle enables Irish people to adjust more rapidly than migrants from faraway parts of the world. However, according to Greenslade (1992) this superficial similarity is a hindrance rather than a help. Irish people like other members of minority ethnic groups are exposed to racism in the form of anti-Irish racist banter and stereotyping. Being white and "invisible" in comparison to a Black person affords an additional tension as Irish people are faced with a choice of speaking out or keeping quiet. Taking the former course risks incurring hostility or ridicule, but keeping quiet risks anger or feelings of guilt. The insidious nature of much of the racism Irish people experience (Hickman and Walter 1997) is likely to be a continuous source of stress with the capacity to impact on health over time. It is also possible that Irish people internalise institutional forms of racism not directly targeted at them. Negative media messages and tabloid representations of economic migrants and refugees as dishonest and dependent on welfare, might be internalised and cause

discomfort. It is also possible, that being white, Irish people are sometimes included and other times excluded, thus creating anxiety and insecurity. The study explores the ways in which Irish people are exposed to and experience racism and considers how they impact on health.

2.2.2 Ethnic identity

Recently there has been increasing consideration of the relationship between ethnic identity and health. Jenkins (1994) suggests that ethnic identity is more than having a name, but relates to what that name means to other people and therefore involves a consolidation of one's own definition and those of others. Individuals have multiple identities and these reflect personal definitions and wider social images (Karlsen and Nazroo 2000). External characterisations of a cultural group affect the social experience and the self-image of those living with that identity. Karlsen and Nazroo (2000) show that identity as a member of a racialised group is strongly associated with poorer health and that this effect is augmented by occupational class.

Negative stereotypes have an effect at collective community level through the way in which people self-identify with cultural traditions or affiliate with their own group and as such indirectly relate to health. Kelleher (1996) and Karlsen and Nazroo (2000) suggest that living in an area with others of a similar background is protective to health. Although people from minority ethnic groups are more likely to be concentrated in unhealthy areas, ethnic density can increase social support and a sense of community and might therefore be protective of health (Halpern and Nazroo 2000). They show that a strong ethnic identity and living with others from a similar background is protective. If people are unwilling or unable to live or engage socially in a positive way with their own community, there is evidence that psychological well-being is poorer than for those who do so (Halpern and Nazroo 2000).

Karlsen and Nazroo (2000, 2002) highlight the relationship between ethnic identity, community affiliation and health for visible minorities and these are no less applicable for Irish people. In theory, there might be a sense of collective identity among Irish people, but in reality a number of factors make this difficult in London. There are differences between people from urban and rural backgrounds, religious or non-

religious origins and Northern and the Irish Republic as well as those relating to age, education and era of migration. The attribution of particular and negative characteristics by British society might lead some to avoid mixing socially with other Irish people or even living in areas of high Irish population. It is also possible that there is pressure on individuals to assimilate in Britain, while families in Ireland expect that they will remain Irish (Lennon et al 1988). The persistence of Irish dancing classes and Irish events suggest that at least some individuals clearly identify with Irishness and Irish culture. The study explores factors impacting on Irish ethnic identity and whether contact with the Irish community in London or in Ireland is related to better health.

2.2.3 Access to health care

The ethnic health literature demonstrates differences in access to health services with high levels of GP consultation by people from minority ethnic groups (Nazroo 1997). However they are more likely to find physical access to the GP difficult, have long waiting times and be generally unhappy with the outcome of the consultation (Rudat 1994). However despite high consulting rates there are lower levels of follow-up care for all groups (Gilliam et al 1989, Badger et al 1989), referral to specialist care (Ben-Schlomo et al 1996) or bypass surgery for heart disease (Shaukat et al 1997). There is widespread evidence of misdiagnosis of mental illness in people from minority ethnic groups (NIMHE 2003). This reflects the inappropriateness of western models of health and illness for diagnosing differing cultural expressions of distress and dealing with mental ill-health. It reflects the persistence of services and practices designed for the majority population some fifty years ago. It is a feature of institutional racism in the NHS which largely fails to provide adequate services for minority ethnic clients and perpetuates ethnocentricity and racism by practitioners (Acheson 1998).

There is a growing interest in the relationship between culture, health and health care and this is reflected in concerns about cultural competence in professional health care practice (Helman 1990, Kelleher and Hillier 1996). The concept of cultural competence is problematic and the terminology used in the literature is often confusing, using different terms like cultural awareness, cultural sensitivity, cultural competence and cultural safety. Although individual authors define how they use particular terms,

practitioners tend to use them interchangeably and without clarity of meaning (Papadopoulos et al 1998). However, the general aim is to promote non-discriminatory practice which recognises and values diversity, understands and respects health beliefs and behaviours and provides help which maintains and supports the cultural and religious values of the individual. The body of literature on transcultural care originating in the US has been developed in the UK particularly in psychiatry and nursing (Fernando 1988, Papadopoulos et al 1998). The model of transcultural skills development by Irena Papadopoulos, myself and our colleague Gina Taylor is particularly relevant to services for people of all cultures including the Irish. It emphasises the importance of the practitioner's awareness of his/her own culture and the impact of wider social structures in generating ethnocentric values and racist practices which impact on access to and the appropriateness of services. It identifies the importance of the interpersonal skills of the practitioner being based on an understanding of the client and his/her culture and experiences. It highlights factors impairing or enhancing the assessment/diagnostic process and effectiveness of therapeutic interventions. This model for the development of appropriate attitudes, knowledge and clinical skills to provide competent care for people of all cultures, has in great part informed this study. It points to the need to examine beliefs about health and illness among Irish people, and explore perceptions and experiences of health and health care. It indicates a need to consider health behaviour and how this relates to the experience of being Irish in London and especially the role of certain behaviours as coping strategies. It informs the intention to explore the extent to which ethnocentricity, stereotyping and racism by practitioners are problems for Irish people.

The literature on access to health care among minority ethnic groups pays some attention to Irish people (Gilliam et al.1989, Mc Cormick and Rosenbaum 1990), citing high levels of consultation with GPs for serious illness. Conventional wisdom in Irish community organisations is that Irish people are reluctant to go to a doctor, have low expectations of health care and prefer to rely on prayer when unwell. While those assertions might be true of older people, it is unlikely that they can be universally applied. Nazroo (1997) highlighted the problem for many minorities of poorly resourced GP practices in inner city areas, lower rates of follow-up appointments, referrals for specialist help, and fewer home visits. GP attitudes may reflect a widely

held assumption that people from minority ethnic groups prefer to rely on family and community for support when ill (SSI 1997). Although the Irish are not considered, it is possible that similar assumptions are made about them. Presumptions about family size mean that families from minority ethnic groups are less likely to be offered support to care for dependent relatives (SSI 1997) and may also be true for Irish families. Similarly ideas of the large, close-knit Irish family ignore the high proportion of unmarried and widowed people without or with limited support networks.

According to Smaje (1995), much epidemiological work in the area of ethnicity and health fails to explore the significance or the experience of ill health for minority ethnic people. The literature on access to health care and uptake of services by people from minority ethnic groups raises questions about experiences of health care which are applicable to Irish people. There is a need to investigate the extent to which Irish people are exposed to racism in health services and in particular the role of stereotyping in this process. There is widespread evidence of the application of stereotypes to people of Caribbean origin in the mental health service (Sashidharan 2001). It is evident Irish people are similarly affected, particularly in relation to stereotypes of excessive alcohol consumption. There is evidence from Irish organisations and Irish service users that they are often erroneously diagnosed with alcohol problems and underlying mental health issues neglected (NIMHE 2003). Similarly the role of alcohol in coping with the symptoms of mental illness may disguise the real illness and lead to inappropriate treatment. The study explores the experiences of Irish people in the health care system and the impact of stereotypes on the assessment and diagnostic process.

There is ample evidence of disadvantage, poor housing and low income in the Irish community as in other minority ethnic communities. There is also clear evidence that although illness and disability are more prevalent in lower socio-economic groups (Acheson 1998), they have fewer material and emotional resources to cope with them. Although the general feeling in Irish organisations is that Irish people are too proud to accept help, it is possible as with other minority ethnic groups no help is offered. It is probable that the racism and hostility experienced by Black and Asian people in the health system, is also true for Irish people and that this influences help-seeking behaviour. There is evidence that services disempower Black people (Dalrymple and

Burke 1995) and the situation for Irish people may not be substantively different. The strength and resilience of minority ethnic communities is documented (Dalrymple and Burke 1995) and this probably reflects the unavailability and inappropriateness of services. The demographic pattern of the Irish in London means that many people, especially in old age have no family or social ties to help and assist them. However significant numbers rely on church or Irish voluntary agencies and use them willingly and with gratitude while rejecting help offered or available in mainstream organisations (Kowarzik 2000,2001). The study considers the relationship between uptake of services by vulnerable Irish people and the sensitivity and appropriateness of provision. It explores the type and characteristics of services deemed acceptable by those who use them.

2.2.4 Health inequalities – the role of relative deprivation and psychosocial stress

Research on health inequalities generally excludes the Irish, but offers ways of understanding the relationship between their position in Britain and their poor health. A growing body of literature from the mid 1990s began to challenge conventional health research and its focus on individual and lifestyle rather than structural and community factors in the manufacture of health inequality (Macintyre 1997, and Popay et al 1998). There is inadequate recognition of the complexity of causal relationships and the role of social organisations and processes in health inequality. Material disadvantage clearly impacts on health, but in addition it has psychosocial effects which potentially interact with poverty and add to health disadvantage (Macintyre 1997). A psychosocial perspective on health inequalities affords the potential to explain some of the health disadvantage of Irish people in Britain.

Psychosocial factors refer to psychological processes originating in or generated by the social environment. The aetiological basis of the psychosocial perspective is the health damaging potential of psychosocial stress and two different pathways to illness have been proposed (Elstad 1998). The first relates to a direct effect on disease development and the second to an indirect route through health behaviour. The latter is less controversial and the role of smoking, and excessive alcohol use will be considered in the following section. It is beyond the scope of this study to address the complex mechanisms involved, but there is increasing evidence that health is affected by

psychosocial factors through various biopsychosocial pathways (Ferrie et al 1995, Seigrist et al 1997, Brunner and Marmot 1999, Freund and Mc Guire 1999). Although the fields of psychoneuroimmunology and psychoneuroendocrinology have expanded, it is true to say that there is still uncertainty and debate. Lay notions of illness over many years have recognised the link between bereavement, loneliness and ill-health and there is little doubt that psychological stress can lead to mental illness and health damaging behaviour (Elstad 1998). Although the picture for physical /somatic disease has been contested, there is ever-growing evidence that psycho-social stress does have an impact on the development of certain diseases (Brunner and Marmot 1999).

The Whitehall Studies were among the first to propose that the psychosocial concept of relative deprivation might have explained gradients in mortality not explicable by health selection and lifestyle (Marmot et al 1978, Marmot et al 1984a). The studies undertaken in government departments in Whitehall in the late 1960s and early 1970s screened around 18,000 civil servants, and found differences in health among different grades of civil servants, which were not explained by conventional risk factors (Marmot and Davey Smith 1997). The earliest studies demonstrated that one of the most significant risk factors for mortality, was employment grade, and contrary to expectations, those in the lowest grades were more at risk. Since even the lowest grade civil servants were not poor by comparison with average wages in England (or developing countries), the findings raised questions about other possible causal factors and in particular hierarchical structures operating at psychosocial level. The findings suggested that compared with colleagues in higher positions, those in lower grades were "relatively deprived of the fruits of a wealthy society" and that this helped explain mortality gradients (Marmot and Davey Smith 1997). Whitehall Studies II incorporate wider psychosocial factors within and outside the world of work into their analyses, examining factors such as control over and pace of work (Bosma et al 1997, Marmot et al 1999) job insecurity and organisational restructuring (Ferrie 1997). Brunner and Marmot (1999) argue that the socio-cultural environment and organisation of work produce adverse biological effects, the worst effects experienced at the lower end of the socio-economic scale.

A psychosocial perspective may hold the key to a number of interrelated issues involved

in generating and maintaining the poor health profile of Irish people in Britain. Although considerable numbers of Irish people have been successful in business, the professions, media and arts, a significant proportion experience discrimination and material and social disadvantage (Hickman and Walter 1997) similar to those of other minority ethnic groups. These have direct effects on health, but feeling materially or socially deprived relative to the general population also has health damaging effects. The experience of discrimination, racial harassment or feeling socially isolated in London are just some of the psychosocial factors adding to the damaging effects of low income, occupational hazards and poor housing for Irish people.

The Whitehall studies and research on the psychosocial environment of work by Brunner and Marmot (1999), Marmot et al (1999) offer insights into the health of people in lower socio-economic groups. Given the concentration of Irish people in sections of the labour market characterised by poor conditions, insecurity and low job control, psychosocial stress conceivably plays a part in shaping the poor health profile. Poor and dangerous working conditions, the absence of union rights and the threat of dismissal are real stresses for Irish people working in the construction and domestic service industries. Not everybody works in such difficult circumstances, but many are exposed to psychosocial stress in the workplace. Irish people in reasonably secure positions are often engaged in jobs at the lower end of hierarchical structures and are therefore likely to have little control over work practices and outputs. Many of the jobs Irish people do, place high demands on the person but give low monetary reward and limited job satisfaction. Job insecurity due to recession in wider society or locally and organisational restructuring pose additional threats to the individual. The subjective appraisal of stress is individual, but if the biological stress response is activated too often or for too long there may be multiple health costs (Brunner and Marmot 1999). This study is based on the premise that a combination of occupational hazards, stress related work demands, economic or organisational constraints have a cumulative effect on Irish people adding to the effects of disadvantage and discrimination. Thus the psychosocial perspective appears to offer a missing piece of the jigsaw explaining the health of Irish people.

For several years, doubts about material deprivation as an explanation for health

inequality has driven an interest in the psychosocial environment (Elstad 1998). The literature on relative deprivation in the 1990s began to look beyond the direct and immediate effects of material deprivation. Wilkinson (1986, 1990, 1992, 1996) in studies in the UK and in different countries, suggests that deprivation relative to others, rather than poverty contributes to poor health. He argues that providing income does not go below a certain level, perceptions of inequality relative to others are more damaging than poverty itself. Comparison with others evokes feelings of anger, shame, low self-esteem. These psychological processes are therefore socially embedded or psychosocial and damage health though various biopsychosocial pathways (Wilkinson 1996, Elstad 1998).

The kernel of Wilkinson's argument is that social inequalities including income, power and status, have a fundamental influence on social relations and social interactions (Elstad 1998). Inequalities tend to produce feelings of anger, resentment, frustration and other negative emotions. Authoritarian power patterns in unequal societies are often mirrored in schools and family and engender feelings of low self-esteem and self-respect. Drawing upon the work of Putnam (1993), Wilkinson demonstrates that social inequalities impact on social cohesion and there is a strong link between social cohesion and health (Wilkinson 1996). The existence of mutual trust and respect between different sections of the community is a reflection of a socially cohesive society and contributes to health (Stansfeld 1999). More egalitarian societies are associated with better social relations and there is greater evidence of trust, mutual respect and belonging. Kawachi et al (1997) suggest that the proportion of people who feel they can trust others, decline as income differentials increase. They argue that with greater inequality social relations suffer, since differences in status generate contempt from above and fear from below. Material and power inequalities often go together with a fear or experiences of the inability to maintain a decent standard of living and where income differences are greater, the social environment becomes less supportive and more conflictual. They argue that a lack of social cohesion leads to increased hostility and crime giving rise to anxiety, fear and lack of trust (Kawachi et al 1997).

Given the levels of inequality evident in Britain in the 1990s (Acheson 1998), the psychosocial perspective needs further exploration. Kawachi et al (1997) found

associations between average mortality, levels of trust, density of group membership and income inequality. For the Irish, the evidence of discrimination in everyday life, harassment under the PTA, exposure to a range of negative media images about Irish people do not generate feelings of trust and mutuality. Living in an area with other Irish people or engaging with the larger Irish community might be protective, but many are unable or chose not to live or mix within areas of high Irish population. The stresses of living on a low income may be buffered by being within a supportive community or with others in a similar position. In common with other ethnic and minority groups, Irish people often experience a hostile and alien environment which creates fear and mistrust, impacts on identity and self-esteem and is potentially damaging to health and well-being. The experience of harassment expressed by Irish people and reported by Hickman and Walter (1997) militates against trust and cohesion. The study explores the relationship between this and limited participation in society, which may add to the effects of material disadvantage on health.

The importance of community was stressed in the model for tackling inequalities in health proposed by Dahlgren and Whitehead (1991). The role of the Irish community in London in providing social contact and support for Irish people needs exploration. Kelleher and Hillier (1996) argue that while Irish immigrants often integrate well as individuals, the failure to form a collective identity in England deprives them of a sense of security which is protective to health. There is evidence that participating positively in one's own ethnic community is linked to better health so a sense of not belonging might be damaging (Halpern and Nazroo 2000). Geography and the physical environment influences opportunities for social support. Traditional "Irish" areas of London have declined and it is probable that people living in areas of low group density have few opportunities for contact with other Irish people. The design of buildings or housing estates also limit social contact between Irish people or other neighbours. As in other minority groups, participation in community life by Irish people is often limited by a lack of material resources and by poor health or disability. Areas of high Irish population density are more likely to have Irish organisations offering social support in addition to or instead of that provided by friends and family. There is a need to establish how valuable such resources are, since having fun and enjoying Irish culture might have positive benefits, it might also discourage integration into wider society. The study

considers factors influencing social relationships and participation in the Irish community in London and their relationship to health.

Debates around social networks and social support systems highlight issues relevant to disadvantaged and marginalised groups and are applicable to Irish people (Halpern 1993, Karlsen and Nazroo 2000). Social networks relate to the number and frequency of social contacts, while social support systems relate to sources of emotional or practical support for an individual (Stansfeld 1999). The availability of social support might explain why Irish people in apparently similar socio-economic circumstances have different experiences of health. It is possible that those with sound support systems are buffered from the effects of social stress and hostility. They are also more likely to have financial, practical and emotional support in times of need. Although Irish people are significantly more likely to be unmarried, divorced or living alone (Owen 1995) and therefore often socially isolated, it is possible that some do not seek the support available to them. People in lower socio-economic groups have fewer resources to rely on and it is therefore possible that family and friends are reluctant to burden them further. The study investigates whether Irish people are reluctant to ask for help, unwilling to express their distress or whether there are other reasons why they are unable to access support which is available.

Apart from the availability of practical help and support, several authors have focused on the importance of the quality of social relationships and social integration to health (Oakley 1992, Seeman 1996, Stansfeld 1999). The research literature suggests that quality rather than the volume of relationships is significant in shaping health. Irish people and men in particular often have large social networks but lack a significant individual in whom they can confide or from whom they can seek support. Although the role of social support systems in providing practical or emotional support in times of need are important, Elstad's claim that these systems promote self-esteem and enhance capacity for self-efficacy is also worth consideration. Self-efficacy refers to the extent to which people feel in control of their lives and is linked to self-esteem and self-concept. Elstad (1998) is critical of stress research which presumes individuals are passive recipients of what happens around them and which focuses on health deterioration rather than health improvement. The self-efficacy approach challenges

ideas of passivity and offers ways of examining wider social factors affecting attitudes to help-seeking and coping. It also provides scope for considering the meaning of ill-health and ways of adjusting to illness. Given the factors impacting on the identity and self-esteem of Irish people in England, the availability of significant individuals and social support systems for self-appraisal and affirmation is important. The study explores the availability and nature of social support, its impact on the way in which Irish people access services, manage health or deal with illness.

2.2.5 Health beliefs and behaviour

Health beliefs are ways of thinking about health, how to maintain it and prevent illness. Health behaviours are the actions engaged in to achieve health, may but also refer to behaviours which are harmful. The health beliefs literature raises a number of issues applicable to Irish people and gives some insights into differences relating to socio-economic status, age and context. Health is variously perceived as the absence of disease (Herzlich 1973, Blaxter and Patterson 1982, Williams 1983, 1990), health despite disease or illness (Blaxter 1983, Calnan 1987). It is also seen as being able to function, to get through the day and carry out routines (Calnan 1987, Blaxter and Patterson 1982, Williams 1993a). People from lower socio-economic groups are more likely to perceive health as absence of disease or being able to function in their everyday lives. Conversely people in upper socio-economic groups have greater expectations of health seeing it as a reserve of strength, a sense of well-being (Herzlich 1973, Blaxter 1983, Williams 1993a) or being able to cope with the stresses of life (Calnan 1987). Studies of health beliefs identify how lay perceptions of health are rooted in social experience (D' Houtaud and Field 1984). The literature does not adequately consider the extent to which some people have little choice but to function despite illness. Neither does it reflect differences in human and material resources and the flexibility of paid work which allow people in higher socio-economic groups to have different expectations of illness.

Karlsen and Nazroo (2000) suggest that while socio-economic disadvantage contributes to ethnic health inequalities, cultural components are also involved. Health beliefs are the ways in which health and illness are understood and are rooted within a cultural context (Marks et al 2000). They influence expectations of health, beliefs about the

causes of illness and in turn influence the health behaviours people engage in to prevent illness or maintain health (Sarafino 1990). The study explores the health beliefs of Irish people, looking at how health is defined, expectations of health and health care and perceptions of being able to influence health. It is possible that for a number of different reasons Irish people have low expectations of health and therefore take few measures to care for it. It is likely that while Irish people are able to maintain their everyday activities they consider themselves healthy and not ill. If they are able to manage their daily lives or have no defined illness it is probable that people in poor health see no need to seek help or to adjust their behaviour. Recurrent themes of fatalism and tolerance in the literature (Mc Cluskey 1989, Zola 1973) appear relevant to Irish people explaining delays in seeking help or persistence in health damaging behaviours. It is also possible that the cost of adjusting lifestyle or health behaviour outweighs the perceived advantages.

The health beliefs literature points to differing explanations of health and illness used by individuals in different situations. Stainton-Rogers (1991) identifies different accounts of health and illness which encompass blame, responsibility, the nature of the individual, disposition, strength of character, self reliance or relationship with God. Socialisation has a role in shaping conceptions of health, but popular medical discourses in magazines, television programmes and the burgeoning "health" industry also convey particular messages about responsibility and independence. Conceivably people may see poor health as a weakness, their own fault or punishment from God and are therefore reluctant to admit it or fearful of the consequences. Contemporary social discourses of independence, responsibility and healthy lifestyle neglect structural and socio-economic factors which contribute to unhealthy lifestyles or behaviour.

A recurrent theme in the health beliefs literature with resonance to Irish culture is the moral and religious imperative of health. A number of writers describe a relationship between religious or spiritual beliefs and ideas about health and illness (Herzlich and Pierret 1987, Sidell 1995, Williams 1983). Some people believe health to be a gift from God or a matter of destiny (Sidell 1995) and illness as God's will or punishment (Williams 1983). Williams (1983) suggests that the influence of religion contributes to a moral imperative to be in good health. This has resonance with Irish people, both

Catholic and Protestant. The ability to resist illness and "not giving in" are described by Blaxter and Patterson (1982), Cornwell (1984), Stainton Rogers (1991), Wenger (1988), Williams (1983) and though not necessarily related to religion reflect socialisation within a traditional society. A moral imperative may influence perceptions of control, as people socialised within an authoritarian society may have no reason to believe they can control their own destiny. Wilkinson (1996) highlights the significance of power and status inequalities in generating ill-health and it is possible that these differentials additionally reinforce feelings of powerlessness. The study explores the relationship between religious beliefs and health and the role of faith and prayer in illness.

Several authors suggest that Irish peoples' views and expectations of health reflect the influence of both the Catholic Church and a traditional society (Kelleher and Hillier 1996, Mc Cluskey 1989). Popular wisdom in Irish community organisations suggests that Irish people are socialised to accept high levels of pain and discomfort and see illness as punishment from God. However while Church teaching might have influenced the beliefs and behaviours of older people it is less likely to do so for younger people. Although there may be some currency in the idea that religious socialisation leads Irish people to tolerate discomfort, there is a need to investigate the role of faith and prayer in maintaining health and dealing with illness. It is possible that traditional beliefs and practices influence patterns of health care access among Irish people. Reminiscence work with older Irish people uncovered a range of traditional beliefs and illness rituals which might influence access to health care (Tilki and McEvoy 1996). However it is also possible that failure to access services reflects other factors. The study investigates experiences of insensitivity which makes Irish people reluctant to use health care except when absolutely necessary, therefore relying on culturally acceptable, tried and tested traditional modes of treatment.

There is limited attention to the health beliefs of people from minority ethnic groups, and none relating to Irish people in Britain. Different beliefs about health care, lay health care or folk health systems might account for delay in accessing health services by Irish people. Pierce and Armstrong (1996) demonstrates that Afro-Caribbean people hold knowledgeable and sophisticated beliefs about their diabetes, but their ideas are often incongruous with medical thinking. This parallels evidence from the US that

Black groups adhere to some traditional cultural beliefs and practices and rely on folk healers despite having assimilated western health discourses. It is argued that this reflects the way in which they are rejected and excluded from the American health care system (Semmes 1996). This explanation may also be true for minority ethnic groups in Britain where there is evidence that culturally insensitive services are not used (Acheson 1998, ALG 2000).

The health beliefs literature until fairly recently has neglected the reasons for people engaging in health harming behaviours. Despite a clear link between health behaviour and poor health, with the exception of Graham's work (1993a, 1993b, 2000), there is limited analysis of what predisposed to smoking, alcohol or substance use. Popay et al (1998) argue the need to understand why individuals and groups behave in a particular way within the wider social context. The experience of being poor, struggling unsuccessfully or feeling in some way inferior to others, not only impact directly on health but indirectly through lifestyle and behaviour (Nazroo 1999). Graham shows that smoking is a proactive strategy adopted by women in the belief that it helps them to cope. The links between disadvantage and health behaviours are examined and the study explores how Irish people justify taking risks with their health.

In a study by Cornwell (1984), working class disadvantaged people in East London believed illness was caused by external or internal factors, but they rarely attributed it to themselves and perceived that they could do little to avoid illness (Cornwell 1984).
Rotter (1966) suggests that people differ in the degree to which they perceive they have control over their lives. Those who feel they are controlled by forces outside themselves have an external locus of control. Bandura (1977) argues that self-efficacy, the belief by an individual that they can succeed, is an important aspect of personal control. A strong sense of control is health enhancing, helping individuals to maintain health and promote recovery when illness occurs (Aneshensel 1992, Sarafino 1999). Mc Cluskey (1989) demonstrated that a significant proportion of Irish people in Ireland believed that their health was largely outside their own control and this is probably relevant to Irish people in Britain. The study explores whether the extent to which people feel in control of their lives reflects an absence of control before or after migration. It questions the relationship between a lack of control in life and Irish peoples' perceptions of their

ability to change behaviours such as tobacco or alcohol use or to believe that if they did their health would be any better.

The work of Antonovsky (1984) is highly relevant to the health of Irish people as it recognises the development of health potential across the life span and emphasises the influence of external factors. He describes " a sense of coherence" which is health enhancing and protective, whereby individuals see their external world as comprehensible, manageable and meaningful. Antonovsky (1984) is highly critical of the pathogenic paradigm commonly used to explain illness and disease. He argues that health can co-exist with disease and that even the healthiest individuals sometimes have aches and pains. The focus on illness he argues, fails to consider the characteristics of wellness, the ways in which people adjust to ill-health and neglects consideration of what makes them healthier (Antonovsky 1984). Coping is the cornerstone of managing disease and maximising health and those with a stronger sense of coherence are better able to avoid, resist or cope with external threats and danger. The sense of coherence develops over a lifetime and is influenced by an individual's position in the social structure and the availability of different resources (Antonovsky 1984). This study examines aspects of early life in Ireland and experiences of being a migrant which might influence the development of a sense of coherence and the coping strategies adopted by Irish people.

While cigarette smoking and alcohol use are not peculiar to Irish people, there is evidence that levels of consumption of both are high in the Irish community. Although culture and lifestyle factors play a part in the health of Irish people, they cannot be separated from the reality of their lives. Overemphasis on health behaviour neglects consideration of social and material deprivation in the general population and it is no different for Irish people. The tendency among policy makers and practitioners to pathologise culture and locate problems in the individual or community suggest the need to examine the link between health behaviour and wider structural factors. Graham (1993a,b) demonstrates the way in which women smoke as a way of coping, and it is possible that this is not confined to women. Although Erens et al (2001) shows that smoking cessation is increasing in the general population, the pattern is slower among Irish people. This study considers whether low rates of cessation relate to continuing

psychosocial distress or culturally sanctioned habits in the Irish community.

People also use alcohol to cope with stress in their lives and although health-giving in moderation alcohol is damaging in excess or in long-term use. The stress of living on low income, in poor housing or being subject to insidious forms of racism may be linked to alcohol consumption or smoking. It is possible that on balance, the human cost of giving up either or both outweighs the perceived health advantages. It is also possible that the existence of poor health and premature mortality in the family or Irish community might not provide a convincing argument for those contemplating changing behaviour. The study considers the social meaning of alcohol and smoking for the Irish community and the role of the pub and alcohol in the lives of marginalized people.

In view of the high level of alcohol-related illness among Irish men in particular, the study explores the interaction between alcohol and mental ill-health. It asks whether alcohol misuse contributes to mental illness or whether mental illness leads to alcohol misuse. Anecdotal evidence from Irish community organisations suggests that Irish people use alcohol as a form of self-medication for underlying mental disorders, thus increasing the risk of misdiagnosis and inappropriate treatment. It is possible that this reflects the inability to access help or a choice not to use services which stereotype or treat people insensitively or inappropriately. While not neglecting the damage to lives and health caused by alcohol, it is possible that that the consumption of alcohol in company might protect people from some of the stresses they are exposed to in life. Smoking and alcohol are pleasurable for many and it is possible that they afford a small luxury in the lives of people with many hardships to endure. Accordingly the study explores the social antecedents of lifestyle and behaviour in Britain considering aspects of Irish culture influencing health or health behaviour.

2.3 KEY IDEAS INFORMING THE STUDY

Existing explanations for the poor health of Irish people in Britain are largely unconvincing, but the ethnic health, inequalities and health beliefs literature suggest new avenues to be explored. This study assumes that factors associated with migration, assimilation and acculturation play a part in the health of Irish people and that some are common to all migrants while other aspects are specifically Irish. Factors which

influence feelings of belonging in London, the intention to return, the close proximity of Ireland and involvement in Irish community activities are potentially related to health. Although the experience of being Irish in England is a factor in the construction of ill-health, it is also possible that aspects of earlier life in Ireland contribute to the production of ill-health or create a vulnerability to it in later life.

Irish people in Britain are exposed to discrimination in Britain, and disadvantages in employment, income and housing predispose them to ill-health. Concepts of relative deprivation additionally suggest that that the nature and meaning of financial independence and security and a "home" in a decent area play a part in health. Irish people are exposed to institutional racism which is insidious, unpredictable and stressful. Therefore in addition to being disadvantaged relative to others, feeling unfairly treated or on guard against harassment works cumulatively with social and material disadvantage to damage health directly and through behaviour. Smoking and alcohol use are closely related to material deprivation and the risks involved are rationalised by individuals to help them cope with distress or manage illness. The social functions of alcohol and the pub are important aspects of Irish culture for those who feel homesick or alienated in England.

Not all Irish people are disadvantaged or deprived and some are in good health or healthy despite some illness. The study aims to explore experiences, beliefs and behaviours which differentiate them from people in poor health. Religious socialisation, and childhood experiences in a traditional society shape attitudes to life and may influence perceptions of health and views about help-seeking. Although in theory Irish people have a choice about accessing services, it is possible that experiences of racism, insensitivity and stigma may be significant factors in the uptake of healthcare. Social support, religious beliefs and practices buffer the effects of hostility and discrimination and help maintain health or cope with illness. Reliance on prayer or spirituality as ways of coping may avoid or delay professional help but equally well, may protect or enhance health. Irish people may have difficulty expressing emotional issues and wary of using mental health services or may be willing to discuss sensitive issues and disclose personal distress in the right environment. The study is based on the premise that there are some ways of coping which are specific to

Irish people, and that aspects of being Irish in London influence help-seeking behaviours.

The high mortality and morbidity rates in the Irish in London are clearly multifactorial and suggest an interaction between different phenomena. Being from either a minority ethnic group or concentrated in lower socio-economic sections of society are health damaging in their own right, but being from both almost certainly increases the risk, impacting on health directly and indirectly through behaviour and psychosocial stress. These ideas have shaped the research design, inform the methodology and method and underpin deliberations at all stages of the research process.

3.0 Chapter three : Methodological considerations.

The study aimed to identify factors contributing to the poor health of Irish people in London and to explore how inequalities in health were generated and maintained. The gaps in research evidence and the need to consider new explanations discussed in chapter two required a methodological approach in which people, their perceptions, understandings, explanations, and reasoning processes were central. The research questions aimed to explore the experience of migration and settlement, and the relationship between relative deprivation, discrimination and health inequalities from the perspective of Irish people. They set out to consider the interaction between structural, cultural and lifestyle factors and health within the individual worlds of the participants. They aimed to explore meanings and beliefs about health, justifications for health behaviour and address individual perceptions of accessing or using health care services and the way in which people coped with health in their everyday lives.

3.1 CHOICE OF METHODOLOGY

Qualitative methodology offered the capacity to illuminate many of the social and psychological issues relevant to the health of Irish people in Britain. The focus of qualitative research is on describing, exploring and explaining phenomena through the eyes of the participants. It is concerned with the meaning of behaviour in context, with concepts emerging from the data and the generation of working hypotheses arising from these rather than from predetermined theory (Henwood and Pidgeon 1993).

3.1.1 Qualitative interpretivist methodology

Within qualitative methodology, interpretivist approaches emphasise the importance of reality through the eyes of the participants, viewing the meaning of experience and behaviour in context and in its full complexity (Mason 1996, Blaikie 2000). Interpretivism seeks to understand the social world within which people live, their interpretations of it and the way in which they reproduce it through their actions. It aims to provide an "insider view", addressing the uniqueness of the individual and unpacking the influence of wider social structures and different cultural patterns on beliefs and behaviour (Mason 2002). Interpretative analyses are particularly relevant to the study of health and illness since two individuals with the same health problem may talk very

differently about their condition thus illuminating personal subjective approaches as they make sense of their situation (Smith et al 1999).

In order to address the research questions and examine the role of social structures in shaping health, the experiences and beliefs of Irish people are central to the investigation. The research needs to examine the meaning of emigration for the individual and to consider what aspects of the experience of leaving home and settling in a new society might have impacted on health. It is necessary to examine individual perceptions and experiences of acculturative stress, the factors enhancing or minimising it and the coping strategies people adopt to deal with it. Although the study is primarily concerned with experiences following emigration, experiences of life in Ireland which might have influenced health or shaped beliefs and behaviour also need exploration.

An interpretative approach allows an examination of how discrimination, disadvantage, negative stereotyping and racial harassment are understood and how these processes impact psychologically on the individual. It is particularly relevant to explore the relationship between employment, housing, discrimination and health through the eyes of Irish people and the impact of these on the individual and in particular on ethnic identity and self-esteem. It allows informants to express feelings and perceptions about how they compare with others, whether they feel disadvantaged and how they believe this impacts on health or behaviour. Given the evidence of widespread discrimination and racial harassment against the Irish community, it is important to consider how these impact psychologically and emotionally on the victims or contribute to perceptions of exclusion.

There is a need to examine how potential service users explain the low uptake of some services and a high use of others and a qualitative study suits the investigation of personal experience of using health services in London. Rather than assume that all Irish people have limited social support systems or are unwilling to use them, the study investigates attitudes and feelings associated with help-seeking. The interpretative approach has the potential to elicit personal accounts of how people cope with everyday stresses, illness and disability and consider the role of religious beliefs and practices in relation to health and illness. It does not assume that Irish people are ignorant of the

dangers of certain behaviours but attempts to identify factors which contribute to health harming activities and to elicit the ways in which individuals justify them.

It is evident that the knowledge, understandings, experiences and social reality of individuals can best be uncovered by qualitative interpretivist methodology. It has the capacity to go beyond simple public descriptions of beliefs and behaviour, to examine how they change in different contexts and with differing people. Instead of assuming that individuals are passive recipients of what happens to them, interpretivism explores the choices people make and the rationale underpinning them. It has the capacity to illuminate factors influencing decisions and demonstrate how actions are justified and adopted or selectively rejected. It facilitates the collection of illuminating data, affords opportunities for generating working hypotheses and provides an opportunity to address major gaps in research on the health of Irish people.

It is clearly important to explore individual subjective experiences of being Irish in London which might impact on health either directly, through health related behaviour or via psychosocial pathways. Focus groups facilitate different of interpretations of the context within which health and illness are constructed which can be explored further with individuals. Focus groups of older men and women allow for differences in experience and understanding across time and gender to be explored. The key informant focus groups allow differing professional interpretations to emerge and enable consideration of wider collective experiences. Although personal and professional perspectives may not always coincide, key informants are more likely to challenge the racism and oppression which individuals internalise, thus illuminating factors which interviewees may not be conscious of or misinterpret.

3.2 RESEARCH METHODS

A number of research methods are priviledged within qualitative interpretivist methodology, and are designed to explore peoples' knowledge feelings and interpretations (Henwood and Pidgeon 1993). Talking to people, listening and interacting with them, getting access to their accounts and articulations in interviews can provide the complex data necessary to address research questions. Such approaches question the stability and attribution of meaning and the way in which it is constituted

through language (Hammersley and Atkinson 1997). Interpretative approaches allow exploration of the inconsistencies which reflect the reality of people lives and afford opportunities to explore complex issues which are not clearly formulated or expressed by the individual (Mason 1996, 2002). They are particularly effective in exploring the impact of beliefs and values on health behaviour, coping strategies and access to health care (Murray and Chamberlain 1999, Ogden 1997). An interpretative approach to interviewing recognises that people express ideas and behave differently in different situations. It allows emerging themes to inform subsequent data collection and acknowledges the effects of the researcher rather than struggling to eliminate them from the research process. Qualitative interpretivist methods are appropriate for exploring the choices people make and illuminating the reasoning behind their decisions.

The appropriateness and feasibility of both group and individual interviews was considered. A group format is cost effective in relation to time and more effective than individual interviews in eliciting discussion and debate, highlighting the justification for different viewpoints. However anxious people, those with mental health problems or who have experienced abuse are often inhibited in the presence of others and therefore best interviewed alone. Individual interviews explore life histories and allow for detailed examination of experiences, feelings, perceptions and elaboration of issues raised in the focus groups. A combination of focus groups and semi- structured interviews are used to obtain the best data. However interviews need to move beyond "public" or acceptable accounts that might be offered a virtual stranger by interviewees. Strategies therefore acknowledge the way in which stories are constructed and aim to unravel inconsistencies and incongruities. My knowledge of the Irish community suggests that an informal conversational approach is less inhibiting than formal question and answer format. A list of topics aimed at generating discussion and a variable sequence afford opportunities to be guided by cues from participants, follow up ideas and tease out inconsistencies.

3.2.1 Focus groups.

The focus group method is increasingly popular among qualitative researchers having been used in the field of business and marketing for many years (Wilkinson 1998,

Kreuger 1988). Health researchers have pioneered the method in social action research and it has been particularly successful in the areas of family planning and health promotion. The approach involves one or more group discussions in which participants focus on a topic or issue most commonly presented to them as a set of questions. The group might comprise of an existing cluster of people or a group drawn together specifically for the research. They might be people who experience the same problem, a shared interest some other common motivation. The crucial factor is the interaction of group participants with each other and with the researcher with the collection of data generated in the interaction differentiating the focus group from individual interviews (Kitsinger 1994a). Discussions between participants are usually taped and transcribed and constitute the data to be analysed by conventional techniques of interpretative qualitative analysis.

According to its proponents, focus groups have the advantage of eliciting peoples' own meanings of health and related matters. They have been used to develop understandings of individuals' life worlds (Di Matteo et al 1993) and are useful for learning about the vocabulary, thinking patterns and the contexts within which they occur (Hoppe et al 1994). The spontaneous interaction between people is said to give rise to deeper insights about beliefs and it is argued that richer data could be obtained through focus groups because of factors which the group dynamic facilitates (Wilkinson 1998, Kissling 1996, Kitsinger 1994a). Contrary to assumptions that people might be inhibited in group situations, it appears that they actually enhance disclosure (Wilkinson 1998). This occurs as participants question each other, disagree or point to inherent contradictions or inconsistencies. Individuals are likely to offer considerable detail when discussing emotionally intense events or experiences that are shared with other group members. Less inhibited participants break the ice for shyer people and in revealing certain matters encourage others to disclose similar experiences. Some researchers have noted that difficult, taboo or socially undesirable opinions and emotions are more openly discussed in groups than in individual encounters (Hoppe et al 1994, Kissling 1996).

Wilkinson (1998) argues that focus groups inevitably reduce the researcher's power and control by following the agenda of the informants. While this might be problematic in some cases, its real merit is in drawing attention to what is important for informants and

to neglected or un-noticed phenomena. Although the literature led me to have some ideas about the causes of ill health, they might not have any bearing on what Irish people perceive as causal. It is inevitable that individuals have differing perceptions influenced by past experience and by wider social discourses. As participants challenge each other, they extend, elaborate and even embroider a sketchy account as they justify actions beliefs or behaviours. Focus groups in particular provide opportunities to explore participants' understandings as they interactively construct meanings about health and illness, forming, expressing, defending or modifying opinions in discussion and debate with others. The interaction between participants is a distinctive characteristic of the focus group method. It provides an opportunity to explore Irish health issues from a range of professional and political perspectives and to examine differences in the way in which health and illness are explained or behaviour structured.

3.2.2 Semi structured interviews.

Interviews are one of the most commonly used methods in qualitative interpretive research. They aim to elicit subjective experiences, meanings and perceptions which cannot be adequately investigated by quantitative means. They take account of the context within which experiences take place and perceptions and meaning are constructed (Burman 1994a). Used appropriately, they allow exploration of what is important for the informant, rather than restricting data to a standardised format.

Individual interviews provide an effective way of investigating the issues identified in the focus groups, exploring in depth the biographies and subjective experiences of informants. Face-to-face encounters enable the exploration of individual issues in more detail, as well as providing a safe forum for those uncomfortable in a group. They allow for closer examination of complex issues and exploration of inconsistencies and contradictions reflecting the reality of peoples lives. They afford opportunities to take cues from the interviewees and follow up their interpretations, reasoning, contradictions and individual contexts.

Semi-structured interviews afford an effective way of collecting information while allowing participants to address issues of importance to them. They afford flexibility to encourage the informants to set the agenda and generate accounts or explanations which

might not be anticipated. They particularly allow shy or reticent interviewees to describe their own worlds and to discuss perceptions, feelings and emotions associated with their lives. A semi-structured approach provides sufficient structure to ensure the research questions are addressed in a way which is logical for the interviewee, but with enough scope to explore underlying contexts, meaning and allow understanding to emerge.

3.2.3 The researcher in the research process

Conducting qualitative research demands consideration of reflexivity at all stages of the research process, extending from developing the research questions through to writing up the research report (Burman 1994b). Qualitative interpretative research involves reflexivity or self-scrutiny, subjecting the role of the researcher in the research process to the same scrutiny as the rest of the data (Mason 1996, Smith et al 1999). In the past much effort went into limiting the effects of the researcher in the research process, suggesting that research could be undertaken in some world separate from that wider society or from the biography of the researcher (Parker 1996). It presupposed that the ways in which problems were theorised and explained were value free (Hammersley and Atkinson 1997) and that the effects of the researcher in the research process could have been eliminated.

Wilkinson (1986) argues that far from being value neutral, there is a need to be explicit about the interests, values and motivations which influence the research from conception to outcome. My interest in the subject is a reflection of being an Irish woman in London for over thirty years, with a professional background as a nurse and academic qualifications in the social sciences and health psychology. It is motivated by my participation in the Irish community in Britain and in Irish voluntary sector organisations and my commitment to tackling ethnic health inequalities for all communities, but especially my own. These motivations have influenced my choice of project, the nature of the investigation and create a potential for bias in my reading of the literature, my hearing, interpretation and presentation of the data. While I recognise that I share some of the experiences of my informants I am also aware that my values, beliefs and behaviour are shaped by my own personal history and by my professional and academic education. I am conscious that issues I consider important may be of less

concern for others and that some which seem unimportant to me are of major significance for other Irish people.

3.3 SAMPLING STRATEGY

At the start of the study my intention was to ask for help though the Irish papers in England, through church newsletters and Irish organisations but I was conscious that these would attract a sample who were linked into an Irish community. I had many contacts in the Irish community but wanted to meet those who were not active in the Irish scene. I knew many Irish health professionals, but wanted to focus on lay perceptions and understandings. Instead I made personal contact with a number of men and women of different ages, backgrounds and health status. This was done opportunistically in the first instance, asking people known to me through work and social contact. Inevitably some were unwilling or unable to help, but put me in contact with others who agreed. I specifically targeted two individuals because of their life experiences and interviewed others because at a superficial level at least, they appeared to represent the " average" Irish person in London. I met two potential informants at conferences organised by the mental health charity Mind. They had survived severe mental illness, appeared to have overcome many of their problems and agreed to be interviewed. As the interviews progressed I was able to identify where the emerging data were lacking. Colleagues put me in touch with former patients, neighbours and friends in response to requests to interview people in a particular age band or socio-economic group. Rather than having difficulty obtaining a sample, I had to reject suggestions that I should interview individuals whom contacts believed to be particularly interesting.

My involvement in the Irish community meant I had relatively easy access to people who might be key informants or focus group participants. I knew many of the workers and community activists in London and most knew I was undertaking health research. Where necessary permission was obtained from management committees for workers to participate in the focus groups. However most workers were keen to contribute to enhancing a body of knowledge which might ultimately benefit their clients. The focus groups were held in community premises and where possible as part of or added to an existing meeting.

Accessing potential interviewees was relatively easy because my community links meant I was able to make contact with difficult to reach informants. I was conscious that a significant number of Irish people and particularly men were suspicious of authority having worked in the informal economy for many years and having experienced or observed harassment by the police. People with mental illness, alcohol users or those who were homeless would have been reluctant to engage with what they perceived as authority figures, but were generally happy to seek services from Irish or otherwise culturally sensitive agencies. One Irish community organisation helping homeless and marginalised people put me in touch with three men and two women who would otherwise have been suspicious and unwilling to trust an outsider. Since these informants were in living in hostels or multiple occupancy establishments I was generously provided with a quiet room at the centre for the interviews.

3.3.1 Research population

Like any other community, the Irish in London are not a homogenous group and are diversified by age, gender, place of birth, social class and other factors. This heterogeneity demanded an approach which recognised how experiences differed at different points in the social scale or for men as opposed to women, or at various stages in the age span. Experiences would have been different for Irish people born in England or for those of mixed heritage and it was acknowledged that being a Traveller or of a gay/lesbian orientation poses additional difficulty for individuals. The scope of the study did not allow justice to be done to all these dimensions of diversity. In order to reduce influence of confounding variables, the investigation was limited to Irish born people aged 30 and over living in London and with at least ten years residence in the UK.

3.3.2 The sample.

The goal of qualitative research is to elaborate conceptually rich and contextually grounded data so the size of the sample was concerned with the ability to generate data and make meaningful comparisons in relation to the research questions. The nature of the study meant that the sample could not be totally predetermined at the start and that emerging issues might have led me to seek new informants. The study is necessarily

limited by time and resources, so purposive sampling is the most effective approach for providing sources of data which permit the development of theory. The sampling frame needs enough scope to generate new data to expose common patterns while still eliciting variations, seeking negative instances and contradictory cases (Guba and Lincoln 1989).

My underlying assumptions are that people are differentially affected by factors such as gender, class, age, housing status etc. The interview sample therefore aims to include men, women, across the age span above 30, from different socio-economic groups, marital status with varying degrees of health and illness or disability. Within that range it is important to include people who are involved in the Irish community as well as those who stay apart from it. The sample includes people who are politically conscious of the position of Irish people in Britain as well as those who are relatively unaware of the disadvantage experienced. No effort was made to target gay men, lesbians and Travellers as their needs and problems are specific and extensive. Although they are not excluded from the sample, only one person, a gay man, identifies with any of these groups.

The intention is not to represent the Irish community in Britain statistically, but to examine categories, types, issues and views relevant to the wider context. For practical reasons it is appropriate to begin with the wider view of the community and narrow in later to the more specific and individual. To this end I first identified the need for a number of different focus groups because of their accessibility and their knowledge of the community. The use of focus groups of both key informants and lay participants affords a cost effective way of highlighting the major issues affecting Irish people, highlighting differences between the older generation and those who left Ireland in the 1980s, between men and women and unskilled versus professionally qualified or skilled persons.

3.3.3 The key informant focus groups

Key informants open opportunities or offer a "key" to the research in two main ways. Their occupational knowledge and their current involvement in different sectors of the Irish community make them sources of essential information. In addition they afford

opportunities for further contacts.

Three key informant focus groups were undertaken.

(i) Key Informant Older People (KIOP) This comprises a group of four men and four women committee members and users of a network of Irish organisations for older people in a north London Borough. The ages range from 64 – 81, all have been in England for at least 40 years and are retired from professional and manual occupations. Some are married or widowed and others unmarried. They describe themselves as generally healthy but experiencing a range of age-related health problems.

(ii) Key Informant Younger Women (KIYW) This comprises a group of five women staff and committee members of Irish voluntary organisations aged between 32 and 44. They are mainly educated to degree level or professionally qualified in social work, psychology, accountancy, clerical work and all have been in England for ten or more years. They are engaged in occupations related to advice, finance, psychotherapy and administration.

(iii) Key Informant Younger Men ((KIYM) This comprises a group of five Irish men aged 30 to 47 working in professional roles in Irish voluntary or statutory organisations dealing with Irish clients. They are mainly educated to degree level with professional qualifications in social work, housing, nursing, counseling and all have been in England for ten or more years. They are involved in provision of housing, advice, employment training, and services for marginalised people.

The primary intention of the focus groups is to identify issues for Irish people in London from the professional perspectives of the participants. However the difficulty of separating the personal from the professional is acknowledged particularly since personal informs the prism through which participants construct meaning within popular and professional discourses.

3.3.3 The lay focus groups

Focus groups are also undertaken with informants who have no professional knowledge of the Irish community in London. The intention is to focus on the participants' experiences of living in London as an Irish person over different periods of time. Their differing occupational histories and their health care experiences are essential aspects of information and it is hoped that these groups afford a personal and experiential perspective. These insights provide clues to unravel the ways in which the experience of being Irish in London impacts on health. They illuminate differences in the way health and illness is defined and how they are managed by ordinary Irish people.

(i) Focus Group Older Men (FGOM) This comprises a group of five older men aged 65 –75 attending a social group for Irish men in a west London borough. They have been in England for over 35 years. Four are married and one is unmarried. Three are retired from construction work, one from shop work and one had started as a barman but moved into textile design in a large London store. They have a range of health problems but consider themselves healthy or fairly healthy.

(ii) Focus Group Older Women (FGOW) This comprises a group of five older women aged 63- 80 attending a social group in a west London borough. Two are widowed, one married and two are unmarried. One is retired from a secretarial job, one from a post as Local Government Officer and three from hotel/ domestic work.

3.3.5 The Interviewees

The interview sample aims to access the experiences of a cross section of Irish people. 20 semi-structured interviews were undertaken and include 12 women and 8 men with ages ranging from 30-79. The respondents span different socio-economic groups, housing tenure and marital status. Between four and six informants from each ten year age band are interviewed with the exception of the over 70s where in view of the two older persons focus groups only one person is interviewed. One interviewee previously participated in a focus group.

30 -39 (4 respondents)

40-49 (4 respondents)

50-59 (6 respondents)

60-69 (5 respondents)

70- 79 (1 respondent)

They span a range of occupations, educational backgrounds, housing tenure, marital and health status. The majority were born in different parts of the Irish Republic and are from the Catholic religious tradition.

3.4 DATA COLLECTION

Key ideas are derived from the literature on health inequalities, ethnic health and health beliefs and behaviour, "grey" literature from Irish organisations in England and the limited research on Irish people in Britain. My work over several years in the Irish community has given me an understanding of the problems experienced in everyday life and in the health and welfare system.

3.4.1 Developing the focus group schedules.

Not wanting to set out with a fixed set of questions, I identified a list of essential topics to be covered and considered the type of questioning most effective in eliciting the best information. I envisaged that in addition to answers to the direct questions, the interactive discussions in the key informant and lay focus groups would raise issues for subsequent exploration in other focus groups and individual interviews.

The emphasis in the different focus groups is to highlight what the participants consider to be the causes of poor health for Irish people in London. The lay focus groups aim to explore conceptions of health, what people do to protect it or what they believe leads to poor health. (**Appendix A)**. The key informant focus groups aim to elicit the causes of poor health from a professional perspective and to ascertain what factors impact on responsibility for health. **(Appendix B).**

3.4.2 Developing the interview schedule

A semi structured interview schedule was developed, taking account of the health inequalities literature alongside the emergent themes from the focus groups. The themes emerging in the focus groups generally reflected the findings of Hickman and

Walter (1997). However they tended to locate many of the problems in the individual or in Irish culture, with less emphasis on structural factors. The interview schedule sets out therefore to explore the relationship between social structures, attitudes or actions, focussing on how individuals define their difficulties and how they cope with them. The focus groups suggested that many of the problems of Irish people originated in Ireland and had some parallels with psychosocial issues identified in the inequalities literature. The interviews therefore set out to examine aspects of experience in Ireland and emigration to England that may contribute to particular health beliefs or behaviour. Questions or cues are identified with the aim of confirming or refuting the assumptions of the focus group informants, addressing the context within which respondents make choices, and how factors such as gender age and socio-economic status influence perceptions and experience. (**Appendix C**)

3.4.3 Ethical considerations

The Statement of Ethical Practice of the British Sociological Association guided the conduct of the research at all stages of the process. I believe that the study can provide new knowledge of benefit to the Irish community in London, though not necessarily to those who participate in it. The study forms part of a doctoral degree with which there are no conflicts of interest related to funding or sponsorship so there was no pressure to present a particular outcome. The mechanisms for supervision and progression guided and monitored my competence as a researcher and endeavoured to ensure that informants were protected and that the research was thorough and efficiently conducted.

Permission was sought from relevant management committees of Irish organisations before research was undertaken within or involving the staff of that organisation. **(Appendix D).**

A letter was given to all potential informants requesting their consent and outlining the purpose of the research, their right to participate or not, or to withdraw at any time without prejudice to them. **(Appendix E).**

In order to ensure participants were able to give truly informed consent I assured them

of measures to be taken to ensure confidentiality. Permission to record the interviews and focus groups were obtained at the start of each interaction and I transcribed recordings personally. Brief notes were kept as an aide memoire and were accessible to participants if they wished to see them. Recordings, transcripts, field notes and biographical data were heard or seen only by me and my supervisors and were stored in compliance with the Data Protection Act. Individual informants were identified by number and the names of focus group participants changed to protect identity. Organisations or individuals mentioned in the focus groups or interviews were not identified other than by pseudonym. Should the experience or attributes of an informant or organisation make them identifiable, permission was sought before making those data explicit.

Participants were informed that the research findings will be published as part of my doctoral research and that although this will not necessarily benefit them, it may help others in the future. Quotations from participants' interviews may be used to illustrate findings but will use numbers or false names to ensure individual or group identity is not disclosed. The research may be presented at conferences or published in books or journals and that the Irish media in Britain might give it some coverage on completion. Participants were informed that the product of the research, a thesis, would be publicly accessible through the university library subject to successful examination. A summary of the research project will be made available to participating organisations or individuals at their request on completion of the study.

I was conscious that power was an ever present dynamic in the research process and that research should not be exploitative in any way. As a professional and successful woman I was likely to be seen as having a position of authority, which might intimidate some interviewees. However I also recognised that the participants were free not to talk to me, to tell me only what they wanted me to hear or even to lie if they thought fit. I was conscious that despite my motives, the research is part of an academic degree which will ultimately benefit me more than any individual participant. I was concerned that all participants felt comfortable and endeavoured to ensure nobody was exploited, particularly the more vulnerable members of my community. No pressure either real or perceived was put on potential participants and they were informed they were under no

obligation to participate and could refuse or withdraw at any stage. When I sensed reluctance to answer a question or address an issue by an interviewee, I did not push the individual but moved on and in most cases the topic emerged spontaneously later in the conversation. I envisaged that some experiences might have been distressing and allowed sufficient time should an informant need space for composure. I became aware that some interviewees were psychologically fragile and in the case of a few individuals I did not pursue issues to the extent I would have liked. I was particularly careful to avoid exposing people to reliving the horrors of abuses they had experienced.

I was concerned that some informants might see the interview as an opportunity for counselling and should this arise I was prepared to set boundaries. I was confident that my nursing skills were sufficient to deal with any distress which might occur, but would make it clear that I could not offer professional help other than referring the person to a professional service. Although I familiarised myself with local services, the need did not arise in the interviews. In an attempt to reduce the risk of exploitation I was happy to offer limited advice, information or referral, if issues arose during the interview. Only a small number of interviewees asked for advice and I was able to provide them with information during the interview or by post afterwards. While I considered ways in which my approach could minimize any distress or embarrassment which might arise, I had also to bear in mind that the informants could control whether they saw me and what they chose to tell me. I was anxious that having informed potential interviewees about their right to withdraw at any time, some might find the process uncomfortable and withdraw. Fortunately this did not happen and conversely people seemed keen to talk openly and honestly about very painful experiences.

3.4.4 Data collection -Focus groups

Focus groups were conducted in accommodation provided by Irish community organisations and three (KIYW, FGOM, FGOW) were either part of or added on to existing meetings. These focus groups constituted people who already knew each other and were part of an organisation either as staff, committee member or service user. Two specific meetings were convened comprising participants from different organisations who did not necessarily know each other but were familiar with issues related to the Irish in Britain (KIYM, KIOP)

Ground rules were established by each group and invariably identified confidentiality, listening, and showing respect to each other. Introductions were made where group members did not already know each other. I pointed out the practical need for only one person at a time to speak, but highlighted that I wanted to hear disagreement as much as agreement. I emphasised that the purpose of the key informant focus groups was to draw upon their expert knowledge of the Irish community, but that I did not wish to preclude the importance of their personal experiences as Irish people. The meetings, which took from one and a half to two hours, were recorded and I took field notes during the process. I started with an opening question about factors which the key informants believed contributed to the poor health or Irish people in Britain. This opened the discussion and I then generally allowed the discussion to flow, teasing out issues, clarifying and encouraging participants to offer different perspectives. On occasions I challenged assumptions, asked for clarification and generally prompted debate. I endeavoured to ensure the voice of quieter participants was heard and to encourage the less articulate members of the group. The need to do this was greater in some groups where it was apparent that not all participants were equally vocal, but my most important role in most sessions was returning the topic when the discussion had gone off on a tangent. This evoked some anxiety in me, as I was keen not to impose constraints on the potential for data gathering, but I was conscious of the time limit and the amount of material which might have been generated.

The group dynamic in the focus group process was also a part of the data collection. In retrospect, although I attempted to keep field notes, my mind was more concentrated on listening and picking up cues. Resources did not allow for the involvement of another person and on reflection it would have been helpful to have the assistance of a second person to watch the recorder, to take some notes and to remind me to follow up cues or engage quieter participants. In general the groups started with one or two participants having more to say than the other, but there was evidence of agreement in the non-verbal cues of the non-speakers. The group themselves drew in quieter members or asked questions relating to their expertise or experience.

As I made every effort to transcribe the recordings as soon as possible after the event, I

could recall much of the dynamics and the body language and I was able to include these in the transcripts. The groups involving older men and women were friendly and there was considerable consistency in the contributions and the apparent understanding. The key informant groups were more diverse, challenging each other and sometimes reaching a compromise and at others agreeing to differ. Some informants were vocal and authoritative in their assertions while others listened more and were either drawn in by myself or other participants.

3.4.5 Data collection - The interviews

Access can be understood at a level which is more than contact. I was conscious that my accent, dress or my demeanour could be either a help or a hindrance. This was particularly so with marginalised or suspicious informants. On the days when I interviewed vulnerable people I took care not to look too formal and followed the dress code of the workers at the centre and wore a jumper and trousers. I arrived early and had a cup of tea in the dining area and spoke to some of the people who were sitting near me making small talk about the weather. I wasn't conscious of changing my accent but am told that when I'm with Irish people I have stronger Irish accent and use many colloquialisms. On one occasion, I engaged in some banter taking place between staff members and some clients and the atmosphere was jovial. Although I was not aware at the time, two of the interviewees were present and appeared at ease when they came to be interviewed.

Gender was not a barrier and may even have been an advantage in talking with both women and men. On meeting the informants I explained the purpose of the research , confidentiality and ethical issues and obtained their permission to record the interview. However they appeared much more interested in me as a person than as a researcher, asking which county I came from and how long I had been in England. A number seemed more comfortable knowing I was a nurse. A few asked about my "strange" (Turkish) surname or my relationship with the person who had put us in contact. Respondents were surprisingly unperturbed by the request to record the interview. The only concerns that were raised were that they would use bad language on the recorder and I jokingly reassured them there was a special device to "bleep" out swearwords!

Before switching on the recorder I completed a brief biographical questionnaire asking details such as age, education, housing tenure. It included health information such as self-defined health, diagnosed illness, smoking and alcohol consumption. This was a useful opening strategy since respondents elaborated on the information and led naturally into the "formal" interview. Interviews were recorded with the informants' permission using a portable tape recorder and field notes were taken.

The interview schedule began with fairly direct questions about life in Ireland, reasons for emigrating and about settling in England. After the first few questions I followed no specific sequence, but was able to cover issues picking up and developing cues from the informants. Although I aimed to avoid leading questions, the recorded material would later show that this was not always achieved. There was mostly free flow of information and in some cases I had to intervene after a time to rein back the conversation.

Only one respondent was very reticent and although she did not appear nervous, my efforts at conversation and humour evoked only brief, monosyllabic and unelaborated answers. Conversely I was surprised at the level of openness and honesty in the individual interviews. One respondent answering a question on preference for an Irish professional expressed that nationality was less important than having somebody "like yourself that's easy to talk to". I was shocked and distressed by the level of disclosure and the nature of some of the matters disclosed to me in the interviews. Two respondents in particular informed me that they had disclosed things to me that they had never discussed with another person.

I was not conscious of making a special effort to be culturally sensitive during the interviews, but listening to the recordings, I could hear the change in my language, use of colloquialisms and banter. My familiarity with Irish terms and expressions meant that long and pain evoking explanations were unnecessary. For example when a man told me he had been in " Artane", I understood that he had been in an industrial school in Dublin and had very likely been the victim of cruelty, physical, psychological and possibly sexual abuse. Similarly the woman whose childhood was "with the nuns" did

not need to explain that she was raised in an orphanage, with the cruelty and abuse that it often entailed. My ethnicity was also a barrier, since people assumed I knew what they meant or had shared their experiences. On listening to the early recordings I was conscious that I had not challenged respondents when they partly described something and then said " sure you know yourself Mary" and from then on I endeavoured to ask for more detail.

I was made aware of the limitations of memory when one respondent described her first image of the home her family had moved to when she was about eight or nine. She nostalgically described a horticultural impossibility of daffodils, peonies, rambling roses and greenhouse peaches all in bloom at the same time. I was conscious that individuals constructed stories in the language of their everyday thoughts and that similar stories were told in simple forms of language, elaborated codes and through popular and professional discourses. I had a sense that at first respondents told me what they felt I ought to know, but as the interview progressed they were more open about experiences and health behaviours. There was no concern about recording the interviews and nobody asked me to switch off the recorder during the interviews. I was not aware of being given privileged information once the machine was turned off as I had been on other occasions. I expected to be asked for advice during the interviews, but this happened much less than I had anticipated.

3.4.6 Transcription

The interviews were recorded verbatim and transcribed very soon after. The quality of the recordings was variable but with the exception of one short interval where the tape had run out, all the focus groups and interviews were on record. A few were difficult to hear because of the quietness of voices or background noise and several were punctuated by telephones, doorbells and emergency service sirens. My field notes were brief but since I was mostly able to transcribe soon after the event I was able to recollect body language, group dynamics and inconsistencies or incongruities. It also meant that one interview could inform the next.

The transcription was painstaking and time-consuming but it truly embedded me in the data. The use of a transcription machine meant I was able to go back and forward over

short bursts of conversation with ease. My slow typing meant that I often went over small excerpts of material several times. This had the effect of allowing me to listen very closely to the material, hearing pauses, hesitations, and often hearing different things emerging each time. I was able to recognise nuances that a professional typist might have missed and I was able to visualise some of the body language and interpersonal interactions which I recalled as I transcribed.

Preparing the transcribed data to be imported to the QSR NUD*IST (Non-numerical Unstructured Data Indexing, Searching and Theorising) package took me back to data I had not worked with for a considerable period of time. Reading them on screen this time rather than hearing them led me to see things I had missed, to see some things in a different light and to make connections between focus group and interview data.

3.5 DATA ANALYSIS

Miles and Huberman (1994) describe qualitative analysis as three linked processes which reflect the anticipatory, interim and iterative character of qualitative research. These are data reduction, data display and conclusion drawing/verification and they lend themselves to the use of computerised analysis software. This approach offered a design which could be developed in relation to the problem being investigated, allowing for modification and customisation as the research proceeded. It was not anticipated that this happen in a loose inductive way but directed by the research problems, the context and conceptual frameworks underpinning the study.

3.5.1 Computer Assisted Qualitative Data Analysis Software (CAQDAS)

I did not feel competent enough to consider a software package for analysis until late in the study. I took refuge in concerns that computerised approaches could alienate the researcher from the data and enforce analysis strategies that conflicted with the methodological and theoretical orientations which were the hallmark of qualitative research (Seidel and Kelle 1995). However the volume of data generated led me seriously consider the merits of CAQDAS. I had to be confident that inputting transcripts would ultimately save time and provide opportunities to interrogate and manipulate the data. Lee and Fielding (1995) argued against the assumption that

computer packages could save time but hoped that it could make the process more systematic. With over 200 pages of transcript, plus field notes and biographical data, there was a need to manage the data systematically, even if only using CAQDAS as an "electronic filing cabinet". The choice of package was largely determined by its accessibility and the availability of colleagues able and willing to support and guide me. QSR (Non-numerical Unstructured Data Indexing, Searching and Theorising) NUD*IST Version 4 met these criteria, as well as being compatible with Miles and Huberman's (1994) approach to analysis.

3.5.2 Analysis of transcripts

Data analysis of key informant, health related focus groups and interviews was undertaken using the principles suggested by Miles and Huberman (1984,1994). They describe the choices made by the researcher as a form of "anticipatory data reduction" which gives direction and focus to the research and from which the explanatory stage of analysis emerges later in the process. As discussed in the first two chapters the research questions were underpinned by a combination of the available evidence and the need to address its limitations and to draw upon a wider body of research for explanations.

My understanding of research relating to both Irish people and relative deprivation had gave me some idea about the concepts, questions and tensions which the data might reveal. I was conscious that the experience of migration and settling down in London would have been different for each person, but anticipated common experiences which might have caused distress in the immediate or longer term. I suspected that these reflected different reasons for leaving home, the social support available in London and the area to which people moved or settled. It was possible that migration and the experience of living in London impacted on the ethnic identity of the individual, their confidence in expressing it and their willingness to engage with the wider English community. I imagined that ethnic identity related to the experience of racism and that this in turn influenced self-esteem. The literature suggested a link between identity, self-esteem and health and it was possible that this impacted on health beliefs, behaviours and willingness to seek help. The link between lifestyle, behaviour and health was incontrovertible, but I anticipated that strategies for coping with adversity

and health would have a specific Irish dimension. Although I anticipated that different social problems contributed to ill-health it was also possible that a reverse relationship existed. It was also imaginable that an accumulation or persistence of "low level" problems in the lives of Irish people might have been more significant than any single "major" factor.

These categories formed the basis of the index codes used in the data reduction stage of analysis. The first level coding related to naming and classifying recurrent themes in the data and resulted in 22 main index codes with up five or six sub categories within each one. The subcategories related to positive and negative dimensions, the presence or absence of particular experiences or phenomena which occurred repeatedly.

Another feature of qualitative analysis according to Miles and Huberman (1994) is its interim quality with the emphasis on data collection and analysis shifting as the research proceeds. The use of a reflective diary helped me to ensure that themes emerging from the data fed into and modified further data collection as I either gained a better understanding or a greater doubt. The key informant and lay focus groups revealed a number of recurring themes informing the individual interview schedule and the coding for analysis. The process of analysis was ongoing and for the most part the first order analysis coincided with the collection of data. In the first individual interviews, some new themes emerged and the extent to which some of the existing ones were confirmed were much greater than envisaged. These led me to modify the interview schedule and to incorporate additional sub-themes as index codes for the analysis of later material. For example, the extent of ill-health and the hardship experienced by interviewees was much greater than the sampling had suggested. The incidence and nature of various abuses in childhood and adulthood had not been considered initially. For example, it became evident that the interviewees were resentful of the forces in Ireland which caused them to migrate. The tensions which arose in relation to the improved economy in Ireland was another unexpected and recurring thread.

The analysis was therefore iterative in that the patterns, hypotheses and themes discovered inductively were verified deductively in turn yielding further inductive insight. While there was a level of consistency between the themes emerging from the

focus groups and interviews, there were also inconsistencies. In particular, the key informants made certain assertions, which the narratives of the interviewees did not always confirm. I was therefore obliged to explore issues in more detail drawing on wider evidence and posing questions from a research base. At times it appeared that the more I learned the less I knew and I consciously had to resist following up every lead and instead focus on commonly occurring themes rather than pursue what seemed more attractive or exciting.

Although analysis had been undertaken throughout the data collection it had been done at a superficial level and required detailed analysis when all the interviews had been completed. I was then able to examine the data in totality and to look more closely for the extent of recurring themes. Data display (Miles and Huberman 1994) was facilitated by the ease with which data could be retrieved, and examined on the screen or paper for links and relationships. It was easy to count the frequency of indexed material and to analyse them by gender, age or other variables. The software package allowed me to check out my biases and assumptions, explore causal relationships and the representativeness of material at the touch of a button, thus fulfilling what Miles and Huberman (1994) call data verification. I was surprised to find that in some cases I was influenced by the articulacy of an interviewee or the horror of a particular narrative. Had I not counted the responses I might have claimed that some issues were far more common than they were in reality. The data were examined and repeatedly re-examined for emerging concepts, for links and causal relationships. They were subsequently categorised and reduced into eight major themes. (**Appendix G).** Each theme provided a partial explanation for poor health but cumulatively and in interaction with each other offered insights into the poor health profile of Irish people.

3.5.3 Reflections on the use of CAQDAS

Even allowing for the time involved inputting the data into NUD* IST, the task of data management was simpler, less cumbersome than manual analysis and the material was scrutinised much more thoroughly than if I had undertaken it manually in the time available. Contrary to the beliefs of some qualitative researchers, I found that I was truly immersed in the data. Transcribing the recordings myself played a part, but the

ease with which I could retrieve a volume of text meant that I was able to move easily between different types of data.

The software package has many extended features which might have been used but I have only used NUD* IST in a very limited fashion as a storage and retrieval system. I am confident that the analysis was facilitated by the computerised package but that any flaws in the process or outcome reflect my inadequacy at some point in the research process. On balance, in terms of making a large volume of unstructured data manageable CAQDAS has contributed immensely to the strength of the study.

4.0 Chapter Four : Overview of findings and the relationship between migration and health.

This chapter begins with a pen portrait of the interviewees and gives a brief overview of the findings before going on to focus on the findings related to migration and settlement in London. It discusses the reasons why people left Ireland, the culture shock they experienced on arrival and why their original intentions to return to Ireland had not materialised. It considers the extent to which interviewees feel they belong in London, the factors which impact on this and the way in which some are able to feel a sense of belonging in both England and Ireland. The chapter focuses on emotions about having to leave Ireland and highlights aspects of life in Ireland which increased the vulnerability of Irish people to the damaging potential of migration. It explores factors influencing how interviewees identify as Irish and engage with the Irish community in Britain. The chapter considers how the Irish experience of migration differs from that of other minority ethnic communities, focusing on the impact of geography. It examines how regular contact with Ireland or the Irish community in London influences feelings of belonging and to what extent this is health protecting or enhancing.

4.1 A BRIEF OVERVIEW

Data from key informants and lay focus groups informed the interview schedule but the findings mainly focus on the detailed personal experiences, perceptions and emotions of the interviewees. Differences or inconsistencies between the interviewee accounts and key informants or lay focus group accounts are highlighted in individual chapters.

4.1.1 A profile of the interviewees

Four of the twenty interviewees were skilled manual workers, six were in the unskilled socio-economic group and the remaining ten in non-manual categories. Six left Ireland on completion of primary school, eight had finished secondary school, three had vocational school qualifications and two were university graduates. Since leaving Ireland five informants had achieved qualifications in nursing, the police force and

ambulance service in England and one was studying for a degree in human resources management as a mature student.

Ten of the sample were married, five were single, four divorced and one was widowed. Of the twenty, only six owned their own home, four lived in local authority housing, four were in the private rented sector. Of the remainder, four were in housing association property and one each in sheltered and hostel accommodation. Twelve of the twenty interviewees had no access to a car.

4.1.2 Overview of findings

This chapter addresses the first research question and describes interviewee accounts which reflect the changing pattern of migration from Ireland since the 1950s. The majority left Ireland to find work but on deeper examination a number of other factors were equally significant. The oppressiveness of Irish society was a factor for almost everybody and many perceived that unfairness and inequality in Ireland contributed to their having to leave. It was notable that a high proportion of the sample left home to escape abuse and cruelty in the family or in institutions. Everybody migrated with the intention of returning home to Ireland and the majority kept in touch and visited frequently. Contrary to the assumptions of the key informants this helped instil a sense of belonging in both England and Ireland, but the majority who felt settled in London, still felt they were outsiders from time to time.

Chapter five primarily addresses the second research question and demonstrates the relationship between discrimination and health inequality. It shows that the experience of racism is still widespread although its nature has changed over time. Not everybody recognised their experiences as racism or discrimination and many accepted their socio-economic situation and other inequities as par for the course of being Irish in Britain. Having an Irish accent and the conflict in Northern Ireland were particular and recurrent problems for every individual. Although some interviewees had experienced overt racism, without exception everybody had been exposed to the subtle ways in which anti-

Irish racism was expressed. The persistence and particular nature of anti-Irish racism had affected all the interviewees, contributing to a range of emotions and potentially damaging coping mechanisms.

Chapter six deals mainly with the third research question about the impact of structural, cultural factors on health beliefs and behaviour. The majority of the sample described themselves as reasonably healthy, with only two self-reporting as very healthy. The self-reports of good or reasonable health however masked a range of serious health problems the interviewees were coping with. The level of poor health in the sample was very high and in addition, the data uncovered a high level of disability in the interviewees' children which had impacted on their social circumstances and health over many years. The interviewees were invariably well informed about health, but many still smoked or consumed alcohol excessively in order to cope with difficult lives or the symptoms of mental or physical illness. Religious or spiritual beliefs were important coping strategies for all the interviewees, enabling them to deal with distress and to access health care services. The findings also suggest that key informants have limited understanding of the health beliefs and behaviour of Irish people.

Chapter seven is concerned mainly with individual, cultural and institutional factors influencing patterns of service use. It shows that although the incidence of ill-health is high in the sample, the level of satisfaction with health services is not. A significant number of the interviewees cited experiences of ineffectiveness, insensitivity and institutional racism. They are reluctant to access health services while they or the family can cope, but the data demonstrate that when services are culturally sensitive and non-judgemental they are willingly used. The tendency towards self-reliance reflects early socialisation and mistrust resulting from cruelty in Ireland and humiliation by statutory officials in England. The absence of supportive networks and the unwillingness to trouble relatives under pressure amplifies this tendency. Although this leads to difficulties for the individual it is often less stressful and more dignified than asking for help in a hostile environment. These findings contrast with the assertions of the key

informants who do not adequately acknowledge the difficulties associated with accessing services.

4.2. LEAVING IRELAND AND ARRIVAL IN LONDON

The interviewees had all been in London for a minimum of ten years. Four left Ireland in the 1950s, seven in the 1960s, two in the 1970s and seven in the 1980s and ranged in age from 30 to 70, mirroring the major waves of migration in the 20th century. With two exceptions, all came from the Republic of Ireland and of the two from Northern Ireland, one was a Protestant and the other a Catholic. Seventeen interviewees were aged between 16 and 20 on leaving home and three were between 21 and 24 when they left.

Table 12 Decade in which interviewees emigrated

Year	1950-1959		1960-1969		1970-1979		1980-1989	
Sex	Men	Women	Men	Women	Men	Women	Men	Women
No.	1	3	4	3	1	1	2	5
Total	4		7		2		7	

When asked why they came to London, seventeen of the twenty gave work or training/education as their reason for leaving Ireland. However during the interviews it became evident that the reasons were much more complex.

4.2.1. Reasons for leaving Ireland

Although woven with different social and personal reasons for leaving Ireland, the main motivation for migrating from the 1950s to the 1980s was work. Two thirds of the interviewees gave a primary economic reason for migration and six of those were already qualified or skilled trades-persons. Three left to undertake nurse training and one came to study at university. One man left Ireland to find work following a broken engagement and two women left to be with a partner in London.

The older interviewees talked about great hardship in the home and poverty in Ireland, in local and particularly rural communities, which played a significant part in their reasons for leaving. While very few people were rich in the 1950s and 1960s, there were differing degrees of hardship in the community, as testified by a woman from a fairly comfortable farming family who left to train as a nurse in 1958.

Int. F15. .....we [our family] were really well fed in them days. There was such poverty around in Castlebar. I remember kids at school ..... this boy in the college..... this poor lad had no breakfast nor no lunch.

The accounts of the older interviewees reflect the historical pattern of emigration of predominantly unskilled people from rural areas to particular sections of the labour market abroad. Most of the older men left having completed primary schooling and came to England as unskilled labourers because there was no work for them locally. Even those, like the following man, who had served an apprenticeship, were unable to find work in Ireland.

Int. M6. Well I served my time as a mechanic in Mallow, but there was no work for me so I came over here.

Women were more likely to have completed secondary education, but that did not guarantee employment. There were greater opportunities in bigger towns or the cities but the cost of accommodation was prohibitive.

Int. F14. There was so little there, no matter what education you had...if you went away from home the next thing was to go to Dublin and you didn't actually earn enough in Dublin to pay for your digs.....

In the 1950s and 1960s, some of the interviewees had been recruited to jobs before leaving Ireland, slotting into traditional labour market niches for Irish people. Men mainly found work in construction and women in nursing and clerical roles, though a sizeable proportion of Irish people found factory jobs. Many had accommodation with family or friends and found jobs when they got here, though women particularly came to jobs that offered accommodation. None of the interviewees expressed difficulty obtaining work and although there was work for labourers, men with a skilled trade were very much in demand especially in the 1950s and 1960s.

Int. M6. I came over with a job to England. I came over with Murphy [construction firm] They had advertisements in the Irish Papers and I just applied and was given a job.

Women too had little difficulty and were slotted into traditional occupational niches. This woman's account typifies the experience of many Irish women and reflects the availability of work in the 1960s for those who had a skill or profession.

Int. F14. No I got the job within a couple of weeks I think...it didn't take me long, I had a secretarial course. I applied to British Airways. You had to take an exam but I got it straight away.

The accounts of younger participants represent the changing nature of migration in the 1980s when the numbers of skilled workers and graduates, mainly from urban areas increased. Of the seven interviewees who left in the 1980s, two were graduates, one of whom was a lawyer, one was a skilled manual worker, one a qualified hairdresser and two had good secondary school certificates. They all left to find work, better opportunities and lifestyles than Ireland could offer them. Secondary or university education had opened up opportunities, though not necessarily in Ireland. Many were forced to leave on completion, because of the lack of suitable jobs or the inability to access those that were available. The account of this man with good Leaving Certificate grades echoes a number of interviewees who were graduates, professionally qualified or skilled trades-people who left in the 1980s.

Int. M2. The only industry there is tourism, so everybody sat the matriculation for the civil service and if you didn't get that or you didn't want the civil service or go to secretarial college then there was nothing in between and you left.

Although unemployment was the major push factor in the 1980s, the narratives highlight a range of more complex issues that were involved. A number left Ireland to get away from what they saw as an oppressive society, full of small mindedness and gossip. The following account by a graduate who left in 1980, reflects the narratives of several women interviewees.

Int. F16. There wasn't very much levity there and when I got my BSc. I wanted to have a bit of fun. I wanted to go out there and go to nightclubs and have boyfriends and I could never do that at home in Dublin. ..... Also the position of women in Ireland I didn't like.....

There was no place in Ireland for people who did not conform to conventional norms and a gay man describes the pressure on him to leave in 1983.

Int. M2. I left in early 1983... left because I always knew I would have to leave. It was quite clear that I would have to leave, that if I wanted to do anything with my life.

Although the accounts describe the impact of gossip and narrow mindedness in influencing their decision to leave, those with mental health problems felt particularly stigmatised and driven to leave their family and community. The following account is by a qualified craftsman with a decent job, who left in his early 20s because of severe mental illness.

Int. M9. ..... to get away from the small minds. My family did not understand me being unwell. You know the usual, pull yourself together, what's wrong with you, cop on to yourself. And again I suppose the narrow minds. You know people continuously pointing at you, the gossip, "he's mad" and it was just to get away from that.

The high level of institutional and family abuse revealed in the sample was totally unanticipated. Three of the interviewees were fleeing physical, psychological and sexual abuse having spent part of their childhood in religious institutions in Ireland. The following excerpt is from an articulate man with severe physical and mental illness, who was released from the notorious Artane industrial school aged 16 and fled to England. His account echoed the expressions of those who left Ireland when released from orphanages or industrial schools.

Int. M7. I was in an orphanage you know. Physically, emotionally sexually abused – terrible, terrible. I was 16 when I came here. As soon I got out I came over here. I've been all over the world since, twice... running, running, always running.

Evidence of this destructive aspect of Irish society has emerged over the last five years having been covered up by the church and state for decades (Raftery and O Sullivan 1999). Similarly accusations of sexual abuse in the family, in schools or in the community have only recently begun to be taken seriously. A man and a woman with

severe mental illness as adults, had both been physically, psychologically or sexually abused by family members as children.

Int. F10. I, and indeed all my siblings, were sexually abused for about three or four years, between the ages of about eight and twelve .....our parents were and still are difficult people and we all suffered emotional abuse. There was some physical abuse but certainly more emotional things.

The following woman was qualified and in a good job in a service profession in Northern Ireland but left to get away from an abusive family dominated by a violent father.

Int. F 13. I was in the hospital after he [father] battered me and threw me down the steps.

The interviewee narratives reflect the writings of a number of Irish feminists such as Smyth (1993), Rossiter (1992, 1993) and Leonard(1993). There is a long tradition of women leaving broken marriages and domestic violence in Ireland and travelling to England (Rossiter 1992, 1993). Patriarchal attitudes and laws in both Northern and the Republic of Ireland meant that domestic violence, incest and rape denied women their rights as citizens (Leonard 1993). The denial of institutional and family abuse meant that there was no redress for victims and emigration was the only means of escape for most survivors. While not everybody experienced the brutality of abuse in the home or in institutional settings, many of the narratives reflect the social backdrop of a controlling, authoritarian and punitive state, lasting well into the 1980s.

4.2.2 Feelings about leaving Ireland

Not everybody had suffered abuses but other emotions associated with migration emerged in the interviews. Apart from homesickness and anxiety about a new life, interviewees' feelings about leaving Ireland had the potential to influence health on

leaving home. The narratives highlight negative feelings related to the colonial relationship between Ireland and Britain. Although differences existed between those who left in the 1950s and 1960s and those leaving in the 1980s, the following excerpt exemplifies the feelings of many interviewees.

Int. F 10. I have this sort of love-hate relationship that a lot or Irish people have. You know from a historical point of view, there's the negative feelings about it, the colonial relationship……..

Greenslade (1992) used the work of Franz Fanon (1986) to explain the double bind Irish people were in; hating the oppressor while at the same time being dependent on him. His argument that this conflict is a contributory factor in the genesis of mental ill-health in Irish people will be developed later.

However the colonial history of Ireland was not the only factor in generating negative emotions about Britain. According to Ryan (1990) when the blame for the causes of emigration could not be fully attributed to Britain, the emigrant became seen as culpable and unable to resist the lure of bright lights and the easy life. The Catholic Church devalued individual action, ambition and personal responsibility, and saw emigrants as selfish and self-seeking. Sermons from the pulpit in the 1950s and 1960s warned of the moral and spiritual danger emigrants faced in England. Paradoxically people saw poverty and few opportunities around them and little choice but to go to England because of the cost and the prohibitive immigration controls of America. So the potential emigrant was exposed to conflict, needing to leave for economic reasons but seen as "deserting" the developing nation in its time of need (Lee 1990).

The interview accounts however highlight other tangible emotions with the potential to be health harming. About half of the interviewees who left primarily to find work, recounted a range of structural processes they believed played a part in them leaving Ireland unwillingly. Despite most interviewees initially explaining leaving Ireland in

economic terms, the narratives uncovered a palpable sense of resentment about unfairness in Irish society from the 1950s to the 1980s. Not everybody explicitly connected this to their own reason for leaving, but the tone of the individual interviews was of resigned acceptance that they had been denied opportunities afforded other people. They recognised that work was scarce, but perceived that jobs or training opportunities in Ireland were not awarded on merit but had more to do with nepotism and class position. The sentiments expressed by this young working class man with a good education who left in 1983 mirror those expressed by participants of all ages and eras of emigration.

Int. M2. A lot of people said to me " it's not what you know but who you know".....We all knew people who got really good jobs at the time, like in the bank, incredibly stupid people, really stupid.....

This reflected Mac Laughlin's assertion that emigration fostered the emergence of a "petty bourgeoisie" by despatching large numbers of young adults abroad (Mac Laughlin 1997). The narratives reflect class divisions in attitudes towards emigration and images of those who had migrated to England. England was seen as a land of opportunity for the unskilled, unemployed or those working for very little as farm labourers (Ryan 1990). For the more privileged, it was seen in a negative light, as a ghetto for Irish people and the only option for those not good enough to get work at home (Mac Laughlin 1997, Ryan 1990). It was even feared that emigrants might be tainted by association and prospective migrants were warned of the evils of England and against settling in traditional Irish areas or becoming involved with Irish people. These attitudes described by one interviewee echo feelings widely expressed in the focus groups and interviews.

Int. M2. They [family] very much look down on the Irish who came to London and that certainly rubbed off on me. I was warned about living in places like Cricklewood and Camden and mixing with the likes of this one and that one.

The stereotypes of Irish migrants those who left in the 1980s brought from Ireland, made them unwilling to live in Irish areas or engage with the Irish community in London. The following quote from a graduate who left Dublin to have some fun and freedom echoes the sentiments expressed by other interviewees and key informants.

Int. F16. I didn't want to get sucked into the Irish scene, the pub scene, the Irish dancehalls. I didn't want to be with that kind of Irish person.

The younger interviewees broadly reflected those who left Ireland in the 1980s with secondary, vocational or even tertiary education or who would have been professionally qualified or from skilled trades and occupations. With the benefits of free education and a modern economy they might reasonably have expected to find suitable employment at home but the reality was different. So in addition to feeling forced out of Ireland and having to handle negative emotions about the colonial oppressor, Irish people who left primarily from economic need were then forced to face the image of themselves as inferior to their peers who were able to stay in Ireland.

4.2.3 Culture shock

Almost all participants experienced culture shock on arrival in London, though it was more marked in those who came in the 1950s and 1960s. Most were aged between 16 and 20, and being the first time outside Ireland they experienced horror at the vastness, noise and traffic. It was the first time some had left their locality and for many, the first train journey they had ever taken.

Int. F11. Coming from a small town, green fields, not many people……multicultural faces, greyness, buildings, traffic, fumes. Going on the tube was frightening.

Although many stayed with friends and family at first, they had to find their way around to obtain work. They had difficulty understanding the accent and colloquial language of

Londoners and found that Londoners had difficulty understanding them. They felt lost, without familiar landmarks and friendly faces and were taken aback to find that when they greeted people they got no response. They found English polite and helpful, but formal and cold. The following interviewee who came in 1960, shares the experiences of many who came from rural areas or small towns.

Int. F 14. My sister and I shared a room so we weren't lonely, but going out and not knowing anybody was strange. The English were always helpful and they'd show you if you were lost, but if you said hello like you would at home they'd stare at you like you were mad.

This may have been more a reflection of the differences between rural and urban settings than differences between Ireland and England. About three quarters of the interviewees came either to a nurses' home or to join friends or family which might have buffered them from some of the stress of unfamiliar surroundings, homesickness and feelings of not belonging. Several men had no contacts and were forced to rely on their own resources or an Irish pub to find work and accommodation. However many of those who joined others were only able to do so as a temporary measure and found themselves having to cope alone within a short time, with minimal support emotionally or practically.

Culture shock however, was not necessarily a negative experience for all and a number expressed pleasure at a range of freedoms they had not experienced in Ireland. Despite their homesickness, they found opportunities for enjoyment in London. According to Lee (1990) young people were drawn by the need to retain continuity of social relationships rather than the lure of bright lights and distant cities. They left Ireland to be with siblings and friends and to be where the *craic* was. *Craic* was the term derived in Connemara to describe fun and pleasure in the jovial company of one's own people. *Craic* was to be found in the dancehalls of Camden Town and Cricklewood and not in the rural villages or small towns of Ireland. Young people were able to have fun away

from the prying eyes of the community and without the restrictions imposed by the family or the Church. The sentiments of several of women interviewees are summed up by a woman who left a small town in 1960.

Int. F18. Oh it was great freedom, for me it was great freedom. We could go and do what we liked…… It was great! There was no one looking at you all the time. I had job in a factory making zip fasteners. Five pounds sixteen. Sure I thought it was great. Dances and clothes even after you sent home a bit……

Although interviewees who came in the 1980s experienced culture shock, they were more likely to comment on the need to confront their Irish identity for the first time in England. The following excerpt by a lawyer who left in the 1980s echoes the expressions of several participants.

Int. F10. I'd never thought about being Irish before. You don't need to do you, when everybody else is the same. Maybe from a different county or that, but mostly the same.

The following statement by a young Northern Irish Protestant woman highlighted the additional difficulties she experienced on arrival in the UK.

Int. F20. My family would identify more strongly with being British so it wasn't a big thing to move across [to England]. And that was very difficult, as I never thought it would be any different being over here at all. It was a real shock to find it was. I was considered to be Irish, which was OK. But it was also assumed I was a Catholic.

Confronting Irish identity for the first time however was not a neutral experience. As will be discussed later, the way in which the Irish were constructed in British society was invariably problematic. This adjustment was additional to the displacement, cultural or social bereavement young Irish people experienced having left home.

4.2.4 Anticipated stay in London.

At the start of their migration, the majority of the informants believed that leaving Ireland was a temporary measure. This woman who left Ireland in 1950, believed like others that she would return home after a particular goal was met or after a certain time.

Int. F11. In the beginning it was my plan to do my training and go home. It was everybody's plan then.

Those who left in the 1980s tended to see migration as a time limited opportunity for personal and professional development, occupational and life experience.

Int. M2. ..... what we said was, if we leave for a couple of years and come back. Get some experience, see life and then go back.

About three fifths of the interviewees had made decisions to stay in London permanently for a variety of economic, social and family reasons. The rest were unsure about returning to Ireland but had not ruled out the possibility at some point in the future. For younger participants, migration appeared to be a process, of which returning home with prosperity and enhanced skills was the end product. Financial and material objectives were important for all, but self-actualisation seemed more significant for some interviewees. This excerpt summarises the feelings of several younger interviewees and suggests that the migratory process is not yet completed to the interviewee's satisfaction. He is a skilled craftsman who could command very high wages in his own trade but chooses to stay in a job in a voluntary sector organisation which is not highly paid but is fulfilling and utilises his abilities.

Int. M9. ..... it wouldn't be an option right now.....going back to what? I ask. In one sense I feel I would like to try it but I wouldn't want to lose anything.....this job

suits me. I wouldn't be able to do a job like this at home. I wouldn't have this opportunity. There is a possibility I will but not yet……..

Although most interviewees originally saw migration as a means to an end and envisaged returning at some point, their plans had changed over time. The focus of migration had changed with marriage as interviewees became concerned with supporting a family. Raising a family was difficult, and the added burden of also having to support the family back home meant that while there was reasonably secure income in London, any thoughts of returning were postponed. Later, the wish to stay with grown up children and participate in the care of grandchildren prevented older people from returning to Ireland. The following excerpt by a married woman with three adult children reflects many of other interviewee accounts.

Int. F14. I came with the idea that I was not going to stay. We had intended going back then after about three years, but as you can see we never[did], forty odd years and three children later.

The need for health care or specialist support for children with disabilities had prevented several from considering returning to Ireland while they were younger.

Int. M17. I make no pretence that if it hadn't been for Charles [son], myself and Bernie[wife] would have gone back home.

Though he spoke about his son, his own health was very poor and necessitated living in sheltered social housing and in need of considerable health care not so readily available in Ireland. This prevented other interviewees, particularly the older ones, thinking seriously about returning to Ireland and people with failing health found the NHS and community care services available in Britain a major factor in keeping them here.

The individual's family and social networks in Ireland played an important part in the desire to return and when parents died and siblings or friends moved on there was no reason for some to go back. This single man in his late 50s sums up the feelings of many of the middle aged male informants

Int. M5. Once the mother was gone, that's when I stopped going to Ireland I didn't want to know any more...It'd be so strange to me now. No I think I'll spend the rest of my life here.

Some interviewees however made a free choice to stay in England but went back regularly for holidays and family events, facilitated in recent years by improvements in transport and low cost travel. The place they left had changed and in their migration they themselves had also changed. This nurse and mother of three highlighted the feelings of many others.

Int. F15. It's a different place altogether now. I wouldn't go back in a million years. I have a house there actually. I love it for a holiday and I go back every three months or so, but not to live there. No way!

About half the interviewees expressed the opinion that after many years in London they would not fit in socially if they returned to Ireland. This woman who had returned to Ireland on a previous occasion expresses a sentiment shared by several interviewees.

Int. F8. Sure I wouldn't fit in there if I went back. Correction. I didn't fit in there when I went back. I suppose you could say I'm neither fish nor fowl now!

Feelings of not fitting in are dealt with later in this chapter but they reflect wider attitudes in Ireland towards those who migrated, which were internalised by the interviewees.

The fear of not fitting in might also be a mechanism to protect the individual from admitting a lack of material wealth impeding return. The socio-economic data suggest that the material resources accumulated by half the interviewees over their lifetimes had not been substantial. The absence of savings or a house to sell might have been more significant in preventing return than a fear of not fitting in. Returning to Ireland with modest means might have been tolerable when the Irish economy was weaker. However, the high cost of returning to a country marked by significant economic development would have been difficult without a fair degree of prosperity. This man, living in sheltered social housing would have returned several years ago were it not for the lack of resources.

Int. M17. We couldn't afford to live at home now. We have a wee bit saved for the boys, but people in our income bracket certainly can't afford Dublin prices nowadays.

Those who had suffered abuses in Ireland had no desire to return home. The effects of disadvantage, illness, low paid work or supporting the family in Ireland at an earlier time, meant that about half of the interviewees could not anticipate going home as what Byron (1999) calls " the prosperous returnee".

4.3 IRISH IDENTITY

A few authors have highlighted the relationship between ethnic identity and health (Karlsen and Nazroo 2000; Halpern and Nazroo 2000) and some specific attention has been paid to the ethnic identity and the health of Irish people in Britain (Kelleher 2001, Kelleher and Hillier 1996; Cahill and Kelleher 1999; Walsh and McGrath 2000; Kelleher 2001). The impact of wider social factors on identity will be explored in chapter five and this chapter will only consider how ethnic identity relates to belonging in London and by implication to health.

4.3.1 Positive Irish identity

Being Irish and identifying as Irish were important for all interviewees. Emigration had brought their ethnic identity into bold relief and they were obliged to come to terms with being different, where before their ethnicity was an unquestioned assumption. At most the interviewees had previously viewed themselves through some regional identity such as being a Cork man or a Clare woman

Int. F20. Well you never reflect on yourself until you see something that's different and then suddenly when you're in the minority you realise you are the different one.

However there were differences in what identity meant and when it was openly expressed. When asked a direct question about whether they identified as Irish, there were positive and unequivocal responses from the interviewees. The following excerpt echoes the responses of several participants,

Int. F10. I love being Irish. For me it's really, really important, part of my identity. I love Ireland, I love Irish history, language, culture, music, literature art, the Irish sense of humour, everything. For me that is very important. For me, that is who and what I am.

However identity was not fixed and immutable, but dynamic and contextual. The interviewees identified with selected aspects of Irishness in different situations as well as adopting aspects of English culture or multicultural London with which they felt comfortable.

4.3.2 Uncomfortable with Irish identity

While all interviewees identified with being Irish, they did not always feel comfortable to express their Irishness and they found aspects of Irish culture distasteful and resisted or rejected them. It was particularly difficult to identify as Irish during paramilitary

activity in England or when the media reported atrocities in Northern Ireland. The experiences of the Prevention of Terrorism Act, will be dealt with in the next chapter but the following excerpt sums up collective feelings of guilt expressed by about half of the interviewees.

Int. F16. When those bombs were going off and when the troubles were at their highest I didn't want to stick my neck out and let it be known that I was Irish because I felt so badly about it. I felt these savages are creating mayhem and it's the Irish here who are suffering most.

At other times there was acute embarrassment about Irish people who drank excessively, were over sentimental or patriotic or who somehow reinforced stereotypes of Irish people. The tone of the following excerpt by a retired nurse in her late 70s, suggests that the adoption of certain behaviours reflected on the Irish community in general.

Int. F11. When I see somebody Irish letting the side down. Having too much to drink, using language which isn't appropriate, being very loud, I do cringe.

The interviewees were irritated by the behaviour of Irish people whom they perceived to exaggerate the hardships of home or conversely had rejected their origins. The next quote by a woman from a relatively well-off family may reflect misunderstanding of how hard life was for people in rural communities without running water or electricity. It may also be an unconscious desire to reject the stereotype of primitive or dirty Irish people.

Int. F14. I hate it when somebody tells the stories of years ago and exaggerates how old Ireland was. It was the same everywhere.....I hate when I hear somebody running it down.

About a quarter of the interviewees expressed intolerance of those who exaggerated the merits of Ireland and carped about England. This may reflect annoyance that they did not recognise the opportunities England offered or suggest a desire to fit in and not be seen as ungrateful by the host society.

Int. F16. Well I think a lot of people have a sentimental attitude to Ireland and how wonderful it is. And I feel like saying " why don't you go back there ?". I don't think Ireland is a bad place, but I choose to live here.

4.3.3 Passing on Irish culture

Despite certain reservations, the interviewees had great pride in their own culture and a commitment to not forgetting their heritage. Religion and religious practices were important ways of defining ethnicity and maintaining a sense of identity for some but not all interviewees. Women in particular took responsibility for the intergenerational transmission of culture and the interviewee narratives recount their endeavours to instil Irish culture in their children. Many used traditional or Irish language names for their children and the majority sent them to Catholic schools. They believed that frequent contact with Ireland and spending summer holidays there had helped children born in England keep in touch with their Irish identity.

Irish dancing schools in England provided an opportunity for social interaction with other Irish people as well as a significant part of transmitting Irish culture. The homes of two interviewees married to English partners were adorned with medals and trophies for Irish dancing. The following interviewee reflects the experiences of the Irish dancing scene for many families of both Irish and mixed Irish and other cultural heritage.

Int. F15. They [children] did Irish dancing and I was very involved in all that. All over the country for feises [competitive festivals] and exhibitions, every weekend for years.

It was clear that while some children born in London clearly identified as Irish, others had strong attachments to Ireland but did not necessarily see themselves as Irish.

Int. M17. No. But they [children] love Ireland .....They certainly have an affinity for it but they probably wouldn't call themselves Irish. They would stand up if anybody criticized the Irish.....

The informants recognised that their children also identified with their English birthplace and in mixed relationships with the culture of their other parent. Within families siblings often identified themselves differently.

Int. M12. Billy definitely identifies as Irish. His brother less so, he's more of a Cockney. Siobhan is half Irish, half English, cos her Mum is English.

It was evident from the data that while individuals were exposed to harassment and even hostility in society, within the home they were free to be as Irish as they chose. In the privacy of home or the safety of the Irish dancing school they could maintain links with Ireland and Irish culture. It was also a place where the second generation and children of mixed cultural heritage could negotiate and work through tensions around ethnic identity. Achieving success at Irish dancing may additionally have offered opportunities for prestige and counterbalanced some of the negative aspects of being Irish in England.

It was interesting to note that several of the adult children of the interviewees had married or were in relationships with other Irish-born or second generation Irish people. This may reflect an affinity towards Irish people, but could also reflect the schools they attended, the worlds they inhabited or the experiences they shared. It does however suggest that despite many difficulties that Irish culture survives and adapts over time.

4.3.4 Sense of belonging

Although a sizeable proportion of the sample had decided to stay in London, the interviewees expressed mixed feelings about where they belonged. The proximity of Ireland to Britain and the absence of immigration controls differentiate the Irish experience from that of migrant people from distant parts of the world. Travel between Ireland and the UK has always been relatively easy by comparison with other migrant groups. People from the Caribbean or Indian Subcontinent might have shared some of the negative emotions about Britain, but cost and the distance of returning home forced them to work harder at settling down. The closeness of Ireland meant that most of the interviewees had been able to return for Christmas and annual holidays and some women spent school holidays there with their children. The key informants argued that such close contact with Ireland was a factor in the inability of Irish people to set down roots by comparison with other ethnic minority groups. This they asserted, contributed to a feeling of impermanence and the failure to develop a sense of belonging.

KIYM (Gerry) I think there is a side where people detach themselves, they don't want to fit in. It does impede peoples' progress. Because they think, I'm not going to do this, what's the point? I'm not going to be here to feel the benefit of it. I'm going back next month or next year.

For the majority of the participants, ties with home had been strong at the start of their sojourn, writing regularly and the older generation in particular sending money. However the data suggest that as they spent time in the UK, those with children in particular became more " Britain centred" but that this took considerable time. The following focus group respondents in their early 40s drew upon their personal experiences and described how it had taken almost a lifetime to realise that London was home.

KIYM (Gerry) Speaking personally it's taken me the best part of 20 years to realise that this is where I live. 20 years to realise this and I think a lot of people come with that, next year or even 5 years, they are going back and it does have an impeding effect.....

KIYW (Finola) It took me a long time to accept that once I became 36 I had lived here longer than I did in Ireland. This is my home now.

Although the majority of participants had settled in London and many felt at home there, a feeling of not really belonging in England still persisted even after many years. There were differences in how this was expressed by older and younger people. Older key informants presented the absence of a sense of belonging as an individual problem of adjustment, suggesting that it was a choice made by some, though not necessarily one that they themselves had made. The following excerpt mirrors an interesting use of the third person by all the older focus group respondents. They described how some Irish people whom they referred to as " *they",* were reluctant to mix with English people, preferring the company of the Irish and living in largely Irish areas.

KIOP (Seán) In my experience over the years, Irish people are inclined to mix around among themselves, they don't socialise amongst English people, they keep more or less to themselves, within their own circle (my emphasis).

The key informants described a time warp where other people, " *they* ", lived in a dream world of 1950s Ireland, despite forty or more years in Britain. The following comments are by an older woman committee member of an Irish community organisation, who is also involved in her local community. She is conscious of the difficulties experienced by Irish people and empathic towards vulnerable men and women. She describes the problems of single Irish men but appears to detach herself from the problem of not adjusting by using the third person. She suggests that being mentally attached to Ireland is problematic for single men.

KIOP(Bridget) But you see its very easy to say we' ve been here for 40 years, yes we have, but you try and explain that, to say, a single man. They are still mentally in Ireland, they haven't left mentally.

This excerpt mirrors the assertions of the key informant focus groups and seems to suggest that living in Britain is in some way incompatible with being psychologically "at home" in Ireland. It suggests a requirement to be one or the other without any scope for feeling at home in both places. The pressure on Irish people and other migrants to assimilate is dealt with elsewhere, but the data indicate from Ireland and the Irish community in Britain to remain detached from British society. It is conceivable that if there is limited scope for affiliating with two societies and developing a hybrid identity, it is also difficult to develop a sense of belonging.

It is possible that the intention to return to Ireland inhibited some Irish people from setting down roots. However it may be also be a mechanism protecting them from the stark reality that they are excluded in different ways by British society. Perceptions and experiences of racism are addressed elsewhere, but the feeling of being an outsider, not fitting in and being different was articulated repeatedly by several interviewees. The sense of being an outsider was expressed differently by men and women and did not necessary get better with time. This man who arrived in the early 1960s describes a fairly typical way in which men were made to feel excluded.

Int. M 5. ……you get a lot of aggro in pubs and that. They kind of side step you. They don't say anything, but you get the message alright. Paddy isn't wanted here.

A woman who left Ireland in the late 1960s echoes how she and other women had more of a sense inside themselves that they didn't fit in.

Int. F 8. I came here 31 years ago and I still feel an outsider. Some of it was a personal feeling I wasn't really up to it or I wasn't coming from the same place as everyone else.

The narratives suggest that developing a sense of belonging required people to actively mix with others rather than confining themselves to a circle of Irish people but that a number of factors made this difficult. They point to the subtlety and unarticulated way in which anti-Irish sentiment is expressed. The following excerpt summarises the sense of exclusion experienced by many Irish women who came in the 1960s and who laughed and joked with their workmates during the day, but had no contact once work was finished.

Int. F 14. In general I found the English quite helpful……I could never say I found discrimination or unkindness. But no communication once the working day was finished. The Irish girls, we used to go dancing together, but not the English girls. If we met them at the Palais they'd smile and say hello, but no more than that.

However, while the key informants and focus group respondents identified that a sense of belonging was a problem especially for men, the individual interviews suggest that at least two thirds of the interviewees appeared to belong comfortably in both England and Ireland. This woman in her 70s highlighted that it was possible to have a sense of belonging in London while also seeing Ireland as home.

Int. F 11. I don't think many of us have left Ireland mentally. We are physically here but mentally it's still home.

A sense of belonging in London was generally more evident in those who had family or other support networks or who were linked into the Irish or local communities. Those, who like the woman in the next narrative, were happy with the area in which they lived and felt safe to go out, were generally more involved locally or in the Irish community.

Int. F13. The neighbours all love me. We all love each other, but we might not see each other for days. You know I have coloured [sic] people on this side and when we meet we give each other a wee kiss. We help each other. I help them out and they help me.

The data describes the way in which Irish people inhabit two worlds simultaneously, facilitated by cheaper travel and telephone contact and visits by family from Ireland. The following excerpt is typical of many of the informants who still have families in Ireland and feel at home in both places.

Int. F10. Yeah I love London. I go home every two or three months and phone every week, but London is home for me. I love the cultural mix, the multi- cultural bit. I have friends from all over the globe. But what I like most is I can be as Irish as I choose to be.

However factors limited the ability of Irish people to feel a sense of belonging in Ireland either. Although migrants strove to retain their Irish identity they were perceived differently by those at home. The following excerpt is by a woman who went home regularly, had a house in Ireland but chose to remain in London with her family.

Int. F14. The worst thing about living in England is losing your identity. I feel that living in England you are Irish. And now after all the years you go back to Ireland you are English and we seem to be something in the middle.

Four of the women recounted how they had worked hard to bring their children up in an Irish (and mostly Catholic) culture but they were still seen as "English" children by the family in Ireland. This woman was infuriated by her mother's persistence in talking about her "English" grandchildren.

Int. F 13. .....I said Mammy, they are Irish, they might be born in England but that doesn't make them English. The girls do Irish dancing, Seán plays the accordion, how

more Irish can they be? They know more about Irish culture than Brian's [brother] kids. And they made their Communion too!

This feeling of exclusion reflects collective amnesia in Ireland (DFA 2002) about Irish people who emigrated. In particular, the contribution of those who left was not acknowledged and there was little understanding of how difficult life was outside Ireland (Brody 1982). The ultimate injury expressed by about a quarter of the interviewees was the way in which they were excluded from inheriting a share of family land or property because they had emigrated. A refuse operative living in a private rented flat, described in a quivering voice how his brother inherited the family farm despite weekly contributions by himself and his sisters over twenty years.

Int. M19. They thought we had it easy here, they forget all what we sent when they didn't have an arse in their pants. He thinks he [brother] made the sacrifice of staying. Not us, we had it easy here……it upsets me.

Maintaining psychological links with Ireland tended to be seen by the key informants as inhibiting emigrants from setting down roots and developing a sense of belonging. On the contrary, the narratives demonstrate that those who had most contact with Ireland felt more settled in London and were likely to feel at home in both places. Echoing Walter (2000), women in particular, claimed to belong in both places at once and this was no less evident for men, with the exception of those who had mental health or alcohol related problems.

The data suggest that positive effects ensued from having a sense of belonging in both places. It was clear that family and community networks contributed to a sense of belonging and that those who also had good contact with family and friends in Ireland also felt more at home in London. The following woman spoke weekly to different members of her family in Ireland and other parts of the world and went home at least three times a year or more often if she could afford to.

Int. F8. The estate I'm living on is nice as housing estates go. Some really nice people living on my block and I've got to know many of the neighbours and the local shopkeepers. It's not Buckingham Palace, but it's a long time since I've felt so much at home.

Conversely interviewees with few social contacts in either country were more likely to lack a sense of belonging in London. One man who had fallen on hard times had broken his links with Ireland feeling his family wanted nothing to do with him. Those raised in orphanages had at least one parent or siblings with whom they had lost contact on leaving the institutions. This man, released from Artane industrial school, had no contact with Ireland or any desire to return there, and although he lived in the same flat for twelve years, he knew none of his neighbours and did not feel he could call it home

Int. M7. I've been in the same place now for about twelve years now but I don't feel it's my home. I'm not sure if anywhere is to be perfectly honest. I'm a loner, always have been……, running from place to place. I married a beautiful girl, a great girl, but she couldn't cope with me, always on the move, on the go……

The interviewee accounts suggest that the absence of social networks essential to a sense of belonging reflected the life and work histories and health of individuals, rather than any active choice not to belong.

4.3.5 Participation in the Irish community in London.

The Irish community in London has the potential to offer a sense of belonging to those who have left their homeland. Irish centres in many parts of London provide places where people meet for pleasure, to enjoy a drink, listen to Irish music or participate in sport or cultural activities. Voluntary sector organisations provide information and advice, housing or community care services and meet the needs of Irish people with a range of health and welfare problems. While the leisure industry has seen the expansion

of "Irish" theme pubs in English cities in the last decade, the authentic traditional Irish pub still thrives in areas of high Irish population. The Irish pub has been a focal point for many Irish communities for years and has provided a home from home, a source of information and a contact point for Irish people, especially for men who felt alienated in Britain. The role of the pub and alcohol as coping strategies will be dealt with in another chapter, but for the purposes of this chapter, the focus is on the community dimension. The traditional Irish pub or local Irish centres provide an opportunity to meet with friends, to enjoy the *"craic"* and keep in touch with Irish people and culture.

Int. F14. We actually go more to an Irish pub or an Irish club. And I feel more relaxed in it. Maybe It's because I feel I have more in common even with a person I don't know personally because you can talk about home and that. There is that little bit more friendliness.

Although recognising that in parts of London the Irish community were badly served, many of the participants used a range of social, cultural and welfare facilities offered by Irish cultural centres.

Int. F10. Yes cultural events. I go along to plays and films and new concerts throughout the year……I travel all over London. I go to Hammersmith for example.

Although some described a natural affinity towards Irish people, a fifth of the interviewees did not seek them out and would actively avoid being involved in the Irish community. This may reflect the distaste which emigration was viewed in some sections of Irish society and the following quote echoes the mirrored in the attitudes that some of the interviewees appeared to bring with them from Ireland.

Int. F16. And I am inclined to be friendly to Irish people who cross my path but I don't go out to look for them. I wouldn't join Irish groups and I certainly wouldn't go to Irish clubs or that. Not my type of people at all.

Younger people who enjoyed and felt part of the multicultural richness that London had to offer, were generally reluctant to get involved in the Irish community perceiving it to be outdated and inward looking. The following interviewee described her local Irish centre.

Int. F8. .....it reminds me of bygone Ireland and bygone days of dirty floors and slap happy bars. Drunken slobs, falling all over the place. I love the culture that comes out of Ireland.....dancing, the craft work, the writing, but the stage Irish, it's offensive.

For other participants, organisations connected with or perceived to be connected with the Church were unattractive. Not surprisingly those who had been abused in institutions were reluctant to engage with any facility run by members of religious communities, and the following excerpt echoes the sentiments of many of the participants.

Int. F 10. When I came I went to Camden Irish Centre and there was a big cross over the door and that was it! It was like a vampire! I just couldn't go in. I had enough of that at home.

Both focus groups and interviewees suggest that reluctance to engage with the Irish community stems from the inappropriateness of what is on offer to the diversity of Irish people who might use such facilities.

Int. F 10. When I came here first it was like stepping back into the 50s, when I used to go to Irish pubs for[music] sessions, they were full of old men dressed in suits, drinking, dark and dingy, sort of like photographs of the 50s. I thought it was a bit dated and ghettoised.

A number of respondents both young and old eschewed the Irish community and Irish events because of their unwillingness to expose themselves to smoky atmospheres and drunken behaviour. This was particularly stated by respondents who had given up smoking or drinking for health reasons.

Int. M 12. No. You have to be able to put up with cigarette smoke. And cigarette smoke for me is a big no-no.

Int. F10. .....the drinking is very difficult now because I don't drink any more. That I suppose and the fighting. So I don't go any more.

Although London is better served by Irish community organisations than many other parts of Britain, there are significant areas of high Irish population without any voluntary sector service or social centre. Even where they do exist, community centres are struggling to survive because of high rents, short term or project funding, weak management and flawed business practices (DFA 2002). Notwithstanding these difficulties, the Catholic Church and Irish voluntary sector were the only sources of support for many Irish people, providing social, material and informational services as well as psychological and cultural support.

KI YM (Michael) Some churches do actually provide a lot of support for people who are isolated whether through mental illness or through physical infirmity or whatever. It is the only social contact that some people have.

The interviewees were all proud of their cultural heritage and played music, read Irish authors and newspapers. Although recent years have seen a burgeoning in Irish art, music and other cultural forms, issues like cost, travel and physical access prohibited many from participation. It was evident from the data that while there was a natural tendency to feel at home with other Irish people, Irish community centres and events

failed to cater for the diversity of tastes which existed. Many were therefore excluded from the therapeutic effects of community and the potential for support in times of need.

4.4. THE RELATIONSHIP BETWEEN IRISH MIGRATION AND HEALTH

The study shows a link between aspects of the Irish migratory experience and health and the data suggest a number of factors implicated in the poor health of Irish people. The experience of migration is not dissimilar to that of other groups, but the narratives point to facets of the Irish experience which are different.

4.4.1 The specificity of the Irish experience

The expressed accounts of reasons for leaving Ireland are compatible with the literature on migration (Kearney 1990, Mac Laughlin 1994,) and reflect changes in the nature of emigration in the 1980s (Hazelkorn 1990, Hanlon 1992, Mac Laughlin 1997). Migration might have afforded opportunities for better health for those who left Ireland, through increased income, improved diet, housing or quality of life, but for Irish people like their contemporaries from other migrant communities the experience of migration and settlement is generally not health enhancing (Acheson 1998). To eliminate the immediate effects of migration the interviews in this study were restricted to those who had been in the UK for a minimum of ten years. The findings suggest aspects of the migratory experience specific to Irish people and highlight a number factors with the potential to be detrimental to health in the longer term. The accounts of the respondents reflect the evidence that Irish migration patterns differed from that of other migrant groups in that Irish people were more likely to migrate alone rather than in family groups (Mac Laughlin 1994, Lee 1990). Table 12 shows the young age at which the interviewees left Ireland in the 1950s and 1960s. This differs from other migrant groups with many leaving rural communities for big industrial cities in early adolescence. The majority of respondents left home at this period of life when important transitions such as self-image, identity and role relationships were being formed. Self-image, social identity and adult relationships are just some of the factors affected by changes and inconsistency during this time (Erikson 1963, Marcia 1980, Coleman and

Hendry 1990). Not only did interviewees have to deal with the transition from child to adult, they had to cope with moving from one society to another and for the majority from a rural to an urban environment. Many came to join Irish people who might not have been emotionally close enough or sufficiently mature to provide the support needed by a young person in a strange environment. At a stage of development marked by identity crisis (Erikson 1963) they were further required to confront their Irishness for the first time in a society which devalued the Irish. The absence of the supportive framework of the family and the lack of an adequate alternative at such a formative time had the potential to be damaging psychologically.

However the study demonstrates that although aspects of the migrant experience in London are damaging for some, factors originating in Ireland have been either directly detrimental or have increased the vulnerability of Irish people to health disadvantage. Although the majority of interviewees left Ireland primarily for work, the data demonstrate a complex range of experiences and emotions beyond economic considerations. In particular, a third of interviewees disclose their escape from institutional and family abuse while others recount wider social factors in Ireland generating resentment and impacting on self-esteem and identity. The narratives highlight unfairness and oppressiveness which led them to migrate at different times between 1950 and the 1980s. They invariably describe their experience of culture shock, but for a number who perceived or experienced Ireland as an oppressive society, the atmosphere was positive and liberating.

The accounts reflect the way in which emigration was constructed at a social level and in particular how interviewees had internalised prevailing negative attitudes in Ireland towards those who were forced to migrate. The troubling sense of injustice emerging during the interviews, may have been smouldering for some time with the potential to influence health. The data suggest that acculturation depends on attitudes towards the dominant society and whether the acculturation process is entered willingly or unwillingly. There were a number of reasons why interviewees were reluctant to leave

Ireland and several had negative feelings originating in the historical relationship between Britain and Ireland. A few held negative images of what it meant to be Irish in London and were then required to re-evaluate their cultural identity within a new culture which attached specific and negative meanings to being Irish. As such, Irish migrants are exposed to negative constructions from both societies and are required therefore to negotiate an identity acceptable in both places.

4.4.2 Pressure to assimilate

Studies of ethnic identity neglect the complexity of identity and tend to assume that a shift from one culture to another involves an "either /or" decision about whether or not to retain original cultural values (Woollett et al 1994). Woollett et al (1994) argue that it is possible to retain original cultural values and to adapt and adjust them in a new society. On arrival in London, interviewees were required to consider their ethnic identity for the first time and to evaluate it against deeply held assumptions about the meaning of Irishness. The prevailing ideology of assimilation in the UK forced interviewees to choose one or the other culture. For many Irish people this meant adopting coping strategies which separated the private from the public, keeping Irish culture alive in the home while attempting to assimilate or at least keep a low profile outside it.

More recently there is wider recognition that moving from one culture to another involves continuous fluid changes rather than a single cultural alteration. Berry et al (1992) suggest that acculturation is the cultural and psychological change brought about by contact with people from different cultures and behaviours and is an individual continuous process. The key informants suggest that Irish people are unwilling to mix and the intention to return home prevents them from making the effort to adjust and make the necessary acculturative change. However interview accounts highlight how women in particular do this effectively, negotiating and managing the public and private worlds. The concentration of Irish men especially in traditionally Irish sections of the labour market and in areas of Irish settlement in London impairs their ability to mix with people of different cultures. Men working outside these sectors acculturate more

effectively. Contrary to the assertions of the key informants, negative attitudes, stereotypical assumptions and overt racism in the host community are more effective in discouraging the interviewees from mixing with others than any unwillingness to mix. Additionally, pressure to remain Irish from family back home and much of the Irish community in Britain, while at the same time being viewed as English back in Ireland is a tension to be negotiated in the lives of the interviewees.

The interviewees who arrived in the 1980s are more educated, confident to mix and able to work outside traditional Irish sectors of the labour market. They are also able to acculturate in a more racially tolerant environment and latterly one very positive towards Ireland and Irishness. The effectiveness of their acculturation is demonstrated in their greater sense of belonging in London, pride in their Irish culture and contact with their own cultural group while enjoying the multicultural life of the city. Notwithstanding these positive manifestations, their accounts still relate a persistent sense of being an outsider and of having to be on guard to monitor and deal with expressions of racism. While these pressures are not unique to Irish people, their fair skin and ability to speak English afford them choices precluded from more visible minorities, but in doing so create additional conflicts. This will be addressed fully in chapter five which deals with racism and discrimination.

The interviews show that perceptions of home and belonging are dependent on a range of factors and have different meanings for individuals. Problems negotiating a sense of place relate to experiences and attitudes originating in Ireland as well as the reality of being Irish in England. These impact more on people in lower socio-economic groups, those who are less educated, in insecure employment or in poor housing. The cultural and material conditions of the place they come from, the historical and geographical context of the place they now live in and their own life histories all impact on ideas of "home". The interviewees who experienced abuse in institutions and many of the others who perceived Ireland as an oppressive society feel happier away from Ireland, though not always more at home in London. Those who have been fairly successful since

migration and who have good relationships with Ireland are conversely more content to live in London.

While the proximity of Ireland and the ease with which Irish people move back and forward is seen as a problem by the key informants, this is not borne out by the accounts of the majority of the interviewees. The data suggest that geographical and cultural closeness is beneficial in different ways for younger and older migrants. For the younger generation with skills, or professional qualifications "migration" is a time limited opportunity for personal and professional development rather than "emigration". This group in particular take advantage of cheap air travel to return home, for holidays, weekends and short breaks. It is evident that developments in travel and telecommunications make it easier for many to maintain family and social connections and to live metaphorically in two places at once.

The key informants suggested that the geographical proximity of the two islands was a major factor in the failure of some of the older generation to settle in England. The data however show, that although most interviewees feel outsiders at least some of the time, many still manage to negotiate a dual identity. The interview accounts suggest that closeness to Ireland actually helps people to maintain their identity and cope with the experience of alienation. The mobile nature of construction work plays a part in men's inability to set down roots, but the Irish culture of the construction industry protects them from the reality of racial harassment and social isolation. Going to Ireland once or twice a year is something to look forward to, and the dream of returning home eventually may help them to cope with the harshness of their lives. As also shown by Walter (2000), going home for the summer holidays with the children gave women a break and probably renewed their ability to survive the difficulties in their lives in Britain.

4.4.3. Home is where the heart is

What is evident in the interview accounts is that for the majority, Ireland is the home in their hearts, whereas England is the home in their heads. The key informants I have

called Gerry and Finola, contributed to the younger men and women key informant focus groups respectively and both spoke of how it had taken twenty years to settle in England but they now felt " home" was here. They particularly enjoyed being part of the richness of multicultural London while maintaining their Irish culture and frequent links with Ireland. They had been able to maintain their Irish identity but had adopted aspects of London identity and were able to move confidently within both cultures. I was not aware at the time that these participants were husband and wife, but considered them individually as some of the best integrated of all the participants in the study. I met them together in June 2001 and found that they were not only married but in the throes of moving back to Ireland. Gerry had been appointed to a job he had applied for opportunistically and Finola had applied for another when his application had been successful. They were taking the precaution of letting their home in London in case things did not work out in Ireland. I was unable to explore the issue with them then, but on reflection it appeared that they were returning to Ireland as reverse migrants in a spirit of opportunity afforded them by their skills and being late 30s to mid 40s in age. Their age, experience and skills allowed them opportunities not open to Irish people who were older or with fewer material resources or skills. In particular, their economic position and relative youth allowed them to retain the option of returning "home" again to London if things did not go according to plan – a choice not open to those without a home or who were unskilled, in poor health or elderly.

4.4.4 Proximity – problem or protection ?

The story of Gerry and Finola and many of the interviewees echo the findings of Buckley (1997) who argues that of all minority ethnic communities the Irish have a unique ability to have a sense of being in two places at once. The majority of interviewees appear to inhabit the two worlds simultaneously and comfortably most of the time. The return migration seen in the economic boom of the 1970s and the late 1990s is testimony to the willingness of Irish people to return to Ireland, but does not necessarily reflect an inability to settle. In contrast to the assertions of the key

informants, those who appear least settled in England have lost all contact with Ireland, through being orphans, the death of parents and older relatives or the migration of siblings. They are in poor health, but the accounts show that this relates more to their earlier lives in Ireland rather than their failure to integrate. Those who were abused in institutions have chosen to have very limited contact with Ireland and this actually helps them cope with living. While some individuals are delighted with the help and support offered by Irish community organisations and professionals, the life experience of others leads them to have low expectations and to be suspicious of all things Irish.

However for many of the interviewees and in particular the most vulnerable, contact with Ireland or failing that, with the Irish community in London is protective. The ideology of assimilation in Britain puts pressure on Irish people to make a choice about whether to be Irish. The great hardship expressed in the stories of the respondents, means little time or energy for attempts at integration into wider London society. Staying in familiar territory both geographically and culturally makes life less stressful, more predictable and generally manageable. In the face of persistent insidious conflict, staying within the safety of the Irish community is a defence mechanism against the harsh reality of the participants' lives. The belief they will one day return home is a dream with the potential to sustain them in a hostile and unpredictable environment.

5.0 Chapter Five : Racism, relative deprivation and psychosocial stress.

One of the key ideas underpinning this study is that racism plays a part in constructing the poor health profile of Irish people in Britain. The literature suggests that it occurs at several levels, from the immediate effects of harassment and hostility, to the direct effects of material deprivation, occupational segregation, poor housing and unequal access to benefits and services. However racism operates in more subtle ways by making people feel disadvantaged relative to others, therefore damaging health through psychosocial pathways. Being in a disadvantaged socio-economic position is damaging in itself, but if accompanied by feelings of anger or resentment due to unfairness and discrimination, it has the potential to accentuate health damage.

This chapter discusses the different ways in which the Irish people in the study experienced racism and considers how these impact on their ethnic identity, self-esteem and subsequently on health. It examines how the experience of being Irish in England and in particular the effects of deprivation relative to others impacts on health. The chapter explores the ways in which Irish people in London perceive themselves excluded from the health-enhancing potential of a socially cohesive community.

5.1 THE EXPERIENCE OF DISADVANTAGE

As discussed in chapter two, poverty and deprivation have a major impact on health and there is evidence from Europe and the US that people in poor socio-economic circumstances have worse health and earlier mortality than better off members of the population (Wilkinson 1996, Kunst 1997, Shaw et al 1999). It is clear from this study that many of the interviewees experience high levels of social stress and it is particularly marked for those in insecure employment or demanding, unrewarding jobs, in inappropriate housing or suffering from in poor health. According to Wilkinson (1996,1999) the absolute level of material prosperity is less important than how it compares and where it places the individual in relation to others. Unemployment, low income and inadequate housing are health problems in themselves. However wider

social meanings attributed to poverty, the symbolism of home ownership, importance of place and the value of independence are potentially damaging to the health of the interviewees.

Although not necessarily articulated as discrimination, the interviewees were concentrated in particular sectors of the labour market, housing tenure and areas of deprivation. Half of the twenty them were from skilled and unskilled manual groups and the rest from non-manual (mainly semi-professional) categories. Just under a third were owner-occupiers and the remainder lived in the social or private rented sectors. Despite half of the interviewees being from non-manual socio-economic groups, only twelve of the twenty had access to a car, suggesting that perhaps they were in the lower paid strata of those groups. This reflects the evidence of Hickman and Walter (1997) that by comparison with the white non-Irish population, Irish people have lower levels of access to a car.

However in addition to social and material disadvantage, the narratives testify to a range of extreme hardships impacting on the lives of the interviewees over several years. Five of the interviewees gave accounts of children who had disabilities, not only requiring considerable care, but requiring additional struggles to access education and health care. Two interviewees had been widowed at a young age leaving them each with five children, one woman with two disabled children and the other with one. The parents of children with disability did not on the whole perceive the difficulties they experienced with services to relate to their Irishness, but focused on the physical and emotional and financial strains involved. It is difficult to say categorically that these hardships were related to anti-Irish discrimination but problems accessing housing, benefits and services are seen as a normal part of being Irish in Britain. The data show that they impose an enormous strain on the families concerned and that difficulties are accentuated by socio-economic and housing position.

5.1.1 The employment experience

The occupational profile of the interviewees was fairly typical though not necessarily representative of the Irish community in London, with a somewhat higher proportion of people in the non-manual services sector. Four worked in skilled manual occupations, and six were from unskilled socio-economic groups. Ten belonged in non-manual categories and included two lawyers, three nurses (one retired), two in administrative/ secretarial roles, a police officer, an ambulance operative and a human resources manager. Nine of the twenty interviewees were unable to work because of ill-health and this was concentrated in the manual groups. Seven interviewees had left Ireland on completion of primary school at fourteen or fifteen. Eight had completed secondary school and three vocational education. Two were university graduates on migration. Since leaving Ireland, five interviewees had achieved qualifications in nursing, the police force and ambulance service in England. One had graduated with a law degree from an English university, another was studying for a masters in law and a third for a higher degree in human resources management, all as mature students.

The number of interviewees unable to work because of illness was higher than average for the Irish community. Chronic ill-health prevented nine of the sample participating in the labour market and five of those had worked in the unskilled sector of the economy. There was a clear relationship between occupation and health for three men unable to work because of work related degenerative disorders or occupational injuries.

In. M6. I worked as a fitter and a lorry went out of control and went straight through the garage and knocked a wall down my back and my legs. My pelvis was shattered but they denied liability and the lorry owner vanished out of sight. I never got a penny to this day.

Like those from other minority ethnic groups, labour market position exposed Irish people to occupational disorders. Anger was expressed at the dangerous working conditions to which men were exposed in the construction industry, leading to occupational injury without adequate insurance provision. Although some men

colluded with Irish subcontractors in the non-payment of insurance and income tax, a number trusted employers to make subscriptions, and were shocked to realise that they had not done so when accidents or injuries occurred. The absence of insurance left many without adequate income, and the resulting fear of having to pay arrears compounded their reluctance to claim benefits or compensation.

However the narratives suggest that in addition to occupational injury, labour market position had the potential to impact on health and health related behaviour. Men who had worked in the construction industry had been through several periods of unemployment or threatened redundancy due to economic decline. This, the interviewees believed, contributed to excessive smoking and drinking to deal with the stress involved. Three interviewees believed their mental health deteriorated when physical illness prevented them from working, leading to later problems with excessive alcohol use.

Just under a third of the sample worked in organisations such as the NHS, social services or voluntary sector which had undergone considerable change and reorganisation in the 1980s and 1990s. A woman working as a hospital domestic assistant retained her job under different terms and conditions when the cleaning contract went to an external company under a competitive tendering process.

Int. F20. .....then we were put on this new contract. Only three weeks holiday now, no sick pay and two buildings to clean instead of one. I suppose I should be grateful, I still have a job, if you can call it that.

According to Ferrie et al (1998a), job insecurity is a health hazard, with health deteriorating in the period of anticipation before any change actually occurs. Although none of the interviewees had actually been made redundant, the stress of undergoing organisational change had caused sleepless nights, relationship strain and increased use of tobacco for several.

In addition to the risk of occupational injury, the nature of work engaged in by men and women in the study generates frequent or continuous psychosocial stress. Working conditions where demands are high, rewards and control limited, exposes Irish people to psychosocial stress with the potential to impact on health in the long term. Several men had spent a lifetime in low paid, dirty or dangerous jobs with little control over their work and with little psychological rewards for their efforts. The following steel erector highlights a common situation in the construction industry where he had sustained a severe injury because pressures to meet deadlines meant short cuts were taken.

Int. M5. When you're on piece work you don't bother with all that [safety]. You never think it will happen to you and the gaffers aren't interested so long as the job gets done.

Three women were housewives and two of them combined this with childminding. Working in the home and childcare might offer some perception of control, but overload, isolation, and repetitiveness, were stressful and depressing for the interviewees. The absence of job control and low reward may not only explain poor health, but may account for the health behaviours engaged in by Irish people. The following registered nurse highlights how even those in relatively well paid and rewarding jobs are exposed to stress because of pressures of work.

Int. F15. You used to get job satisfaction. Now you don't, cos you haven't the time to do all the patients' needs. A quick wash, up and out. You know it's not right, but you do your best and hope that they don't complain. You don't go home with a feeling that you've done a good days work any more.

The interviewee narratives describe how mental health deteriorated when illness or redundancy prevented working. A number who were forced to give up work, now had further problems related to excessive alcohol use. The data suggest that the inability to work is a primary cause of mental ill-health which drinking seeks to alleviate.

Int M6. It's so hard, everything is on hold. I got so much tools inside in my room lying there doing nothing. All I do is...it upsets me to look at them cos I can't put them to use. I feel so useless, so bloody useless. That's why I drink, it blots it out.

Excessive drinking and smoking clearly plays a part in the continuing ill-health of those unable to work, and this probably reflects the importance of employment to self respect and self esteem. It has long been recognised that work affords a number of non-financial benefits which includes self-respect and the esteem of others (Warr 1987). Greenslade (1997) argues that Irish men in particular, develop a sense of self around their capacity to work and being unable to work is highly damaging to self- esteem. A number of interviewees felt forced to undertake occasional paid or charitable work, rather than live with the humiliation of being idle or dependent on benefits.

Over the last two decades it has been shown that the incidence of mortality and morbidity increases the lower down the employment scale the worker is situated (Marmot et al 1984a, Marmot et al 1997, Seigrist et al 1990). Although a number of interviewees were semi - professionals or white-collar workers, none of them were in senior positions and all had limited control over their work. The majority of interviewees had been or are still in stressful work with high demands and low job control where there is evidence of an increased the risk of cardio-vascular disease (Karasek and Theorell 1990, Hemingway and Marmot 1999). Graham (1993) highlights the link between stress and smoking as a coping mechanism. However, recent research shows that even when controlled for lifestyle factors, job control and reward are significant factors in relation to coronary artery disease (Bosma et al 1998, Seigrist et al 1997). It is easily conceivable that the position of Irish people within an occupational hierarchy plays a part in constructing the patterning of poor health.

5.1.2 The housing experience

Only six of the sample owned their own homes and the majority lived in rented housing in areas of London experiencing economic decline. Four lived in local authority housing, four were in housing associations, four in the private rented sector and of the

remaining two, one was in sheltered and the other in hostel accommodation. Ten of the interviewees were married, five described themselves as single, four were divorced and one widowed.

Interviewees who arrived in the 1950s and 1960s met their first experience of racism when seeking housing, with notices stating "No Blacks, No dogs, No Irish". A woman who left Ireland in 1958 describes an experience common to many.

Int. F15. When I came to England there was no blacks ,no dogs, no Irish. I remember well, seeing an ad for a flat in the post office. I put on an English accent on the phone. Banged the door in our faces when she heard the accent. Bloody Irish Slam!.

Although older people did not necessarily use the terms racism or discrimination, they were aware that they or other Irish people were treated unfairly in the housing market.

Int. M 6. When I came here in the early 50s you were wasting your time putting your name on a housing list. You were told you might be lucky in 25 years.

Although the interviewee believed that the situation was now better for Irish people there is evidence to the contrary which confirms that Irish people are still discriminated against in housing (Cope 2001).

Six of those in rented social housing, felt they were living in decent accommodation with local authority, housing collectives or housing associations. They had poorer health than the home-owners, but felt secure and generally able to manage their lives. Those who lived in local authority housing were reasonably happy with the quality of accommodation but not necessarily content with the repairs and maintenance. Interviewees in insecure or poor quality housing had significantly worse health and believed the limitations of space, the absence of central heating and the lack of privacy and quietness was a major factor in the genesis of their ill-health. Men and women living in hostel or communal accommodation lacked privacy and were bothered by

noise and women in particular felt exposed to sexual and racial harassment.

Int. F3. When I go to bed at night he [fellow tenant] comes in and he might be drunk and he's banging my door and shouting obscenities

Eight of the interviewees perceived they were in poor quality accommodation, at the mercy of landlords for repairs and maintenance of the property.

Int. F18. You can't get him [landlord] to do any repairs. There was this leak, the walls running with damp, six weeks we waited, phoning every day.....We had problems with upstairs, the noise like. Pat complained to the landlord and then he [tenant] came down and started to abuse us and call us dirty Irish bastards.

Macintyre et al (1999) argue a relationship between housing and health, with tenure having a symbolic meaning above and beyond the quality of accommodation. The six interviewees who were home owners, were in better health and appeared to derive ontological security from their homes despite three of them living in fairly rundown localities.

Int. F15. There's a lot of muggings round here. There's always a police helicopter over the estate, but I just switch off. I mind my own business. I have a nice home and a lot to be thankful for.

Features of the home and the area in which it is located can be health promoting or health inhibiting to both physical and mental health. While housing tenure and quality is a real issue for many interviewees, the relationship between housing and community may be more relevant. Several expressed concern about localities which had changed character becoming rundown, dilapidated and dirty. They regreted the loss of employment, shops and services that went with economic decline.

Int. M5. It's gone downhill here now. Used to be a post office, Woolworths, Boots and all those. Now its only Paki [sic] shops. All the Irish families gone. It's full of refugees now, you can't go out on your own. It's all drugs and muggings. All living on benefits, getting council flats. It wasn't like that in the old days.

5.1.3 Additional exceptional hardship

The sampling could not have predicted the experiences of severe hardship which the interviews uncovered. The high incidence of institutional and family abuse is mentioned elsewhere, and the incidence of marital or relationship breakdown was also high. Two women had undergone treatment for breast cancer and the level of physical and mental illness (which is dealt with elsewhere) is highly significant.

The incidence of disability among the children of the informants was unanticipated and is particularly high. Five interviewees, two of whom were widows, had children with severe disabilities which placed significant financial and emotional demands on them. Two children were born with hydrocephalus, one had cerebral palsy from problems during birth, one had brittle bone disease and another had a cleft palette. This woman in her 70s, was widowed at 38 when her husband, a construction worker died suddenly in the 1960s leaving her with only minimal benefits.

Int. F11. I was left a widow with five young children, two of them disabled. The subbie [subcontractor] came down and offered me 100 pounds because his cards weren't stamped and I got the lousy sum of £8 a week pension. At the time I should have been getting three times that amount.

Another woman was widowed in her mid 40s when her husband died of cancer in the mid 1990s, after a prolonged and painful illness. Their house was repossessed when they were unable to keep up the mortgage payments and they now lived in housing association property. She was left with five teenage children, one with a learning disability caused by hydrocephalus. She highlights the emotional costs which added to the financial difficulties of having a disabled child.

Int. F8. I had to find schooling for my oldest son who is disabled. The real problem was when they wanted him to go to a mainstream school. I knew they didn't have the support he needed. Now that was a real fight, but I won in the end.

The following account by the father of a clever boy born with hydrocephalus in the mid 1970s echoes the experiences of the other parents of children with disabilities. The narrative is part of a long account of having to take time away from paid work to visit hospitals, schools or outpatient appointments.

Int. M17. We always struggled in a sense. We struggled financially because of Charles, because we were spending on average (unclear) pounds a month. Additional needs, with visiting him every day in hospital, it was costing me and Bernie and this does a hole in your resources.

Only the above interviewee perceived his health problems were linked to having a child with disability. However the level of stress, the reduction in income and physical and emotional strain of caring was likely to have been damaging for all the parents concerned.

5.1.4 Relative deprivation, psychosocial stress and health

As discussed in chapter two, it is increasingly recognised that psychosocial health is affected by the significance and meaning of disadvantage relative to others in society (Wilkinson 1996, 1999, Brunner and Marmot 1999, Elstad 1998). Psychosocial health effects attributable to low social status have been found in both human and animal studies (Brunner and Marmot 1999, Shively and Clarkson 1994). The psychological literature suggests that issues of shame, inferiority, subordination and disrespect are important but unrecognised sources of recurrent anxiety resulting from status hierarchies (Wilkinson 1999). More than half the interviewees in this study were on low incomes and just under half in poor quality housing in areas of deprivation. Feelings of shame and insecurity are expressed repeatedly in the interviews and marked

in the accounts of those with lower socio-economic status and poor health. The wish to work was great, but health problems prevented several from being able to hold down a job. The following excerpt highlights the experience of a lawyer unable to work because of ill-health and therefore having to rely on benefits and social housing

Int. F10. I suppose the most difficult thing for me living here, has been going from working full time as a solicitor and having a breakdown to ending up on state benefits and in social housing. And you know that has been really difficult to come to terms with.

While material deprivation and poor housing were a problem for the majority, the feelings of shame that went with them were emphasised by the interviewees. The following account by a divorced man with a painful and longstanding occupational injury describes his shame in a voice quivering with emotion.

Int. M6. I feel so low living inside in a room. Is this all I'm worth. I'm worth nothing and like if it was only known, but I wouldn't let anybody know. I don't need to be more embarrassed at what I am, totally, totally, embarrassed. That to me is my biggest problem. Stuck there in one room. I'm so ashamed.

Two of the interviewees with chronic health problems were divorced and bringing up children as single parents. One highlights the indignity of having to ask Social Services for financial help in family emergencies in the absence of support from the father. The lack of respect and dignity afforded by statutory agencies echoes the experience of other interviewees.

Int. F13. I struggle on just myself ...I am on benefits and they treat you like dirt. If you go up to the social for an emergency loan, they do mess you around..... You don't need them to make you feel worse, but sometimes there is no choice but to ask [for financial help]

In addition to the stress of making ends meet, the indignity of being worse off in comparison with others in the population is damaging to health. The knowledge that other Irish people have done well probably reinforces the impression that the individual is to blame. A number of the interviewees were affluent earlier in life before ill-health, or misfortune befell them, so in addition to being disadvantaged relative to others, they were worse off relative to their former situation. This interviewee lost his home when unable to work following an industrial injury for which there was no compensation.

Int. M 6. I had a house paid for by 1975. Me and the missus had two cars, a holiday every year, a house back home. Now I'm living in a single room. I am so ashamed.

The decline in local areas in which Irish people lived was also a source of shame for people living in their own homes or in local authority accommodation. Sadly several of the interviewees had adopted racist discourses about minority ethnic and refugee groups and were unhappy the deterioration in their locality. They compared their own efforts to be independent and perceived newer groups were having an easier time. Although not explicitly including the Irish, dominant discourses about economic migrants and "genuine" asylum seekers had influenced the attitudes of some of the informants shaping assumptions and stereotypes of those groups. Rightly or wrongly, the belief that new groups were accessing benefits or housing stock the Irish were still struggling for, caused bitterness.

5.1.5 Comparisons with peers in Ireland.

During the interviews it became obvious that in addition to comparing themselves to others and their former selves, there was a further dimension not previously considered to any extent in the literature. It became apparent that a number of interviewees compared themselves with siblings or other family members in Ireland. The booming Celtic Tiger economy of Ireland in the 1990s had changed the wealth of many of their families. In several instances the material assets of the family at home had surpassed that of their sisters and brothers in England. A comfortably off woman echoes the

experience of a number of interviewees who for many years were more successful than their family at home, but in recent years the pattern had reversed.

Int. F15. I'm the poor relation in my own family. My brothers have done very well in Ireland. I think their lives have improved considerably as opposed to mine. Before that I thought I was doing really, really well.

This lone parent compares her own comfortable pleasant council house with the homes of her siblings in Ireland. Like other interviewees there was a mixture of pride and resentment.

Int. F13. They've got all wooden floors, en-suite bathrooms. Really beautiful. Not like my little hole here. They've had it easier than me. Without a doubt.

There was some resentment about family property which had been inherited by those who stayed at home. A married domestic worker, living in a private rented flat, without access to a car, shares an experience common to several of the interviewees.

Int. F18. Well I've only the two lads [brothers] and they have the land at home. When my father died he gave it to them and they seem to be getting on very alright. Better than we are, much better. No rent, hardly any rates and all the oul subsidies that farmers get.

Inheriting land or property and the lower cost of living meant that many in Ireland had life much easier than their siblings in Britain. A former ambulance operative, living in housing association sheltered accommodation without access to a car compares his life with that of his sister. He was particularly troubled that his wife still had to work outside the home to make ends meet.

Int. M17. Material wise, she [sister] was very successful, much better than I. They have the family house and they didn't have the responsibility I had. Jimmy had a good

job in the post office. She didn't need to work like poor Bernie [wife] did. They were able to go on holidays and do things that we couldn't.

But although only a few stated it explicitly, there was an undercurrent of resentment about the neglect of the contribution of Irish people in England to the family and national economy.

Int. F1. Sure they wouldn't have had clothes on their back or shoes on their feet if we hadn't sent a few bob religiously every week. Some of mine have very short memories about who kept them in shoes and clothes.

Although the experience of being Irish in London had its own stresses, it was possible that being able to support the family at home and appear successful relative to them had given confidence and a measure of esteem. However when the situation changed and the family in Ireland became more affluent, it encouraged migrants to consider the futility of their efforts in England. Indeed while the majority seemed proud of the success of the Irish economy, the failure to acknowledge the individual or collective contribution of migrants generated feelings of disillusionment especially among older interviewees.

5.2 THE EXPERIENCE OF RACISM

While relative deprivation was a factor generating psychosocial stress, the Irish in London were exposed to another stressor in the form of racism. This had the capacity to operate in different ways, generating anger and resentment, impacting on self- esteem and influencing health behaviour. Several interviewees claimed never to have experienced racism, but went on in the course of the interview to highlight different episodes which made them feel uncomfortable, angry or humiliated because of being Irish.

About a quarter of the interviewees recognised the institutional racism which concentrated Irish people in the lower paid and less desirable parts of the labour market. However most appeared not to question what they perceived as traditional employment

for Irish people and some even believed that working in traditional Irish sectors protected them from discrimination. A small number of interviewees felt they had been protected from racism by working in the construction industry or were less vulnerable because they had skills in short supply.

Int. M5. Well its not the same with the buildings, cos they are all Irish anyway. No I think I was lucky in that respect. I never had any problems getting work even in English firms.

This lack of insight may reflect the tendency of popular discourses about racism and discrimination to refer to black people, and that to acknowledge such experiences is to identify with a group normally viewed in a negative light. Several interviewees believed that at least some of their experiences with statutory agencies, related to incompetence or to discrimination on the grounds of gender, class, age or disability rather than ethnicity. It was also possible that not thinking about discrimination or attempting to tackle it may well have been a coping strategy which was less stressful for the individual.

Although the language and concepts used by the key informants and interviewees differed according to age, educational status and political consciousness, there was consensus about the reality of racism. Older participants tended to describe incidents of direct racism but without necessarily using the terminology of discrimination. The following interviewee highlights how discrimination had changed since she was recruited to nurse training in 1950.

Int. F11. When we first came here it was after the war.... "Paddy didn't join the war, Paddy went home, they were sat on the buffers". Then time moved on and the troubles in Northern Ireland. We were all tarred with the same brush, we were all IRA. It still happens, it's just different things at different times.

Younger people and in particular those who were educated or professionally qualified used discourses of oppression to describe their perceptions and experiences in both

personal and professional capacities. They were conscious of ways in which the Irish community in Britain were racialised and acknowledged problems caused by conceptualisations of ethnicity based on skin colour. They were comfortable to draw upon the similarity of their own experiences to those of Black and Asian people.

Int. F20. Asian women would find that they are immediately defined by the colour of their skin…… I think Irish people can be confused that some times they are invisible and more times they are visible. They can be picked up in the street and they are very visible…… yet they are supposed to be the same.

They highlighted feeling uncomfortable when expected as a white person to engage in racism against others, while within themselves knowing that they too were outsiders.

Int. F10. ……the office chit chat about the refugees and the welfare scroungers. The "why don't they go back where they came from" brigade. You are expected to go along with all that crap, but you're never sure if they are having a pop at you as well.

Although most had not experienced the direct racism of the older generation, they were conscious of a more subtle type and described a range of stereotypical and exclusionary practices. Women in particular described a feeling within themselves of being an outsider, never being quite the same as a British person and always having to prove themselves.

Int. F10. I suppose I was trying to give the example that you are never, never in the same position as the indigenous person. Whatever it is. It's not always negative but it seems like …the other…yeah that's it, the other.

The differing feelings as to whether Irish people still experienced racism probably reflects changes in how racism has been expressed since the race relations legislation of the 1970s. The narratives testify that 1950s racism was more overt and Irish people

were directly targeted, but more recently it is likely to be indirect, subtle or institutionalised through the operation of stereotypes.

5.2.1 The subtlety of anti-Irish racism

The narratives suggest that the way in which anti-Irish racism was expressed made it difficult for some interviewees to be sure if they were being racially abused. If racism was direct and explicit, it angered people. However it was often unsaid, generalised, not directed specifically at the individual and occasionally even claimed to exclude them. The following narrative by a woman typifies the experiences of other interviewees.

Int. F8. There was bigotry about Irish people. Irish people swept the dirt up the walls and left it for six months and they left old cars in the back yard. And they were culturally and educationally subnormal. They were only good for holding up the bar and that was very prevalent. But that was never said, they were much too polite for that. It was always other people, never you.

When racist jibes were cloaked as fun or a joke it was equally difficult to rebut them. A retired refuse operative describes a scenario common to many Irish people.

Int. M19. When I worked on the dust [refuse department], the council, say you went in with a bag, " there's not a bomb in that bag is there ?" they'd say . All these oul dry jokes and that. They wear you down, they do.

A number of people of all ages described a sense of uncertainty about whether they were being treated in a racist manner. Interviewees did not enjoy the jokes, and felt uncomfortable with innuendo or collective generalisations of Irish people.

Int. F8. Well nobody exactly called me a stupid Irish Biddy, but more like "what do you expect, you're Irish" and " all the Irish are mad " or "the Irish are lovely people but.....".

However many of the interviewees expressed anxiety about responding to things said supposedly in jest or not directed at them specifically. This was particularly difficult around paramilitary activity in Ireland or in the UK. The impact of the "troubles" in Northern Ireland will be dealt with later in the chapter, but the following narrative is one of several which describes the confusion and uncertainty experienced by Irish people at work or in social gatherings. A domestic assistant in an educational establishment recounts her experiences at work when there was paramilitary activity in the UK.

Int. F18. I would have been there 21 years in February and I was the only Irish among 22 staff, the office crowd and the teachers and all that. And if any trouble was in Ireland you know you'd always get that funny feeling. They never said it outright. " Only joking" or they often said like " sure you don't know who you are living next door to". I said " surely to God you don't feel like that with me" and they said " well you don't know". You're never quite sure if they are having a go at you. I used to say to Paul [husband] " oh I wish they would stop bombing over here cos we never live it down". They never let us live it down. It'd be talked at coffee break. It'd be talked at lunch, at teatime .....all day, everyday.

In particular a number of participants recounted the overt nature of stereotyping especially around alcohol consumption, which was particularly prevalent in the media and in the NHS. Racism in the health care system is dealt with in chapter seven, but the following account describes one of the most common forms of racism against Irish people in a range of settings.

Int. M17. One of the first questions the doctor is likely to ask is " do you drink" and if you admit to taking a drop at all, it's automatically assumed that you are an alcoholic.

5.2.2 The significance of an Irish accent

Although the fair skin of the informants might have rendered them invisible protecting them from the racism experienced by Black minorities, there was ample evidence that they were far from inaudible. One of the most forceful themes in the data is the

problem experienced by interviewees because of their Irish accent. Recognition of an Irish accent evoked a change of attitude and behaviour in other people and often invoked outright abuse for interviewees.

Int. F16. I remember people with strong Irish accents telling me how they have been afraid to open their mouths, going to work on the bus, when there was any trouble.

It was annoying and offensive to be asked to repeat things several times or to have pronunciation or grammar corrected or laughed at. The following is part of a lengthy narrative by man working in a voluntary sector organisation where he catalogued the double standards of those claiming to adhere to the principles of anti-discriminatory practice.

Int. M 9. She's [a colleague] a person who goes on about equality and racism and all this crap and she tries to make me feel about two inches tall by keep repeating and saying to me every day of the week " I can't understand your accent"

The interviewee accounts testify to humiliating experiences relating to the Irish accent or use of English. The following narrative describes her own experience and that of a neighbour who was a native Irish speaker whose second language was English.

Int. F11. Even with the English doctors, when you say something the way we do, they correct you and make you feel very, very little. My neighbour .....I said to her "go to the Citizens Advice Bureau". She said "I can't go there, they laugh at me there because of the way I speak". They laughed at her, they actually laughed at her, up at the Kentish Town CAB because of her pronunciation and the way she was saying things.

The following narrative is typical of the way in which some interviewees felt under pressure to change their accent in order to get housing, to be considered for jobs or just to avoid harassment associated with IRA activity.

Int. M2. There were times when I first came here, I had a much stronger accent then, I remember being accused of playing my accent down. And I think that was right, I was doing that. I didn't think I'd get a particularly good job if I had a strong Irish accent.

Only the younger interviewees saw problems associated with an Irish accent as a form of racism as testified by this worker employed in a mainstream voluntary sector mental health organisation.

Int. M9. And the thing about it Mary, is it doesn't get any better. I have it here. For instance if I'm trying to get somebody referred and I ring up and I get " sorry Tim I can't understand you". And you get all sorts of nationalities working here and it's politically correct. The Benefits Agency have Asians, Somalis and all these people working there and it's right that they are. But the problem is that I'm Irish and somebody else is Somali and we don't speak the same language. The needs of the Irish are not even considered and that's racism in my book.

5.2.3 Response to racist comments or stereotyping

Racist experiences annoyed people, but the accounts of the interviewees suggest they evoked little anger. This may relate to the fact that some of the informants were not sure whether they were being targeted and if they were, how best to respond. They may not have wanted to recount outbursts of verbal or physical aggression, or they may actually have avoided them for fear of reinforcing another common stereotype. Instead they appeared to have adopted non-confrontational ways of coping by trivialising the problem. Men were more likely to challenge their counterparts than women were and this may reflect a macho expectation that men will not be slighted.

Int. M6. If I was in bad form like and they were to address me as Paddy I would take offence. I would say I was born with a name and why should I answer to that name. That's the only thing, if I was in really bad form I would take offence.

The following interviewee was typical of many women who coped with racist comments by not taking them too seriously, trivialising their importance or by rationalising that not responding was the best way of dealing with them.

Int. F1. At first I used to be upset but then I thought well sod it if you don't want to talk to me I'll get on with me own life and that was it. There were more important things to worry about.

However a number of interviewees felt the need to adopt other strategies to enable them to get by. This is similar to the concept of "passing for white" in literature on Black people in the USA. The colour of their skin was not a problem for Irish people, but like Black people the participants felt the need to give up aspects of their identity in order to achieve success or to just lead a peaceful life. One man called Patrick described the difficulties he experienced because of his name.

" I was the butt of jokes anyway and being called Patrick, people automatically associated that with being thick. And I'm not sure how much truth it was [laughs], but when people said it, the inference was that I was thick and therefore I had to prove myself more than other people"

This according to the following informant was a source of persistent and continuing stress for all migrants.

Int. F8. And over here, there is this other dimension always around, stress really, because no matter what institution you go to, there is that extra little something that you have to take on board. That you know, where you are a citizen from another country, a second class citizen or whatever. One becomes aware over a number of years that there is a stress, an additional stress to being here as an immigrant

While Irish people were exposed to specific types of anti-Irish racism there was an additional source of tension when other groups of immigrants or refugees were being

targeted. Being "invisible" they were often assumed to be English and as such expected to hold prevailing negative views about "outsiders". Although some interviewees were clearly influenced by dominant racist discourses, a number felt very uncomfortable about the negative high media profile about immigration, asylum and refugees.

Int. F10. It's how they are with other cultures…… you know the racism that always has been there …it makes you feel very, very strange……You are often expected to get involved in the sort of "paki-bashing" because you are white and they expect because you look the same as the indigenous population that you resent the outsider as well.

Although directed at other groups or individuals, identification with the experience of other minority ethnic people placed them in a situation of conflict. They could have challenged and risked being ostracised or they could have kept quiet and risked feeling bad about themselves.

5.2.4 Police harassment

The police came in for particular criticism from the informants for their harassment of Irish people in general. The key informant below described a situation from the 1950s, but the participants argued that similar targeting still happened almost 50 years later.

KIOP (Seán) I saw eight Black Marias outside the Galty [dancehall] of a Saturday night in the 1950s and everything perfectly normal in there, just waiting there to get people and if they didn't come out fighting the police put them fighting.

People who were homeless or with mental health problems were particularly susceptible to harassment because of their high visibility in the streets. Although the following interviewee described the experience of street-homelessness due to mental illness in mid 1980s, the police response was similar to that of other interviewees who came in contact with them.

Int. M9. I went into to Bow St Police Station, I was looking for directions and I ended up in a police cell and brought to court the next day ..... in my experience of police officers when they recognise you are Irish, they get stroppy, you get lifted...when you open your mouth they will provoke you, they will try and provoke you in a certain way and you'll get aggressive back and they'll arrest you ...treat you like the criminal fraternity, being arrested for vagrancy, being a tramp and subject to all kinds of abuse, comments like " is this all the Irish do, drunk all the time and living off the state, living off us" and all this kind of crap.

The following " insider" account by a former police officer is resonant of the " canteen culture" aspect of institutional racism identified by the inquiry by Lord Macpherson of Cluny, into in the way in which the Metropolitan Police handled the death of the black youth Stephen Lawrence (Macpherson 1999)

Int. M12. I must have a good sense of humour because when I went into the police force they took the mickey out of me cos I was Irish. When I went to Cxxxxx to work they took the mickey out of me cos I was Irish, then when I went to Hxxxxxx they took the mickey out of me again because I was Irish.

5.2.5 The Prevention of Terrorism Act 1974.

Although the data collection took place during the calm of the peace process in 2000, it was clear that the problems in Northern Ireland had exposed participants to increased police harassment when there was any paramilitary activity in the UK. The informants were acutely aware of the Prevention of Terrorism Act being used to justify the criminalisation of a whole community. A number had been stopped, searched or had been detained at ports and airports and others had family members who had experienced the same

Int. F10. I was coming through Dover when the Brighton bomb had just gone off, so I was questioned under the PTA and have been questioned a few times under the PTA.

As well as police harassment, the interviewees had all been made feel uncomfortable and some actually subjected to direct hostility during periods of paramilitary activity. This woman describes her experience in London in the 1970s.

Int. F11. I remember being in the gardens at the back of my house. I was in there the time of the Hyde Park bombing. I had my children with me. And I was ordered out of the gardens. And I didn't know it had happened. I knew nothing about it.

Interviewees recounted how their children were ostracised at school and the experiences of friends and family. The following account by a nurse describes her own experience at work and that of her friend who lived in Enfield in the early 1970s.

Int. F15. I had it with patients. I remember going on to the orthopaedic ward; the Irish and the bombs " ye're all the same". Especially the time of Ross Mc Whirter. That was very local. You know Vera Nolan [friend] ...she had to move out of Enfield because they got so much hassle.

The narratives demonstrate how the whole Irish community was racialised and forced merely because of their Irishness to feel guilty by association. This human rights lawyer highlights the difficulty experienced by the average Irish person who abhorred the bombings, but was reluctant to incur any further harassment by challenging stereotypical accusations.

Int. F10. It's difficult to tackle them when you take on that sort of collective guilt. You can't afford to stick your neck out for fear of the backlash against you.

The single most significant factor in the generation of psychosocial stress for all the interviewees was the lack of trust and security relating to the paramilitary activity in England and in particular the impact of the Prevention of Terrorism Act. Although the interviews took place following the Good Friday Agreement, the memories were vivid and painful for many and all welcomed the cessation of paramilitary activity. Having an Irish

accent exposed all the participants to harassment or outright abuse when bombs exploded or even during bomb scares. The narratives described how every Irish person became a potential target for the public, the media and the police. This impacted on all aspects of their lives and the lives of their families and at times hostility was overt and brutal, and at others it was subtle and insidious. A small number of participants cited examples of their own or vicarious experiences of stop and search or being detained, and their reluctance to challenge hostility for fear of ostracised or worse still, being associated with terrorism.

5.3. THE RELATIONSHIP BETWEEN RACISM, RELATIVE DEPRIVATION AND HEALTH.

The data demonstrate similarities to other groups in London, but there are specific factors differentiating the experience of Irish people which have the potential to impact on health. The purposive sampling elicited interviewees with different socio-economic, income and housing profiles. However it did not anticipate the level of difficulty experienced by the all the interviewees and particularly by people who appeared to be getting on with their lives contentedly and reasonably successfully. The sample could not have predicted the extent of hardship, personal and family ill health and misfortune which emerged from the study. In addition to social and material disadvantage, the narratives testify to a range of extreme adversities impacting on the lives of interviewees over several years.

5.3.1 The specificity of anti-Irish racism

Although direct racism is exclusionary, the specific nature of anti-Irish racism not only excludes people but leads them to exclude themselves from wider society. Being fair skinned and English speaking, Irish people are exposed to overt prejudice and institutional racism long past the introduction of Race Relations legislation. Skin colour is not an immediate identifier of difference for Irish people, but like Black people they have to give up aspects of their identity in order to achieve success or to lead a peaceful life. They have choices which Black groups do not have and unless racism is explicitly directed at them they do not necessarily have to reveal their minority ethnic status. Interviewees admitted to keeping quiet, sometimes changing their accent and occasionally going along

with anti- Irish banter rather than challenging stereotypes and jokes. The choice of challenging racist remarks or conversely colluding with them is an additional source of psychosocial stress which might damage health over time.

While most of the time interviewees were "invisible" they were rarely inaudible and invariably evoked negative responses because of their Irish accent. A few women maintained what Morgan (1997) refers to a "double silence" where they not only avoided speaking, but censored themselves by not speaking about Irish issues outside the safety of an Irish environment. Several interviewees described situations where the racism was so subtle they were unsure whether or how to respond. At an individual level the cost of changing an Irish accent, constantly having to negotiate an appropriate response to jokes or distancing from certain expressions of Irishness could have been high. These actions resonate with the concept of "passing for white" in literature on Black people in the USA (Fordham 1988). Ang –Lydgate (1999) argues that assimilation on the basis of passing as something one is not, is psychically costly and exhausting. It depends on constant negotiation and is only ever only partially successful (Ullah 1985). It is evident from the data that despite the apparent similarity to the host community, all the informants were immediately identified by their accent which meant they were therefore consciously on guard. Such tension was no more than a nuisance for some but was a major cause of stress for the majority.

5.3.2 Self-esteem, respect, trust and psychosocial stress

Self-esteem is increasingly seen as an important dimension in quality of life, coping with illness and in particular with positive health behaviour (Sarafino 1990, Marsh and MacKay 1994). It is partly generated by the difference between self-image and the ideal self, which is the kind of person an individual would like to be and the greater the gap between self-image and the ideal self, the lower self-esteem will be (Gross 1996). The interviewee accounts identify many threats to self-esteem to which they had been exposed since arrival in London and over several years since. The potential for long-term illness and especially mental illness to damage self-esteem are well recognised in the general population (Radley 1993, 1994, Williams 1993a). Abuses in the family or in institutions

clearly damaged the esteem of those who had fled to England to escape, but interviewees without any history of abuse were also exposed to factors damaging to self-esteem. Greenslade (1997) argues that being unable to work because of ill-health is a particularly salient challenge for Irish people since their identity in Britain is closely related to ability to work. The inability to make ends meet or provide adequately for the family and subsequently having to rely on state benefits were major threats to esteem for about a quarter of the interviewees. In addition, having a low or seriously reduced income had the capacity to exclude people from activities engaged in by others thus depriving them of sources of affirmation and support.

5.3.3 The impact of relative deprivation

The narratives highlight a number of factors contributing to feelings of shame or inadequacy relative to others in society. Failing to live up to their own or family expectations and acquire a decent job and a sustainable income are potential sources of shame for about half the interviewees. Reliance on benefits through age, illness, unemployment or low income are all damaging in a society where youth, health, work and personal responsibility are highly valued. Homeownership, decent accommodation and a nice area to live in are all sources of pride and affirmation, but are precluded from a significant number of the interviewees.

Even the narratives of those in fairly satisfactory circumstances, highlight the persistence and insidiousness of structural processes causing psychosocial stress. Feelings of inferiority are not limited to interviewees who are disadvantaged, but those who are comfortable and successful are generally better able to articulate and rationalise them. Negative stereotypes of Irish people in Britain influence the willingness of successful interviewees to identify with aspects of being Irish. The accounts demonstrate how interviewees felt driven to take action at times to detach themselves from the Irish community or play down aspects of their identity. Although this group are much less exposed and have better support systems than their less advantaged peers, the capacity to evoke negative emotions is still considerable. In addition a number of interviewees recount feelings of inferiority in relation to those who did not leave Ireland, and the data

suggest that negative comparisons with the recent success of their peers in Ireland may afford a further dimension of psychosocial stress.

5.3.4 Social cohesion

There is increasing evidence that societies with high levels of social cohesion have better health than those with lower levels (Wilkinson 1996, 1999, Stansfeld 1999). Social cohesion is the existence of mutual trust and respect between different sections of the society and contributes to health. It relies on people being accorded dignity and respect and is related to the level of social inequalities. Societies with smaller inequalities are associated with greater trust, more security, better social support, self-esteem and a greater sense of belonging (Wilkinson 1996, 1999, Elstad 1998). There is evidence of increasing inequality in Britain (Wilkinson 1999) and it is inevitable that this impacts on Irish people who are concentrated at the lower end of the socio-economic scale. The data demonstrate a number of threats to social cohesion experienced by the interviewees. Institutionalised forms of anti-Irish racism and direct discrimination by police and other professionals all impact on trust. Personal or vicarious experiences of police harassment, miscarriages of justice, hostility associated with paramilitary activity deny Irish people in London the health enhancing benefits of a socially cohesive society. Racial harassment, anxiety about crime, and the deterioration in local neighbourhoods lead interviewees to feel insecure. Humiliation frustration, anger and powerlessness ensue from encounters with statutory services. The data show that these experiences encourage some interviewees to keep their heads down and to distance themselves from the wider community or from seeking help to which they have a right.

Greater inequalities in status, power and material wealth produce fear, anger, hostility, insecurity and other negative emotions which impact on health (Kawachi and Kennedy 1999a). Although the data show differences between interviewees, there is a consistent theme of feeling excluded and being marginalized across the narratives. Some exclusionary processes are highly overt, while others are subtle and insidious, but invariably lead people to take measures to exclude themselves. Unemployment, insecure employment, low income, poor housing or living in areas marked by decline exclude a

number of the interviewees from full participation in society. Poor physical or mental health, high levels of disability and the absence of social networks serve to exclude others in a similar way to that of other minority and minority ethnic groups. While any single factor might be detrimental in the long term, it is clear from the interviewee accounts that cumulatively they serve to exclude Irish people and impact on their ability to live in the healthy environment of a socially cohesive society.

5.3.5 Relative deprivation and the Celtic Tiger

A number of general and specific factors about life in London create stress and have the capacity to impact on health. However the data demonstrate a specifically Irish dimension influencing the informants' self-evaluation of their social status. In addition to comparisons with the host community, the majority of interviewees describe their status relative to siblings and peers who had never left Ireland. By comparison they describe themselves as generally less affluent, in smaller houses with fewer amenities and driving less prestigious cars. These differences emerged with the expansion of the Irish economy in the 1990s and reversed the situation, leaving Irish people in England materially worse off than those at home. Although success is attributed to the Celtic Tiger economy, it is clear that older participants sent remittances home to support younger family members often leaving them with few resources in old age. While younger informants are less likely to have sent money home, they believe they contributed to the family economy by becoming independent. There is a perception that wealth has come easier in Ireland than in England. Although several are proud and happy for those at home, other accounts are resentful, and a number feel angry and rejected about being excluded from the division of family land and property. There is anger among the older generation that their remittances are not acknowledged, and that many older people are living in extreme deprivation here, but with no rights to housing or community care should they wish to return to Ireland. The absence of a family home to visit and the perception that the interviewees or their children are not Irish is a source of grief which leaves a number with a feeling of also being excluded in their native land.

5.3.6 Racism, socio-economic status and health

There is an increasing body of human and animal research on psychosocial health which demonstrates the relationship between social organization, biological factors and health (Hemingway and Marmot 1999, Brunner and Marmot 2000, Sapolsky 1983). Whilst these studies are not without their critics, they provide evidence of a number of psycho-neuro-endocrine pathways through which social stress acts on different organs of the body enabling them to adapt in the short term. If activated too frequently or for too long these mechanisms can result in increased susceptibility to infection, heart disease, diabetes, stroke and other disorders. These health problems increase progressively down the social strata and may explain much of the premature mortality and morbidity of Irish people in England.

It is evident that poor health cannot be explained by any single factor and the data point to a complex interaction of a number of factors operating separately and cumulatively. Socio-economic inequalities clearly play a part but they cannot be separated from the way in which social divisions are constructed by racism. Being poor or disadvantaged is important, but the effects of these are augmented by feelings of inferiority associated with being an outsider, being out of work, on benefits or having a disability. The accounts of the interviewees highlight many factors predisposing to persistent or recurrent stress potentially contributing to poor health or exacerbating existing problems.

6.0 Chapter Six : Health, health beliefs and behaviour

This chapter begins by discussing the interviewees' self-reports of health and illness. It considers definitions of health and explanations of illness offered by the key informants and focus group respondents before comparing them with those of the individual interviewees. Explanations for illness are examined, looking at aspects of biography which shaped interviewees' ideas of health and illness. The chapter then addresses health- related behaviour considering in particular smoking and alcohol consumption and comparing this with existing data. It discusses the relationship between health behaviour and the social circumstances, and personal biographies of the interviewees and considers factors within the Irish community in Britain which perpetuate health damaging behaviours.

6.1 HEALTH STATUS

The interviewees were selected to provide a cross section of Irish people in London. The sample includes men and women, people in different age groups, socio-economic status, housing tenure and those with and without health problems. The aim is not to be statistically representative, but to reflect the diversity of the Irish community in London.

6.1.1 Health profile of the interviewees

Interviewees were asked to describe themselves on a four point scale of very healthy, reasonably healthy, not very healthy or definitely ill. Of the twenty interviewees, only two defined themselves as " very healthy". One was a young woman who experienced depressive episodes, but at the time of interview was well. The other was a man with paralysis of the lower body requiring a colostomy and permanent catheter in his bladder to facilitate elimination of faeces and urine respectively. His only medication was antispasmodic drugs and although his mobility was severely limited, he looked and sounded the picture of good health.

Thirteen interviewees reported themselves as " reasonably healthy". Only five were not receiving treatment from a doctor or complementary practitioner. Although recognizing that it is possible to be healthy in the presence of disease, it was evident that some of interviewees were being treated for serious illness while still classifying

themselves as "reasonably healthy". One woman in her late 30s had multiple health problems including severe cardiac arrhythmias, but still claimed to be in reasonable health. She had been operated for bilateral cataracts and was now losing her sight due to macular degeneration. She had persistent respiratory problems following pneumonia the previous year and was awaiting further investigation with a view to lung surgery. Despite this she looked well, was cheerful and managed a reasonably active lifestyle as a childminder. Two women in their early sixties were taking the breast cancer drug Tamoxifen having had surgical removal of a breast lump and radiotherapy for cancer in the previous five years. Both were working part-time and although one was awaiting the result of a biopsy of a recurrent mass at the time of interview, both were optimistic about their health. Another woman in her late 30s was on heavy medication for depression having had a mental breakdown two years previously and was waiting for cognitive behavioural therapy. The other interviewees describing themselves as reasonably healthy were having treatment or on-going monitoring for a range of chronic conditions including coeliac disease, myxoedema, unspecified liver disorder and musculo- skeletal problems.

One man in his early 60s who described himself as " not very healthy" was taking medication for hypertension, heart failure, vertigo and arthritis. He had been forced by ill-health to retire from work three years previously and had recently moved to sheltered accommodation with disability access because of difficulty with steps and stairs.

The five interviewees (three men and two women) who identified as " definitely ill" ranged in age from 32 to 65 and all had multiple health problems. Four of the five suffered from depression and three were on medication. One of them, a woman just turned 50 suffered extreme mental illness for several years and although now psychologically better, she was unable to work due to rheumatoid arthritis. Two others used the counselling services of an Irish voluntary organisation. The oldest interviewee in poor health was in his late 60s, had undergone gastric surgery previously and now suspected he had a recurrence of tuberculosis. He was not on treatment but came to an Irish organisation for lunch, and used no particular support service. Two men in their early 50s and 60s had occupational injuries which left them with severe chronic pain

and unable to work at their skilled trades, resulting in depression. The youngest of all interviewees was a woman whose severe heart problems prevented her from working and required a number of drugs and frequent hospital appointments.

The level of mental ill-health in the sample was high. The interviewees clearly articulated the difference between feeling low and suffering from clinical depression. Twelve of the twenty at some point experienced mental health problems which required treatment. They ranged from mild depression following bereavement to severe enduring mental illness and alcohol related disorders. Treatment varied but included counselling, psychotherapy, drug treatment and hospital admission. During the interviews, six interviewees from the "reasonably healthy and definitely ill" categories revealed that they had attempted to take their own lives at least once.

In selecting the sample it was known that four people had specific health problems and anticipated that up to six others might have physical or mental illnesses but the exact nature or extent of ill-health was not known prior to the interviews. The incidence of illness and its severity among all the interviewees and across the range of age, socio-economic status and occupational history was shocking. The age profile of the sample did not immediately suggest a high level of illness and some of the poorest health was in younger informants. Those who defined themselves as healthy or in reasonable health despite the presence of illness reflect the reality that both can co-exist. The data however question the self-reported health measures. Without doubt, a number of the interviewees appeared to be relatively unaffected by their illness and had learned how to cope with it, so that leading a normal life was not only possible but therapeutic. However for those with more severe illness, the self-definition of "reasonably healthy" may have reflected the absence of any choice other than to get on with their lives. It masked the major adjustment, adaptation and accommodation which interviewees required to enable them maintain an acceptable level of activity.

6.2 HEALTH BELIEFS

The key informants, focus group respondents and interviewees showed remarkably high levels of knowledge about health and illness, embodying contemporary popular and medical discourses in their descriptions and explanations. Participants used a number of different concepts, often using them simultaneously or inconsistently when talking about health. Both the focus groups and the interviews highlighted inconsistencies, incongruities, shifting ideas and explanations reported in the wider health beliefs literature. (Blaxter 1990, Stainton-Rogers 1991, Furnham 1994).

6.2.1 Defining health – the key informant perspective

Ideas of health differed between older and younger participants but this was a feature of educational level and socio-economic status rather than age. Older groups and both men and women were mostly from manual occupations and saw health more in terms of functional ability and the absence of disease. This mirrored definitions of working class people described in the general health beliefs literature (Calnan 1987, Cornwell 1984, and Blaxter 1983). Younger people and those who were educated or middle class were more likely to use a wider conception of health which included psychological and emotional health and general well-being, consistent with work of Pierret (1988) and d' Houtard and Field (1984).

Definitions of health reflected wider social norms about the maintenance of health, the prevention of illness and the adoption of sick roles (Radley 1994). There was a strong moral tone about not giving into illness among older key informant and focus groups. Younger key informants were more likely to accept that they were ill, but challenged the ways in which they were socialised to think of their bodies and of illness in general. They were generally more educated and more articulate than the older informants. Some were qualified or experienced welfare professionals and a number had been in therapy or counselling and saw health and illness from those perspectives. The following excerpt echoes the expressions of the younger key informants.

KIYW (Catherine) There was a lot of offering it up, putting up with it, and ideas that you lacked moral fibre if you gave in to it [illness].

This, they argued, reflected religious upbringing and in particular, an ascetic tradition in Irish Christianity which scorned concern for the body in the hope of eternal salvation. It impacted on health in a number of ways, but primarily by encouraging people to tolerate pain and suffering unquestioningly, discouraging any concern for self.

KIYM (Sean) If you were from a Catholic or Protestant upbringing, the emphasis was very much on putting up with things, on suffering them and not complaining, and having low expectations of life and putting up with pain and suffering and offering it up to God.

Older focus group participants and key informants focussed on physical health but recognised the importance of psychological health. Younger participants showed more concern with psychological distress with both men and women like the following social worker speaking freely about their own mental health.

KIYW (Mona) I drank quite a lot, self harmed quite a bit. I was quite suicidal for a while and then, I suppose the big step was when I got counselling psychotherapy. That was quite significant.

A complementary view of health, integrating physical and mental dimensions is more common in those with higher socio-economic status (Chamberlain 1997). It may also reflect the age of the group who had less reason to be concerned about physical health, but were more concerned with the everyday stresses of relationships, childcare and work pressures.

6.2.2 Interviewee definitions of health

The interviewee definitions of health incorporated attitudes, behaviours and actions around being healthy and preventing illness and were broadly in keeping with conceptualisations used by the key informants and focus group members. They generally recognised the co-existence health and disease but the majority tended to define health primarily in terms of their ability to function in their everyday lives. Of the two interviewees who described themselves as healthy, one had a range of problems following a road traffic accident

requiring some medication but a high level of self-care and community care support. However suitably adapted housing, specialised mobility support and community care services allowed this former police officer to lead an independent life as a lone parent with three children in their teens. His personal definition of health was not particularly functional and included a sense of psychological well-being, the reserve to cope with the stresses of life and being able to enjoy things like music, reading and holidays.

Int. M 12. I just consider myself as a creaky gate or a car that's not necessarily going to get through every MOT, but I got through the last one and with a bit of care and attention I'll get through the next one.....It's about control, not in the physical sense .....I'm very much aware of what is happening to my body on a daily basis.

The other "healthy" interviewee was a young woman who experienced severe bouts of depression but now felt positive about life, enjoying a new relationship and a new career pathway which would be fulfilling. While these interviewees did not confine their ideas of health to everyday function, their sense of psychosocial well-being depended on the ability to lead active and fulfilling lives.

Of the thirteen describing themselves as reasonably healthy, about half had minor aches and pains which they treated themselves, with advice or treatment from GPs or alternative practitioners. However several in this category had quite severe health problems which did not necessarily stop them leading relatively full lives, but required medication and monitoring by their own doctor or specialists. Two women who had experienced breast cancer were on Tamoxifen, a drug with uncomfortable side effects. They were regularly checked at the hospital but both had experienced scares about recurrent cancer. They led full lives and worked part time in addition to caring for the home. Both believed their cancer was "just one of those things" and felt fortunate to have been diagnosed and treated early. They articulated the power of positive thinking in helping them recover and in preventing recurrences. Despite a resigned acceptance of their misfortune in getting cancer, they adapted their lives and took measures to avoid or manage lifestyle.

Int. F15. I did think about it all the time at first, but you live it through. You have to be positive and optimistic……..I go to bed early now. I eat very good diet. You wouldn't catch me smoking now and I drink very little.

Two interviewees had mental health problems which were under control at the time of interview. Both believed their illness was due to external factors, but that personal resources were the primary ways of dealing with it. One was on heavy medication and awaiting psychological therapy which she had insisted on. The other had given up medication and stopped hospital appointments three years earlier as he believed they were harming rather than helping him. In a long narrative he identified how culturally sensitive nurses helped him realise his own abilities and perceived that recovery came from within his own resources. His experience is not dissimilar from that of the other interviewee who had not yet reached this point.

Int. M 9. I often say that the doctors and the psychiatrists kept me alive long enough to do something with myself ……..the emphasis of psychiatry is dealing with the consequences not the cause of mental illness……..I would either get angry and wreck the place or I would get depressed. So with the help of the right people I learned about myself and about what was wrong with me.

Both recognised they had not been cured, but that they were in control of their illness, independent, positive and managing. They perceived they could cope with most things in life. They described a sense of achievement in having overcome the effects of childhood abuse and surviving the mental health system. While mental illness and its social and economic effects were painful and prolonged, both felt they had grown personally through illness.

Int. F10. It's a strange thing to say, but parts of this have been good for me, made me a stronger person. I feel very positive about things now and I do see a future. Its only a few months since I saw nothing, no future everything was black, my confidence was zilch…….. I'm not ready to practice yet, but I've been doing voluntary work. I'd like to get into academia ……..I have my hopes and my dreams now. It's what keeps me moving on.

One woman in her late 30s had a range of severe health problems requiring different types of medication and monitoring by hospital specialists and her GP. She could no longer work as a hairdresser being unable stand for long periods, and now cared for children in her own home. Another woman in her 70s had a range of health problems managed by drugs and diet and monitored by her own doctor and a hospital consultant. Both women led active lives within the limits of their illness by adapting and adjusting their lifestyles. It was also possible that the reality of their lives meant they were forced to carry on and that denial was an actual coping strategy for them. Their definitions of health may well relate to their ability to function, but as indicated in the narrative of the older woman, it is possible that in comparison with other people they are healthy.

Int. F 11. My health is great by comparison with many other Irish people my age. I was saying to Colm [husband] the other day that the men in the couples we used to go dancing with, are now mostly dead. All the women are widows, young men cut down in their prime. I can't complain.

By contrast, those interviewees who described themselves as not very healthy or definitely ill, had a range of health problems diagnosed and currently being treated or in need of treatment. This young woman in her early 30s has severe health problems due to a damaged heart valve.

Int. F 4. I don't be too well at all myself..... I go up to the Royal Free every two months to the clinic and also for blood tests. I'm on things to thin the blood. My GP used to be saying to me "get out and get yourself a job". But I can't work. I'm not able to lift anything or stand for too long cos it affects my heart.

None of these interviewees were able to work because of their ill-health, though three did charitable or occasional casual work when they felt well enough. Their definitions of health related very much to their ability to work but other factors were also significant. Housing was an additional stress for the majority of these interviewees. This woman lives in an Irish

housing association property, with her own bedroom but sharing a living area and all other amenities with the other tenants.

Int. F3. You're hemmed in. I don't suffer from claustrophobia but you need space, you need to be able to walk through the house, to use the phone or the kitchen or the bathroom without people watching you and harassing you.

However the life stories and the magnitude of problems experienced by these interviewees suggest that not only did they define health in a functional way but felt unable to control major aspects of their lives. They saw the relationship between wider social factors and health, but their inability to influence these afforded little hope of improving health status. Only one of the interviewees identifying as "not very healthy or definitely ill" was in decent or suitable housing, with the support of a partner and family or a sense of purpose or meaning in his life. He was unable to work and this made him depressed, but he tried to keep occupied while his wife was at work and believed it helped him cope with his long-term illness.

Int. M17. It gets me down that she [wife] has to go out of a morning and that I can't do more. I do everything I can in the house. I'm not a great DIY man, but domestic wise I'm fine. I take my time and it keeps me occupied. I also go out with my [disabled] son as he has trouble filling the car and doing the tyres. I can do things like that and it gets me out of the house.

A number of interviewees who self-defined as "healthy or reasonably healthy" and particularly those described in the preceding narratives demonstrate what Antonovsky (1984) calls a "sense of coherence", whereby illness is comprehensible, manageable and meaningful. They had located and understood the cause of their problems, learned how to adjust and make life reasonably predictable and manageable. They had a purpose in life related to their family or to their own sense of self or personal development. Illness (and other adversity) had encouraged them to review what was important in life and gave them a challenge from which they derived a sense of achievement and growth.

A number of factors differentiated the relatively healthy interviewees from those who described themselves as "definitely ill" and who largely lacked a sense of coherence. Generally the former were better educated, had greater self-esteem, were able to access social and professional support and had reasonable housing. Above all, they had a strong belief in themselves, and perceived they had a fair degree of control over their lives. In contrast, those with very poor health had low self-esteem, were less well educated, in poor housing and without supportive social networks. These interviewees invariably had troubled childhoods, and three out of six of them had been raised in institutions.

6.3 EXPLAINING ILL-HEALTH – the key informants and focus group participants.

A number of differences emerged in the explanations for ill health offered by younger and older focus group members and between the key informants and focus group members. The older key informants and focus group respondents generally saw problems originating in the experience of migration and lifestyle. Younger key informants recognised these but emphasised that difficulties were also generated in childhood. They emphasised the role of religion and socialisation in Ireland in shaping expectations of health and in some cases creating poor health. Religion was discussed at length in all groups with older participants generally seeing it as beneficial and younger ones as damaging.

6.3.1 Lifestyle factors

In keeping with the findings of health beliefs literature (Stainton-Rogers 1991; Cornwell 1984), the explanations of health and illness in this study contain inconsistencies and combine different theories of cause and effect. In general, poor health is explained by younger and older people differently, broadly reflecting their definitions of health, as well as their personal and vicarious experiences. Both groups use a combination of lay and medical discourses, although the older informants appear to adopt a more victim-blaming stance than the younger ones. The older focus group respondents and key informants highlighted a range of lifestyle and occupational problems leaving a legacy of illness or disability for older men.

KIOP (James) Many Irish people, it was their own fault anyway, working on the buildings. They forgot themselves when they finished work they went to the pub and spent the whole night in it, wet and damp oul clothes they had on them all day, no proper food or that.

Though there was a marked degree of understanding and sympathy for those who were ill, the older focus participants tended to emphasise individual reasons such as drinking, or not eating properly and or staying in damp clothing after work. These sentiments reflect the individualism of political ideology and health promotion messages of the 1980s and 1990s.

KIOP (Lola) It's their lifestyle, self-abuse I think it is, but especially with the people who are not married, they end up in a situation and it's their lifestyle

The use of the third person *they* is particularly interesting and suggests that this explanation does not apply to them. The next explanation for poor health implies that their own good health reflects wiser choices about lifestyle. The narrative not only offers an explanation but by implication constructs a picture of the key informant as sensible and responsible.

KIOP(John) A lot of it is got to do with if they're a kind of a moderate type of person and understand what they want in life , like a job, if they want a home or a house or want to get married, settled down. And that all helps to stabilise them in life and make them more responsible.

Younger key informants were more likely to blame poor health on structural factors. They recognised the impact of lifestyle on health, but were more likely to see this as a way of coping with socially constructed situations. These key informants were more educated, worked in various professional capacities in Irish voluntary, voluntary or statutory sector organisations and were more politically conscious than some lay focus group participants.

KIYM (Maurice) If you haven't got a proper place to live……..it probably brings on a certain amount of depression. And then if they start hitting the bottle as well and after work and they get up the next day they feel worse again and continue on at that……..

This relates to the key informants' professional experience but it also reflects definitions of health which are less functional and embrace psychological and emotional dimensions.

KIYM (Gerry) ……. among the Irish particularly in Britain is their reluctance to express their ethnicity because of the trouble it brings on them……. for some people that created problems for them inside, about their identity about who they are and how they could express it. And suppressing it led to mental ill health and maybe physical health too. I don't know. The sort of " white skins white masks" syndrome……..

6.3.2 Migration

The emphasis in most of the focus groups was on the experience of men and with the exception of the younger women focus group, much less attention was paid to that of Irish women. Loneliness and isolation were common but may have been more to do with the change for the majority of men (and women) from a rural to an urban environment.

FGOM (Richard) ……..they become a bit isolated you know, whereas if they were living in Ireland they could walk out the road and everyone would talk to them.

However the nature of accommodation and the tendency for Irish men to remain unmarried amplified the problem. According to the lay focus groups, living in "digs" without proper facilities for cooking, relaxing or having company contributed to ill-health

FGOM (Terry) ……..after a day's work when you can go home to a nice home. I think people can sit down and feel comfortable and relaxed, somebody to talk to, have a bit of

grub. When they don't get that, I think that over a period of time, this will bring on depression.

Women also experienced homesickness and isolation but by contrast were relatively protected by the companionship of the nurses home or tied accommodation.

FGOW (Molly) You did feel homesick and lonely but never for very long, cos there was always somebody around and we used to go to dances or to Mass or out and about, wherever……..

While younger key informants focused more on structural factors in British society, the older participants had vivid memories of the exploitation of Irish men by Irish sub-contractors and publicans from the 1950s until the 1970s. Some of the most vitriolic criticisms by older participants were directed at Irish subcontractors (subbies) and publicans whom they believed were responsible for many of the social and health problems of Irish men and their dependents in later on in life.

KIOP (Bridget) It's very easy to blame them [Irish men] but they are victims of circumstance. The two worst things that ever happened to Irish men in this country was the Irish subbie and the Irish publican. The Irish publican kept the pubs open until 3 or 4 o'clock in the morning. They weren't able to go to work the next day.

An informal economy of labour known as the "lump" meant that Irish men were recruited on a casual daily basis and transported to construction sites to be paid in cash in a pub at closing time. According to the older informants the pub was central to the operation of this system. Fit, healthy men could earn excellent money working in the "lump" until the recession in the construction industry in the 1970s. Eamonn had been a bus conductor and was retired on a decent pension unlike many of those who had earned much higher wages working for subcontractors.

FGOM (Eamonn) ……. these people that worked on the buildings, in one day they were earning 70, 80, 90 pounds a day and the bus conductor was drawing 50 pounds

a week or 60 pounds a week. They could have demanded their cards stamped I suppose, but there wasn't much incentive on that kind of wages.

The reality of cash in hand and possibly the intention to return home meant that there was no provision for illness and old age. When accidents happened, when the building industry collapsed or when men retired through old age or ill-health, they and their dependents were not entitled to benefits.

FGOW (Patsy) When these unfortunate people come to our age and they try claim the pension and state benefits they find because the subbie didn't stamp their cards they're not entitled to any benefits.

The fear of large bills for unpaid taxes prevented men claiming benefits and the ensuing hardship added to the stress of being ill and unable to work.

6.3.3 Childhood experiences

Although there was much emphasis on the relationship between migration, lifestyle and ill health, the younger key informants considered a range of factors in Ireland contributing to the poor health of Irish people in Britain. They proposed that a number of health problems resulted from the damage to Irish society by an all-powerful Catholic Church. They identified the evidence of abuses in school, by religious people and in institutions as causal factors in the poor health of some Irish people. Such issues have emerged in Ireland in recent years, as Irish society opened up and individuals began to question the hierarchical structures of Church and state.

Although the issue of abuse was to prove relevant to a significant number of the interviewees, the focus of the key informant groups was the damage done to individuals by the oppressive power of the Catholic Church rather than the direct effects of abuse. They suggested that the whole Irish social system had been detrimental to the well-being and self-esteem of the majority of Irish people and that this in turn impacted on health.

KIYM (Michael) To have any kind of positive feeling about yourself in Ireland was pretty hard.

According to the key informants, religion had a wide reaching impact and indirectly influenced peoples' ability to take control of their lives. It was believed that the power and influence of the Catholic Church in all aspects of Irish life left few opportunities for the exercise of autonomy.

KIYM (Gerry) Irish Catholicism again, the power they had was bordering on absolute power and it became corrupted. All my schooling was Christian brothers and de la Salle Brothers and the control that they exercised, not just in the schools but in the locality, and the priests as well.

The accounts of the focus groups and key informants and particularly the older participants, testify to the harsh discipline of Irish schools and the hardship and authoritarian discipline experienced within the family. The discipline of the Christian Brothers is well documented (Coldrey 1996) and there is an increasing body of knowledge about cruelty by other religious orders and lay teachers. The following is part of a long contribution by a man in his early 40s of his schooling with de la Salle Brothers, but fits with the accounts of the informants educated both by religious orders and by lay teachers in National and secondary schools.

KIYM (Gerry). The whole thing is rooted in self-worth and self-esteem……. But the education system in Ireland was designed to keep your spirit down, to sort of keep your self-esteem under wraps. The class system in Ireland keeps certain people down. Because it needs to, it needs people to work in the factories and on the farms.

It is recognised that discipline and corporal punishment in schools were not unique to Irish society, but it could be argued that such regimes were tolerated by parents who saw no other way of achieving social mobility for their children.

The scope of the study did not permit detailed examination of research on family life in Ireland, but the accounts of a number of the participants echo the descriptions in popular novels by authors like McGahern (1991) and McCourt (1996). This key informant generated considerable agreement among the focus group members about cruel and belittling practices experienced or witnessed in the home.

KIYM (Peter) It wasn't just the educational system, it's the family. How many of you recall the old saying " self praise is no recommendation" and " who do you think you are" .

6.3.4 Religion and religious socialisation

The older key informants and lay focus groups tended to see religious beliefs as supportive and therapeutic. Although they did not specifically identify ill-health as punishment from God, there was a sense that that it was something to be tolerated and that faith in God would see them through.

However the young women key informants held very strong beliefs about the damaging impact of religious beliefs and practices on the health beliefs and behaviour of Irish people. Although some believed religion and religious socialisation directly impacted on their own and others' health, a number saw them as damaging in the way they evoked a high tolerance of suffering, a fatalistic outlook and a propensity to cope alone. The following excerpt expresses the views of many of the younger key informants, and older men in the focus groups.

KIYW (Catherine) There's an awful lot of offering up and not going to the doctor about your situation. ..... offering up hardships rather than actually healthily expressing them and letting people know what's going on.

Younger key informants tended to see the reliance on religious practices as destructive to health, delaying help seeking and possibly resulting in more serious illness in the long term.

KIYM (Peter) They might well be putting up with suffering and offering it up to God when there could be treatment available for it.

Without fail younger key informants highlighted the role of the Catholic Church in Ireland in generating feelings of guilt which damaged self-esteem and was at the root of many health problems among Irish people.

KIYW (Finola) The Church thing, all the guilt they lay on us. My early memories of Catholicism, that you were constantly in a state of sin, no matter what you did. So from the start you were deemed as being bad, so you were constantly having to prove yourself.

It was vehemently argued in the younger key informant groups and by some interviewees that Irish Catholicism was particularly punitive compared with Catholicism in other parts of the world. This reflected the influence of Jansenism and a political hegemony in the Catholic Church which was not only sexually repressive but stifled any form of dissent (O Mahony and Delanty 1998).

KI*YM (Gerry) .....it was a very punishing power and it was a God of fear rather than a God of love, and it did do people a lot of damage. So on the whole it wasn't nurturing or liberating religion. But religion is different here, they seem much more relaxed over here.....*

Younger women key informants suggested that Papal dictates about human life promoted the idea that women had no choice over reproduction and that this led them to believe they had no control over other aspects of their lives.

KIYW (Catherine) There are real restrictions and repressions around your sexuality…… and not having control over your body, not being able to control your fertility. It's almost as though your body isn't yours and if your body isn't yours, how on earth can you look after it?

There was a lengthy discussion about the repressive nature of Irish Catholic education especially for girls. Young women key informants believed that Church teaching around sexuality, marriage, reproduction and womens' roles in general was responsible for creating stress and generating guilt in womens' lives and these led to ill-health.

KIYW (Finola) The Blessed Virgin was the image we had put in front of us. We all had to be pure and virginal and submissive like the mother of Jesus. Who could live up to that image…… part of marriage was that you would reproduce, that's what marriage was for. It was not to do with sexuality and your body and it was certainly not for pleasure.

The oppressive nature of Ireland in the 1950s and 1960s has already been identified in chapter four as one of the reasons why people emigrated. According to the key informants, the role model of the Blessed Virgin meant that Irish women were subservient and had many tensions in their lives around duty to their husbands, family planning, sexual pleasure or contraception. Conservative attitudes to sex outside marriage, illegitimacy, and abortion were not just the remit of the Church but were enshrined in public policy and social values. They therefore impacted on the lives of everybody, not just those who were religious and as such had the potential to contribute to poor health in those who struggled with the tensions of real life.

Younger men key informants emphasised way in which the Catholic Church preached values with the potential to impact on health. However, they also believed that it provided a framework for living important to some people and that this was a double-edged sword which could be both disempowering and sustaining. Although the participants tended to refer to the controlling effects of the Catholic Church, in discussion it was agreed that the same could be said of the Protestant Church in Northern Ireland. Leaving home meant leaving religious upbringing behind if the individual was to move on and grow. However it

was recognised that getting away might be positive for some people but a potential problem for others thrown into a new and alienating environment.

KIYM(Michael) I think that it's probably a positive thing for Irish people coming over, getting shot of the shackles of Catholicism. But it's also a negative because a lot of people don't replace it and it's a big belief system. There's a sense of getting back to the word "community" around the Catholic Church. If people don't replace it with something, they possibly replace it with something a lot worse and you can add to the alienation. The church brings a lot of negatives but it also brings positives and it's routine, it's habit. And a lot of people struggle when they don't replace it with something or they replace it with negative. For example the pub again or whatever. It can have an effect on people when everything is gone suddenly.

6.4 EXPLAINING ILL-HEALTH – The interviewee perspectives

Individual explanations for ill-health were complex and reflected the tensions, conflicts and inconsistencies in personal accounts described in the health beliefs literature. (Chamberlain 1997, Murray 1997, Blaxter 1990). The interviewees often identified a clear explanation for a health problem but later in the interview described a different one. They gave primacy to different explanations in different narratives and highlighted factors which challenged the consistency of any single explanation.

6.4.1 The stress of being Irish in London

As discussed in chapter four and five a number of interviewees highlighted the stresses associated with migration, racial discrimination and being Irish in London, which they believed had influenced their health. A third of the interviewees believed their ill-health had either been caused or aggravated by their housing and four mentioned that worry about paying bills and supporting a family contributed to their own health problems. The humiliation of having to rely on welfare benefits and being unable to plan for the future were linked to poor health by about half the interviewees.

Only one man indicated that his ill-health resulted from the stress of having a child with a disability. He emphasised financial and emotional strain but recognised that lifting

and moving an adult child had contributed to a degenerative back disorder. Two women who had been widowed with five children, some with disabilities, identified physiological causes for the illness they experienced but felt that the stress of raising a large family alone had made matters worse. Both had suffered health disorders which they believed were exacerbated by financial stress and pressures of raising children with limited practical and emotional support.

In addition to the social factors identified in chapter four and five, a number of interviewees identified a clear pathological reason for their health problem. These included spinal cord damage, food intolerance, occupational injury and the ageing process. Several smokers / former smokers and those who used or had used alcohol excessively recognised the effects of their behaviour but had only changed when health deteriorated. Those with mental health problems particularly highlighted aspects of their early lives which they believed played a part in the manufacture of ill-health.

Smoking and alcohol use will be dealt with under health behaviour and coping but some interviewees from non-manual groups admitted that the use of both had taken their toll on health.

Int. M17. It's easy to be wise after the event. You always cod yourself that you're drinking less than you are and that you can give up whenever you want to. We all know somebody who lived to 90 and smoked 40 a day……

About a fifth of the interviewees related their ill-health to work in the construction industry which had caused occupational injuries or exacerbated wear and tear.

Int. M 6. Working out in freezing weather, wet clothes……heavy lifting and just hard physical labour……

6.4.2 Childhood in Ireland

The socio-economic and behavioural explanations for ill-health broadly reflect the health inequalities literature, but the interviewee data highlight a more specifically Irish factor. Interviewee accounts affirm the assertions of the key informants which highlight a link between childhood in Ireland and ill-health. The majority did not locate causes of ill-health in the family, but identified the harshness and discipline they had experienced in the home and school

Six interviewees had reason to believe their health problems were directly related to childhood experiences. The next interviewee was sexually and emotionally abused with her siblings within the family for several years. Her story is similar to that of another male interviewee who suffered severe mental illness he believed to be related to childhood sexual abuse.

Int. F 10. The root of my problems lies in my childhood in Ireland. So I think that's where the problem lies.....I probably suffered depression from when I was child. I certainly have been having suicidal thoughts, ideation since I was about 15 and a number of suicide attempts over the years.

While abuses in the family were described by two interviewees, a further three were physically, psychologically and sexually abused in institutions and this contributed to the serious physical and mental illnesses they now experienced. It is estimated that about 40% of those leaving institutions in Ireland came to England as soon as they could on reaching the age of 16 (DFA 2002). This woman describes experiences common to the three interviewees who were raised in institutions.

Int. F3. I went into the orphanage when I was about eight. My brother was younger. My brother is...we both are...am I allowed to swear ?...pretty fucked up. I suffered terrible abuse, physically mentally and sexually at the hands of the Mercy order. He's a drinker, very violent, very abusive.

A significant proportion of those in institutional care had been taken away from parents believed to be unfit to care for them. The above interviewee described physical and psychological abuse by nuns and sexual abuse by a priest in an orphanage. She vividly recounted the pain of separation from her younger brother and the lack of human comfort and affection other than from her sexual abuser. She highlighted the lack of education in the orphanage which left her without life skills compounding her ill-health later in life. These factors, she believed contributed to self harming behaviour in early adulthood, severe depression, suicidal attempts and the development of rheumatoid arthritis as an adult.

A number of interviewees of both sexes had undergone, or were in the process of psychotherapy or counselling necessitated by some aspect of their early lives. Four of the women interviewees identified abusive relationships at some point in their lives which were causal factors in their ill-health and particularly mental illness. This young woman with a history of depression and self-harm, believed initially that her mental health problems resulted from an abusive relationship. However in therapy she came to realise that her early life might have been more significant.

Int. F 20. I was involved in a very abusive relationship and that I suppose made me feel that I was, sort of different and I suppose this did damage my self-esteem.....I thought all the things I felt badly about myself were purely because of that[abusive relationship] and once I started psychotherapy, quite quickly that became much less of an issue than my whole childhood.....a lot of my insecurities are very much exacerbated by the abusive relationship I was in. I would quite strongly feel that the way I was brought up made me the perfect candidate for being in that kind of relationship.

Abuse of children is not easy to define but it was evident that while some interviewees were beaten, sexually abused or mistreated within the family, others had been subject to demeaning behaviour by adults. The extent these differing abuses in the interviews were alarmingly high, and a number of the interviewees felt that the root of their problems lay within the family. About a third of the interviewees who were reasonably

healthy had experienced depression or stress related disorders at some point in their lives and saw these originating directly in childhood experience. Only a quarter of the interviewees described a truly happy childhood, and the majority in all age groups had memories of strictness and discipline at home and at school. Many also had considerable responsibility for housework, childcare, farming or other family business.

Not everybody made a clear connection between childhood, earlier hardships and ill-health, but the interviews were remarkable because of the extent of severe hardship experienced by a significant number of the informants. The narratives testify to a range of social and psychological pressures which could have seriously impacted on physical or mental health. This was true across all age and social groups and for many was protracted and impacted on several areas of their lives. However what was significant was the way in which many interviewees appeared to accept these difficulties as part of the normal course of events. This may have been a coping strategy for the interviewees or may relate to the influence of religious beliefs or particular aspects of socialisation in Irish culture.

6.4.3 Religious socialisation and beliefs

Although none of the interviewees explained health or illness in purely religious terms, there appeared to be an unsaid belief among some older interviewees that health was related to the will of God. The following excerpt echoes a number of others who suggested that rejecting or denying illness was a socially learned response influenced by Irish Catholic schooling. This interviewee draws upon her personal beliefs and her experience as a nurse in an elder care setting.

Int. F15. We were taught at school to offer it up and not complain about it. I'm like that myself and I notice it here with the patients. The Irish patients won't ask for painkillers, they won't complain and there are so thankful for any little thing you do for them.

There was some support for the idea that in Christianity, sickness and ill-health were perceived as God's visitation and it was the duty of the individual to be good and to care for

and look after the body. Illness therefore implied weakness, and people who became ill learned to feel guilty, ashamed and undeserving of help or treatment. The following narrative describes how his own religious background impacted on the mental health of one interviewee.

Int. M9. ..... that sort of feeling spreads out to your whole life. You are not a worthy person. You are bad unless proved otherwise. You are a sinner. A lot of my behaviour in my depression, when I was suicidal, when I came over here, was thinking like this. Taking alcohol, it was shameful, what you are doing, you are shameful and you shouldn't be like this. You shouldn't beg, you shouldn't steal, you 're respectable.....All the crap of Catholicism, the contradiction.

According to younger key informants and some interviewees, being socialised to feel guilt and shame impacted on peoples' ability to care for themselves and therefore affected their health. This was expressed by one young woman not raised in the Catholic faith as suggested in the focus groups, but in a Northern Irish Protestant religious tradition.

Int. F 20. ..... deep down the part of me that thinks, equates itself with being a bad person. I wouldn't think I deserve to look after myself. Just never really having seen myself as something, as a good or bad person without any other qualities. I didn't really think about my needs or I think early on I grew up in my head and really detached from my body.

While some interviewees felt that religious values had impacted on their health, the tone of several narratives highlighted the greater damage done in the name of religion. Many were angry about harshness and cruelty they had personally experienced from members of religious orders in school. Several interviewees had actively rejected Catholicism giving accounts of disgust with the hypocrisy they had either experienced or observed.

Int. M9. Being taught by a servant of Jesus, who tells you, who dictates to you " you should love thy neighbour" and still turns around and beats you up. It's contradicting.....

The interviewees like the younger key informants were critical of the influence of the Catholic Church on the state and schooling in particular. The above narrative highlights the confusion engendered by members of religious organisations which damaged the trust of Irish people. The impact of the Church on the State led to mixed messages, and individuals were attributed blame for all types of social ills by authority figures and wider social attitudes. Such beliefs were easily internalised in a traditional and closed society as attested by the following interviewee who had been sexually abused for four years.

Int. F 10. When I was sixteen I told a priest in a retreat about the abuse and he said "all your sins are forgiven". I accepted it at the time but a few years later when I began to deal with the abuse, it really turned me off the Church.

However while the attitudes and behaviour of clergy and religious orders were potentially damaging to Irish people, there was also a notion that a religious or cultural framework provided a sense of security which was particularly important for some interviewees and helped them in times of distress. Although religious beliefs were more apparent in the accounts of the older informants, the following narrative was from a young woman from a Protestant background.

Int. F 20. But to me it [religion] was personally really, really, really important when I was growing up.....I just found it quite difficult child wise. My personal relationship with God was and still is very important..

Although nobody blamed their own or others ill-health on God directly, links were made by interviewees between religious socialisation and ill-health. However in a contrasting way, the repeated use of terms like "with God's help" or " God willing" suggested that faith might also be a significant part of getting better. The narratives demonstrate the importance of both religion and spirituality for the interviewees and will be discussed later and in chapter seven.

6.5 HEALTH BEHAVIOUR

The key informants and lay focus groups highlighted the role of lifestyle in the patterning of health for Irish people. The emphasis in the focus groups and individual interviews was on smoking and alcohol, and behaviours like exercise and diet were not explored in any detail. Key informants, lay focus group participants and interviewees were all well informed about factors contributing to health and preventing illness. Although some participants used lay language, there was evidence of a sophisticated knowledge of health matters. Both older and younger informants highlighted the importance of diet and exercise and moderation in life in general and drew upon discourses from television programmes, newspapers and women's magazines. There was general recognition that emotional and psychological factors played an important role in the maintenance of health and prevention of disease. In keeping with contemporary health promotion messages, great emphasis was placed on the virtue of moderation.

However despite a fairly sound knowledge of factors contributing to poor health or specific illnesses, the interviewees did not necessarily adhere to what they knew was healthy. The data demonstrate high levels of smoking compared to UK smoking norms and an excessive level of alcohol consumption in some of the sample. The interview evidence identifies a number of factors impacting on health behaviour and appearing to enable the interviewees to justify risks to their health.

6.5.1 Smoking

Of the twenty interview informants there were ten non-smokers (four men and six women). Only two had never smoked and most had given up for reasons of health, wealth or both in the previous five years. One had reluctantly given up smoking about 60 per day following his second heart attack and still missed them years later. Although the size of this sample makes direct comparison impossible, there are similarities with Irish patterns of smoking and cessation in the Health Survey for England (Erens et al 2001).

The smokers, six women and four men were all cigarette users and the consumption ranged from 2-3 roll-ups to 60 per day, finances permitting. Some interviewees had cut down and others had tried unsuccessfully although not in the previous twelve months. They admitted smoking more under pressure and a number expressed the wish to give up but had not attempted it recently. Graham (1993a) showed that for women, smoking was an active strategy which enabled them to cope with the stresses of everyday living. The following highly educated woman echoes the beliefs of many members of the public and the other interviewees

Int. F10. Oh yes, it's definitely related to the depression. It probably doesn't, but I feel it helps my nerves, sort of calms me down. I know what it does to me, but I can't cut it down until mentally I'm better.

Some interviewees felt that not only did a cigarette help them cope with a stressful part of their lives, it was one of the few pleasures they had. This mirrors a number of the other narratives and fits with the work of Lupton on the pleasure of smoking and other behaviours (Lupton 1995). The following interviewee recounts what Lupton described as a "discourse of release", where individuals perceived health to be improved by relaxing control and escaping the discipline of work or the worries of everyday life.

Int. F 3. It's the only pleasure I have left. I don't drink, I have no money, I live in a crappy room with shitty neighbours. The few rollies [roll ups] makes life a bit bearable.

Interviewees recognised the impact of smoking on health but invoked a sense of denial that it actually damaged them. They recognised the difficulty of giving up and this man forced to do so after his second heart attack still craves a cigarette years later.

Int. M 17. Maybe if I'd stopped at the first heart attack, I wouldn't have gone on to have another, but it was hard, the craving makes you murderous ..... there are still times when I could kill for a fag.

The accounts of the participants echo the findings of other studies and describe the use of smoking and alcohol to regulate mood, manage stress and cope with strains that are a part of material deprivation (Graham 1987, 1994, Chamberlain and O Neill 1998). Living in circumstances of deprivation relative to others and having to cope with insidious and persistent denigration of Irishness were an everyday hassle for many of the participants. The privilege of " release" is common in the discourses of working class people who have little control over their lives (Crawford 1984) and related very clearly to the stories of several interviewees. It might also be argued that as suggested by younger key informants, smoking was not just a form of release, but a symbolic gesture of control by people who had little control over their own lives.

6.5.2 Alcohol

Four of the interviewees did not use alcohol at all and five admitted drinking heavily, but the majority described themselves as light drinkers. Twelve described themselves as light or social drinkers, consuming a few units at weekends or an occasional bash on special occasions. The majority of interviewees were able to identify the number of units of alcohol which conformed to Sensible Drinking (DOH 1995) guidelines and most could convert their own use of alcohol into these units.

The key informants and some interviewees highlighted the social role of the pub for Irish men. The pub provided opportunities for company, food for those unable or without facilities to cook, music and *craic* in a culturally sensitive environment. According to the focus groups and interviewees it afforded protection from homesickness, loneliness and isolation.

KIYM (Shane) Many Irish people emigrated alone and there isn't the extended family here in the same way as there is for other ethnic groups and it[pub]does help, otherwise you're sitting indoors on your own.

Key informants and lay focus groups identified an Irish culture of drinking related to the construction industry. They described pub culture as a part of adolescent

development and for men and Irish men in particular, part of their masculine identity development.

KIYM (Peter) For very young men it is still a rite of passage the whole thing about getting into drink and proving yourself……..

There was a suggestion that although some Irish men moved on, others stayed within a drinking subculture and this was particularly true of men who worked in the construction industry.

KIYM (Michael) But most men grow out of that, but some men remain in, who mix with that kind of crowd still continue particularly...historically on the building sites and that you socialise by going out and drinking.

Apart from the economic dimension of finding work through contacts in the pub, there was an associated culture of hard drinking which men were expected to engage in

FGOM (Walter) On building jobs sure you had to row in with them and go along with them whether you liked it [drinking]or not. It used to be about 10 or 12 pints a night. And two whiskey chasers……..

There was less of a drinking culture among Irish women but a younger interviewee described a culture of drinking among young people working in the City of which she was part for a time. This had helped her to cope with the stresses of work, but had created other problems. She had since cut down and now considered herself a moderate social drinker.

Int. F20. It seems so hard to unwind without taking work home with you, that the easiest thing is to go to the pub and try and drink it away rather than to actually go home and deal with it.

Her work colleagues were mainly English people, but the friendships she developed were with the few Irish people who worked in the City. She believed there was an added and particularly Irish dimension to work-related drinking culture.

Int. F20. .....a lot of people drink, who work in the City in stressful jobs, but I'd say we [Irish] were less measured. We would always have been drinking more, to a much greater excess.

Three informants, two women and one man did not consume alcohol at all. None followed the Irish tradition of being "Pioneers" [members of temperance movement] or lifetime abstainers and all three had given up because they perceived it had contributed to mental ill-health. Interviewees recounted the role of sexual abuse, domestic violence and unemployment in their mental health problems and subsequent misuse of alcohol. All described how they had used alcohol as a form of self-medication to deal with a range of psychological distress although only one identified that she had become dependent.

Five interviewees might be classified as fairly heavy or heavy drinkers and of these four were men with multiple health and social problems all of which emerged after arrival in England. This excerpt is by a divorced man living in one room, in chronic pain from an occupational injury three years earlier

Int. M6. I just suffer on and going to the pub and a few jars and forgetting all about them [pains and aches], until the next day anyway.

Another man who drank heavily described how he used alcohol to deal with flash-backs which he still suffered almost fifty years after leaving the industrial school in Artane.

Int. M7. I'm not saying it [memory of abuse in orphanage] hits me every day. It doesn't, but it does now and again, I can't sleep, it starts, this coming back into the mind.

But although alcohol may dull the pain it can create longer-term problems for the individual and their families.

Int. F8. It was a way of blocking out pain. It takes the edge off the pain. There's an element of pleasure in it to begin with but then the addiction, the whole lifestyle is associated with it.

There is increasing awareness of the use of drugs and alcohol as a form of medication not just in Irish people, but in the population in general and there are concerns that it leads to misdiagnosis, inappropriate treatment and use of compulsory detention. While the interviewee accounts suggest that alcohol was used as a form of medication, in some cases it is not clear to what extent this was a culturally acceptable coping strategy or whether it reflected their inability or unwillingness to access other interventions.

6.5.3 The symbolism of smoking and alcohol for Irish people.

Those with better health were generally in higher socio-economic groups and they emphasised personal responsibility and ability to influence their own health (Chamberlain and O Neill 1998, Lupton 1995). They believed they had more control over their lives and although continuing to engage in health harming behaviours they identified other aspects of their lives which would protect them. As in the study by Chamberlain and O Neill (1998) they perceived they could change behaviour if and when they chose to.

In an interesting paradox, one of the four heavy drinkers was a woman with a very comfortable lifestyle who acknowledged she drank more than was good for her. She was fully aware of the health risks associated with high levels of alcohol consumption, but enjoyed having wine with her food and a few drinks to relax at evenings and weekends. She made a joke illustrating a paradox in the symbolism of alcohol to different groups. For one group it was problematic and risky while in another it meant good taste and affluent lifestyle.

Int. F16. I do drink more than is good for me but I drink because I enjoy it. If I was sitting on a park bench somewhere drinking that much I'd be labelled an alcoholic!

According to the key informants unhealthy behaviour was an individual choice related to the pleasure afforded by smoking or alcohol.

KI YW (Mona) I was actually thinking that some people actually choose an unhealthy lifestyle. And I'm one of them. I do actually choose, I know all of this, I know the dangers.

Some interviewees chose to risk their health for the enjoyment of smoking or alcohol but others lived in a world where things were mostly outside their control. The issue of choice and control was articulated more widely by younger women key informants.

KIYW (Catherine) It's my body and I'll do what I want even the most destructive thing. Sometimes it's about control, the only area you can control is your body.

Continuing to smoke or use alcohol might have afforded some individuals a perception of control in a world where they had little influence. However, although some interviewees acknowledged the damage caused by smoking and alcohol, they were less likely to feel they could influence health by changing behaviour. The majority emphasised factors over which they had little control as the main causes of illness suggesting an external "locus of control" (Rotter 1966). This might also reflect the effects of religious socialisation mentioned in the earlier section of this chapter. The narratives described the role of alcohol in dealing with mental and physical pain, loneliness and isolation. In a study of the antecedents of female drinking by Patterson (1995) in Ireland, depression, psychiatric disorders, incest, homelessness, unemployment and aggression were issues commonly encountered in those who sought treatment. Although Patterson (1995) referred only to women, the same factors were identified by both sexes in this study and played a significant part in causing them to be mentally ill, and subsequently using alcohol excessively. They therefore believed they had little power over their own lives and that fate, luck or external forces directed what

happened to them. Some also believed that whatever they tried to do they would not succeed reflecting the literature on self- efficacy (Bandura1977). A number of authors have demonstrated that people from lower socio-economic groups have a more fatalistic orientation to their health (Blaxter 1990, Ross and Mirowsky 1992) and this was evident in narratives of those with the poorest health. The persistent inability to get decent housing in a nice area or to access effective sensitive services, were common themes in the narratives. These added to the experience of powerlessness in childhood, the impact of religious socialisation and probably served to confirm to the most vulnerable that they could do very little to alter their situation in life.

6.6 THE RELATIONSHIP BETWEEN HEALTH BELIEFS, BEHAVIOURS AND SOCIAL AND SOCIO-ECONOMIC CIRCUMSTANCES

6. 6.1 Health status of the interviewees

Despite the preponderance of interviewees claiming to be reasonably healthy there is a high level of illness among the sample. The methodology prevents direct comparison, but the broad picture painted by the findings is consistent with what is already known about the health and health behaviour of Irish people in the UK (Erens et al 2001, Aspinall 2001). Heart and circulatory disorders, arthritis type illnesses, depression and alcohol related problems were cited most commonly and levels of limiting long-term illness are substantially elevated at a much earlier age in comparison with other men in Britain. Finding two women in their early 60s who had treatment for breast cancer fits with the evidence of Harding and Allen (1996).

Although concerns around mental health in this study are not directly comparable with the work of Erens et al (2001), they do suggest that psychosocial health is poorer than that of the general population. This may be a reflection of the sample which includes two interviewees with known mental health problems and five people in insecure accommodation accessing voluntary sector services. However the high levels of mental ill-health among the interviewees echo the elevated risk of psychiatric morbidity among Irish men (Aspinall 2001). The interview data demonstrate that six interviewees had either attempted to take their own lives or had engaged in behaviour likely to endanger

life. Although there is no research evidence on attempted suicide among Irish people, the mortality figures for suicide are high for Irish men (Neeleman et al 1997). For at least some of the interviewees, suicidal attempts were associated with significant distress and the inability to access help.

6.6.2 Differences in health beliefs

Differences in health beliefs reflect socio-economic status, age and education. Definitions and expectations of health are influenced by past experiences and the reality of peoples' current lives and functional definitions or low expectations of health cannot be separated from personal history or the context within which people live. Socialisation within a culture decrying concern for the self or the experience of cruelty or abuse, shapes individual values about what health is. This may contribute to ideas of health which are concerned with the physical ability to engage in activities of everyday living. They may shape a perception that concern for psychological, social or emotional well-being is self-indulgent, unrealistic or unachievable. While popular messages about health encourage individuals to look good, take more exercise, eat healthily or relax more, a lack of money, pressures of work and family make this difficult. The data demonstrate that while few of the interviewees are affluent, those with the poorest health are deprived, in poorer housing, working in the less secure parts of the economy, long term sick and in some cases health is a low priority.

The way in which the majority of the sample describe themselves as "reasonably healthy" is worthy of comment. While they all lead active and independent lives, about half have serious illnesses requiring lifestyle adjustments, medication or hospital attendance for treatment or monitoring. While they are able to carry out their normal duties it is possible they do not perceive themselves as ill. Some interviewees are in secure jobs providing sick pay and allowing a degree of flexibility around hospital appointments. Others working in the home or with poor terms and conditions, and the pressure for income, are probably required to carry on regardless of how ill they feel. However as the next chapter suggests, functional definitions of health might also reflect the inability of interviewees to have illness sanctioned by not being adequately investigated or diagnosed.

6.6.3 The relationship between material deprivation and health behaviour

There is no indication that interviewees lack knowledge about what contributes to health or causes disease but health-harming practices are influenced by wider social factors and are closely linked with the experience of being Irish in London. The narratives echo the findings of other studies showing higher levels of alcohol and dangerous patterns of consumption in deprived groups and among homeless people (Erens et al 2001, Wardle et al 1999). Some interviewees had stopped smoking, abstained from or reduced alcohol but others despite wanting to do so, had tried unsuccessfully or had chosen not to. The role of smoking and alcohol in coping with stress and illness and in providing pleasure is significant in the interview narratives, but early socialisation, life in Ireland and London influences motivation and the ability to alter health-harming behaviour. Perceptions and experiences of having little control over everyday life and the persistent inability to achieve living standards comparable to others in society are all factors perpetuating health risk.

6.6.4 The social acceptability of smoking and alcohol in the Irish community

While structural factors generate and maintain deprivation, cultural factors determine the acceptability of certain health behaviours as coping strategies. Smoking is more socially acceptable in lower socio-economic groups and has declined less than in higher groups (Lupton 1995) and although some change has occurred is still widely acceptable in the Irish community in Britain (Erens et al 2001). A number of individual and social factors make cessation or abstinence difficult, but the narratives suggest that factors in the Irish community are also important. Several participants commented on the resistance to change to smoke free environments. There is therefore less social pressure to reduce smoking, and in the absence of appropriate role models and it is even possible that there are more pressures to continue than to give up. The interview accounts suggest that for men working in construction there is considerable peer pressure to drink excessively and therefore those who want to reduce or abstain have little support to do so. However given the stress expressed in the accounts of the participants, and persistent stress experienced by sections of the Irish community, the role of pleasure, release and self indulgence must not be underestimated as factors involved in smoking and alcohol use.

There is also some evidence that poor health and early mortality in the Irish community in Britain is influential. Several people recounted stories of neighbours and family members who developed cancer or dropped dead despite living moderate lives and of others who died following accidents. These experiences have some resonance with Davison et al (1992), who argue that while people in disadvantaged circumstances know that stopping smoking prevents them getting cancer, they are less convinced it can prevent premature death. The stress in the lives of some interviewees and the inability to see benefits in the longer term means that on balance the short-term cost of behavioural change may be too high.

The data demonstrate that health beliefs and explanations of health and illness are socially constructed in both Irish and British society. Health related behaviours such as alcohol use and smoking reflect the wider patterning of social life. While recognising the risks, the narratives of vulnerable people in particular suggest that the beneficial effects of the pub and alcohol should not be forgotten, since drinking for the majority is an essentially social activity, rather than being undertaken alone. Moore (1992) argues that drinking is not simply destructive but has many beneficial effects. Aside from its central function in relation to the construction industry, the pub still provides a meeting place for those living in poor accommodation. It offers a sense of community for those who are reluctant to access other opportunities for social contact such as the Church. It affords access to Irish music and culture and an environment where it is safe to be Irish. The use of tobacco and alcohol as coping strategies will be developed further in chapter seven but the data show that a number of structural and cultural factors play a role in health related behaviour.

7.0 Chapter seven : Coping with ill-health in a stressful environment.

This chapter begins by briefly considering problems of access to health services which interviewees shared with others in the population and goes on to those more specific to them as Irish people. It discusses what key informants perceive to be obstacles to accessing health care and show how these perceptions differ from the explanations offered by the individual interviewees. In particular, the chapter provides insights into the experiences of insensitive and inappropriate care which contribute to the reluctance of interviewees to make use of health provision. It throws light on aspects of cultural sensitivity for Irish people. Issues around social support are addressed, looking especially at factors which influence help-seeking behaviour. It finally considers the coping strategies adopted by Irish people with health and social problems and considers whether there is a culture of self reliance among the Irish community in Britain and the factors which may contribute to it.

7.1 ACCESS TO HEALTHCARE

As discussed in chapter six, a number of participants were receiving treatment from GPs, hospital doctors and other practitioners. Some were generally happy with the help they were getting while others were quite dissatisfied. The narratives show that in many ways Irish people are no different from other sections of society. The scope of the chapter cannot do justice to the reasons for dissatisfaction but will focus on those more specific to Irish people. Most interviewees tried to treat themselves first, adopting a wait and see strategy, using self medication and only resorting to professional help if these failed. In keeping with increasing numbers of the general population, the interviewees made use of the internet or other sources of information about health.

7.1.1 Issues in common with other groups

Prevailing ideas linking concern about personal health to hypochondria and neuroticism discourage people from complaining or from going to the doctor. Fear of being told "its all in the mind" and the tendency to blame ills on aging or health behaviour are barriers for all communities. For those working in manual occupations, the fear of having to take time away from work is a constraint and anxiety about not being able to work, recurrences of illness or confirmation of worsening health may prevent them seeking help. Getting an appointment is difficult, then explaining the problem to a busy doctor

when feeling physically or psychologically fragile is an additional barrier. A number of interviewees were unhappy to consult with doctors who appeared to fob them off with medication, rather than listening to their problems. The frustration of trying to communicate with a doctor who didn't understand when they were in distress led a number of interviewees to wait and see if things got better and attempt to solve problems alone.

The key informants highlighted particular difficulties for people with mental health problems. The experience of the following interviewee with severe mental health problems testifies to this, and reflects difficulties common to people who are homeless and to young Black men (Cole et al 1995).

Int. M9. He[doctor]didn't believe in giving me anti depressants or anti-psychotic drugs. He said the only difference between me and the junky on the street was that the junky paid for his drugs... and Tim [referring to self] would be behaving very strange and throwing TVs out the window and plates going out as well and what I've become in the past is extremely violent and I'd always be put in hospital on medication but he wasn't interested. I was sitting in this waiting room, reciting nursery rhymes and poems and rubbish and I think the general public could tell I was mad, but nobody was prepared to work with me or help me. The result to that was I ended up being arrested. Until I was arrested and hospitalised the amount of help I got was very little.

Like people from other minority ethnic groups, the interviewees were not offered psychological therapies initially but two who were unhappy with their drug therapy, had fought for it. The following excerpt highlights a man's experience of insensitivity in therapy, an experience common to many and not exclusive to Irish people.

Int. M 9. Not offered [psychotherapy] at first, and then it was done to business. "Tell me what happened when you were five and a half years old, tell me what happened when you were 12". But I was having double blocks at that time about this. Cos he had a student in the corner taking notes. I was kind of badgered into disclosing certain information. I was made to feel I hadn't adjusted very well and I should not be taking up their precious time. But I was badgered into disclosing information about myself. A

woman standing with a flip chart and she's telling me sexual abuse, child abuse, she 's giving headings of problems and a student in the corner taking notes. Particularly a female and I found it very, very difficult and embarrassing and in that sense it was destructive. And also the fact that I was badgered into this and at the end of an hour I had to go away with those feelings.

Previous experiences of a lack of empathy, interpersonal skill or clinical effectiveness are barriers to all, but more relevant to people from working class or disadvantaged backgrounds. The language of the professional encounter is a particular difficulty for people from these groups (Acheson 1998). It is not possible to identify the extent to which interviewees were different to others in the population but there were clearly issues which made them reluctant to access services.

7.1.2 Access and Irish people – health as a priority

The key informants postulated that a lack of knowledge of the NHS was an issue for Irish people even after years in the UK. The following man who managed a community care organisation shared the views of other key informants that knowledge was only part of the problem.

KIYM (Donal)…….there's a kind of reticence by Irish men to access services, to even feel they have a right to services, health services. It's like accessing them they're causing some kind of bother almost. It's not just not knowing their rights, but they don't want to go that one step to have their rights or their needs met.

They informants recognised the similarities with men in general where health is low priority and there is with reluctance to talk about health matters (Cameron and Bernades 1998).

KIYM (Peter) ……men generally don't prioritise their health. It's not just an Irish issue. Men tend to be more reactive. They'll sort something out when it becomes a real problem. It's not just an Irish thing.

It was however evident that work in the building industry took men all over England, and would have necessitated changing doctors every few months. The irregular life style of some interviewees meant they had difficulty registering with a local doctor, could not keep appointments and therefore relied on Irish community agencies for help and access to health care.

However key informant narratives repeatedly argued that there were specific beliefs and attitudes held by Irish people and within the Irish community that made them reluctant to seek help. The following narrative suggests that health issues were a low priority in the Irish community by comparison with other minority ethnic groups.

KIYM (Donal) There is much more focus on health and social care issues with the Afro-Caribbean and Greek centres whereas Irish centres tend to be alcohol focused. There's a pushing away of more intimate issues like social care and health.

There was an impression among the key informants that reliance on prayer was a factor contributing to the reluctance of Irish people to access services. As discussed previously, younger key informants perceived that Irish people influenced by Catholicism were stoic and believed that considering their personal needs was self-indulgent. The following statement by a key informant working with Irish women, suggests that although women were more familiar with the NHS than men were, many were still reluctant to seek help preferring to treat themselves or to resort to prayer.

KI YW (Finola) We have got women from Ireland who deal with stress in their lives through religion.....they will get it in the next life, it will be OK in the next life.

Recognising that a problem existed and making a decision to do something about it was difficult for Irish people according to younger key informants. They perceived Irish people, and older people in particular were prone to believe their needs were not be as great as others.

FGOM (Eamonn) They crawl into the doctor hardly able to stand up and they go "sorry to trouble you doctor".

Key informants and focus group participants perceived that Irish people were reluctant to access health services because they did not want to be any trouble, that others were in greater need or they preferred to cope though prayer or self-medication. However the individual interviews highlighted factors such as racism and cultural insensitivity which were much more relevant.

7.1.3 Cultural insensitivity and racism

Terms such as cultural awareness and cultural sensitivity were used interchangeably by the key informants, but as identified in the literature in chapter two, there was little clarity about the meaning. However they were deemed desirable aspects of care and according to key informants, their absence meant Irish people did not access services. While interviewees did not use this professional discourse, they highlighted experiences of insensitivity and racism which led them to avoid or delay using services. Lack of cultural understanding was off-putting for the interviewees and they had to struggle to explain their problems when doctors made assumptions about them. This woman highlights an experience shared with other Irish women.

Int. F14. There was always a lack of understanding and consequently thinking because you were Irish and Catholic that you were going to continuously have lots of children.

Some of the most recurrent experiences of focus group members and interviewees were stereotypical assumptions around alcohol and the problems related to accent mentioned in the and earlier chapter.

Int. M19. If you go to the doctor the first thing he says to you " do you smoke" and if you don't smoke do " you drink " " no I don't drink". He doesn't know what to say to you then. If you do say "yes" first thing then its " give up the drink, give up the smoking and everything will be all right then and I'll give you a prescription" and then run you off to hell.

While most interviewees were annoyed to be asked about alcohol consumption, a few were not believed when they said they didn't drink or drank very little alcohol.

Int. F11. I said to him " I don't drink " and he said " What, an Irish person who doesn't drink?" And that's the absolute truth. I was furious.

Interviewees were irritated at having to repeat things several times before they were understood. They were humiliated and angry when a doctor or other professional made fun of their accent or corrected their grammar as described by this articulate woman.

Int. M17. He corrected my grammar. He made me feel very, very small, very small indeed.

The relationship between Irish accent and racial harassment are dealt with in chapter five but the inability to understand or be understood by a doctor whose first language is not English was cited by several interviewees. Several interviewees expressed particular difficulty communicating with Asian doctors.

Int. M9. Trying to communicate with a Pakistani doctor when you're really ill is crazy.

The focus on Asian doctors may reflect the large numbers of GPs from India and Pakistan practicing in London, rather than any culturally attributable characteristic. It might also reflect the real strains experienced by single-handed GP practices, in dilapidated premises in inner city areas of massive deprivation (Rudat 1994). There is no reason either to assume that interviewees had not assimilated the institutional racism of British society.

In particular, interviewees with mental health problems described the emphasis on alcohol in assessment and treatment. The following excerpt highlights how a lack of cultural sensitivity can contribute to misdiagnosis and subsequent mistreatment.

Int. F10. Yeah, it [alcohol] certainly did come up number of times and I was saying " no that's not the problem. I do drink, but the problem lies much deeper than that". And I've always been quite strong and adamant about that.....There were things I would

say to her [psychotherapist], and laugh about things which she wouldn't see funny, or see the point..... And she was looking at me and maybe thinking it was inappropriate laughter.

Two interviewees highlighted difficulties getting help for children because of assumptions of family dysfunction. The following excerpt is part of a long narrative about her son's severe mental health problems which were put down to family dysfunction. They had been fobbed off by the GP for several years while her teenage son became a danger to himself and others, until she picked up enough courage to tackle the issue. Her son was admitted to hospital the same day under an involuntary section of the Mental Health Act and was still in compulsory detention at the time of interview two years later.

Int. F18. I said "Dr....I don't want to offend you but whatever is wrong in our family, you are not trained to deal with it". And he came back to me and said "if that's how you feel I'll give you an emergency number". I really felt like saying why couldn't you have done this years ago?

It could be argued that the above scenario had little to do with the ethnicity of the family. However it had a major impact on the ability of the respondent to trust the clinical judgement of her GP again. The following excerpt is similar to the way in which Black families are pathologised by health, welfare and education professionals, rendering the root of problems in some aspect of the culture or lifestyle of the family. Problems are attributed to factors such as family size, lone parenthood, poor parenting while structural factors and ethnocentric practice neglected. This interviewee was describing her GPs attitudes towards the youngest of her five children who was behaviourally disturbed in the months following death of his father.

Int. F8. But we were told he [son] was dysfunctional, that he was exhibiting the dysfunction of the family. We weren't a family in grief, we were dysfunctional.

Although the interviewee did not necessarily see the problem related to her Irish identity, it reflected the accounts of other interviewees and two key informants who had

children with disabilities. There is evidence of an increasing tendency towards the pathologisation of Irish families (Walter 2000, Garrett 2000) much in the same way as occurred with Caribbean families (Dalrymple and Burke 1995). Such assumptions may account for the misdiagnosis of the same interviewee whose other son had been exhibiting aggressive and anti-social behaviour for some weeks. Her own experience told her this was caused by a blockage in the system relieving the pressure of cerebro-spinal fluid from his brain.

Int. F8. I had a particularly bad experience with my son who has hydrocephalus and epilepsy. Four years ago he had a blocked shunt and it took me a month and I had to threaten to sue the whole practice before my son was taken into hospital and within 12 hours of admission he had major surgery to replace his shunt and valves.

7.2 MENTAL HEALTH ISSUES

In addition to the reluctance of Irish people to seek help from doctors or other service, key informants believed that there were particular problems around mental health and psychological or emotional issues.

7.2.1 Inability or reluctance to express emotions

The key informants believed that Irish people and particularly men were unable to seek help as they had difficulty expressing emotions.

KIYM (Gerry) Irish and emotions don't mix well and especially Irish men and macho emotions. Go to a funeral and you don't cry, you hold your chin up…….. It's OK to cry in your beer, but not in any authentic way. It's about not being manly. Big Irish men don't cry.

The inability to express emotions was not confined to men and the following key informant suggested that while it was acceptable to have a physical problem, psychological or emotional problems were not discussed.

KIYW (Catherine) I think its difficult as an Irish person to talk about your health in terms other than physical. It's completely acceptable to have a tumour or an ulcer or a cold, but then to say how are you feeling is taboo. It's like the psychological and emotional is switched off.

The above narratives are offered from a professional perspective and suggest that the inability or unwillingness to express feelings is a particularly Irish phenomenon. However they neglect the tendency of men in many cultures to be stoic and to express emotions in different ways. They also neglect the way in which people with limited vocabulary express distress in physical rather than psychological terms.

Some younger key informants believed that their own upbringing had not equipped them adequately to keep in touch with their with inner selves and that this was common in Irish society.

KIYW (Maura) Well I think it depends on how much access you have to your own feelings. Like my Dad, his Mum died when he was about 17 or 18 and he is completely devoid of emotion…… he has very little access to his feelings.

There was an impression that people learned to repress, deny or not express a whole range of feelings from pride to anger. The following narrative mirrors several contributions by younger key informants and interviewees. This may reflect their ability to articulate more effectively, their professional preparation and even the experience of counselling or therapy.

KIYM (Michael) Feelings were not really encouraged. Certainly not anger……. It's sort of seen that feelings are quite weak and he[father] wouldn't really express any kind of feelings at all. Quite blind, quite numb in that area.

According to the following key informant the inability to talk about problems, feelings and emotions depended on having adequate social skills learned both in the family and the school.

KIYM (Shane) It comes from your background.....I know from my own upbringing we were very conservative, conservatively quiet, extremely so..... Irish people and men especially need to learn social skills but it takes a bit of education because we were never taught that in school.

This is echoed in the narrative of the next key informant from a mental health background. He met considerable resistance when he suggested setting up a counselling service in an Irish organisation. However he followed his clinical intuition, the service was set up and contrary to expectations finds difficulty coping with the demands placed on it.

KIYM (Donal) When I first started work in XXXX, I was thinking about starting a counselling service. One of the staff said to me " Irish people don't want counselling. It would be a waste of time as they won't enter into a counselling relationship". I thought at the time that it was the greatest load of bollocks I ever heard but there was some truth in it, in the difficulty Irish men have expressing themselves. But if the service is culturally sensitive this can be got round.

The key informants and focus group respondents mostly suggested that Irish people and particularly Irish men were not only reluctant to express feelings and emotions but to access help for psychological or mental health problems. However the narratives of the interviewees challenge these assertions.

7.2.2 Attitudes to counselling, psychotherapy and mental health services.

A number of interviewees had sought counselling or psychotherapy on their own initiative, whereas others accessed them as part of treatment for severe mental illness. Some of the interviewees also had a professional or academic interest in psychological therapy and were well informed about the potential benefits.

Contrary to some assumptions of the key informants and focus groups, a number of men recognised the benefits of counselling, both for themselves and potential clients. This human resources officer had not only used counselling himself, but had done some training as part of his paid work as well as in a voluntary capacity.

Int. M2. I've accessed that [counselling] for different things. So there have been periods when I've been in counselling and so certainly I feel I understand a bit about counselling.

According to key informants Irish people were reluctant to bother others with their troubles and this was particularly true for older people and evident to some extent in the narratives relating to psychological health. There was a tendency among the majority of interviewees to minimise their own needs, acknowledge them later and believe that counselling was more suitable for people with severe problems. In the following account of an experience with an occupational health nurse, an articulate professional woman in her early 30s echoes the perceptions of a number of other interviewees.

Int. F20. .....She talked to me briefly about it [abusive relationship] and said it sounds like you could benefit from some counselling.....She never rang back and she was the first person I ever told about my relationship. So I wasn't averse to the idea of counselling, but I felt because she didn't ring back, she had second thoughts. I thought she thought I was malingering, it wasn't serious, it wasn't genuine, I was making it up and so you minimise things in your head.....And I think I just I thought it wasn't for people like me. It was for people with a worse experience than me.....

There was an assumption by some of the key informants that the stigma of mental illness prevented Irish people from accessing help, but this was not particularly evident in the data. While a small number of interviewees expressed reluctance to seek psychiatric help, on the whole there was considerable openness about accessing psychiatry or psychotherapy. This widow with a teenage family had taken her children to family therapy following the death of their father.

Int. F8. And I did take the family in the beginning for family counselling, but they expected too much from me. I couldn't handle my own grief, let alone the grief of five children.

There was evidence from the interview and focus group data, that despite initial reluctance, those who made use of psychological help found it therapeutic.

Int. M17. She[doctor] said" I have a very good psychologist attached to the surgery and that might help you, but you don't have to". I said " well I'll give it a go". I had six consultations and it was great.

The interviewees who were best able to discuss emotions were those who were educated or professionally qualified. While the majority of the sample were articulate, a number appeared to have a limited vocabulary within which they could express complex concepts. However the interview accounts show that less articulate and more vulnerable interviewees availed themselves of opportunities for psychological help, but did not necessarily use the term counselling. As in the account of the next man, who was living alone, in chronic pain and on medication for severe depression, many were happy to " talk" or "chat" about their problems in a safe environment.

Int. M5. Well you know I'd rather come up here, than go to the doctor, and talk to Pauline or Charlie one of those [workers] I feel comfortable talking to them because they understand.

There was ample evidence from the data however, that some interviewees had nobody significant with whom they could express their feelings and emotions. There was also a number whose life history was so terrible that not giving vent to their emotions was probably a coping mechanism.

7.2.3 The meaning of cultural sensitivity

The key informants, focus group respondents and a small number of interviewees identified the importance of cultural sensitivity for Irish people. Although this reflected professional discourse, there was limited clarity about the meaning of cultural sensitivity and different terms were used interchangeably, mirroring the confusion in the ethnic health literature (Papadopoulos et al 1998). On the whole, the key informants were better able to describe examples of cultural insensitivity around accent, language

and stereotypes than they were able to describe what constituted culturally sensitive practice.

Papadopoulos et al (1998) suggest that cultural sensitivity takes account of the way in which respect, empathy, trust, and acceptance are communicated to the client. It does not suggest that only staff from the same culture as the patient can provide culturally sensitive care, but that it can mean a better understanding of values, beliefs and experiences.

This man with alcohol related mental health problems used the local Irish voluntary sector agency for support and counselling rather than go to his GP. He did not use terms like cultural sensitivity, but he named two staff who were not Irish, but who understood him and did not judge his behaviour.

Int. M5. I sort of feel more at ease when I'm talking to them. No, they're not Irish, but they understand me. They have way of being so relaxed and they bring it out in me...and, and they're not criticising you. They take you as you are.

The following narrative by a key informant working in an Irish housing association, stresses the importance of cultural sensitivity but highlights the difficulty of identifying what it means for any cultural group. Since culturally sensitive care is respectful, empathic, accepting and appropriate it tends to be taken for granted.

KIYM (Gerry) I think cultural sensitivity is very underestimated. The effect is not recognised..... whether its health housing or whatever.....It's funny because the people who are in receipt of culturally sensitive provision immediately take it for granted. They don't even recognise they haven't been having it for so long, once it's provided the expectations rise and there is complete change in attitude towards it and the expectations go through the roof.

The key informants generally believed that clients gained greater therapeutic benefit from services by Irish practitioners or service providers.

KIYM (Donal) I see it where I work, a lot of the much older Irish people tend to operate totally differently when the service provider is Irish or English. You can see a huge differentiation between the way people interface with people from their own country.....my impression is when our Irish clients work with Irish providers it's far more therapeutic than if it was the opposite.

Although key informants did not refer to the relationship between cultural sensitivity and clinical competence, the interview narratives highlighted the potential for misdiagnosis and inappropriate treatment evident in the literature (Papadopoulos et al 1998). The following interviewee describes the stereotypical assumptions and value-laden judgements informing his treatment. These acted as barriers to accurate assessment, they closed off alternative pathways in the diagnostic process and ultimately resulted in inappropriate treatment. Although the narrative described a mental health context, it is also possible that alcohol stereotypes play a part in physical misdiagnoses especially around accidents injuries and gastro-intestinal problems. This interviewee attempted suicide on a number of occasions, not because of the inability to access help, but of the inappropriateness of the help he was offered.

Int. M9. Tim [self] is a drunk, he drinks too much and that's the root of his problem. There doesn't seem to be willingness to ask the question " well why do you drink".....' I can't do nothing for you, you're only a drunk". Today I know the other side of it. Why is he so drunk, why is he psychotic? Ten pints of Guinness doesn't make somebody psychotic. It doesn't make somebody that depressed that they want to go and throw themselves off Battersea Bridge..... It's clear to me that these people do not have any insight.

Cultural sensitivity is difficult to define for any ethnic group and there is little evidence about whether or how it enhances care and improves outcome for any client. However the following excerpt highlights the importance of interpersonal skills and knowledge of the client's culture, in delivering effective care. It also highlights the therapeutic benefit of a practitioner from the same cultural background.

Int. M9. ..... One or two people I've met were the key to me sorting myself out. You know I met a ward manager, a Kilkenny man and we talked about Ireland we talked about hurling..... and we would talk about stuff like this. He could understand me and where I was coming from. I suppose it was beneficial for me because I did have some one to talk to and from that I learned ..... He treated me as equal, it wasn't the nurse relationship .....he had an understanding of Irish ways and he gave me information I never had access to. Nobody denied me information but they just assumed I knew what to expect.

Although the assertions of the focus groups were that Irish people were reluctant to seek help or to express feelings, the importance of cultural sensitivity became clear during the course of the interviews. It was also apparent that despite a reluctance to express emotions, even the most vulnerable informants were happy to seek support and talk about themselves in a culturally sensitive environment. This was evident in the fact that a number of informants disclosed matters never previously discussed with anybody else. One vulnerable man thanked me for letting him "get something off his chest" while another felt he would be comfortable expressing his health concerns to somebody as understanding as I was.

7.3 SOCIAL SUPPORT

One of the factors shown to be involved in the protection and maintenance of health is the support of other people and studies have shown a relationship between psychosocial health, disease, mortality and social networks (Blaxter 1990, Berkman and Syme 1979, House et al 1988). This is related to a web of social relationships tying an individual into his community, the number of relationships giving an indication of the degree to which the person is socially integrated. However, equating social support with the existence of a network of social relationships is problematic and it is noted that certain social networks can have a negative impact on health (Rook 1984, Williams 1993b).

7.3.1 Support networks

About half the interviewees had a significant person in whom they could confide everyday worries and who would support them in times of crisis. Those who were married or in a relationship generally confided in their spouse or partner. Some had one

person to rely on but others were able to choose from one or two confidantes depending on the nature of the problem. Adult children were the main source of practical and emotional support for several of the interviewees.

The accounts demonstrated differences in the social networks available to the interviewees. Those who were economically secure and educated tended to have access to effective support networks and appeared to cope better with life's difficulties. This mirrors William's (1993b) argument that those with economic security, social networks and educational advantage are better able to accommodate illness.

Emotional and practical support was a reciprocal arrangement with interviewees giving and receiving help at different times and several had built up a network of friends who provided a listening ear and a lot of understanding. These were generally articulate interviewees who were more likely to be in comparatively comfortable socio-economic circumstances. However the size of a social network did not indicate the importance of individual contacts or their willingness to give encouragement and support when times were difficult. Interviewees relied on a small number of individuals in times of need, discussing different problems with differing people.

The public house was identified by the key informants and focus group respondents as the main source of human contact and social support for young people and for middle aged and older men in particular. However while the pub may have been a source of social contact, the following key informant believed it was unlikely to have been an environment providing emotional or practical support.

KIYM (Gerry) I'm thinking of all the people who I know who came here alone and who would you go and talk to. Well maybe you would go down the pub and cry in your beer but not in a structured or a healing sort of way. There was no route to counselling or to unburden yourself.

Although the pub, the church or any organisation might have provided social contact, what perhaps was more significant than a large social network for the interviewees was having a significant individual to confide in. It was clear from the data that a number of

interviewees had limited support networks or lacked a significant individual with whom they could share their problems. The next excerpt is part of an emotional account by divorced man with poor physical health who was living alone in a single room.

Int. M 6. Lots of friends yes, but, no...no...Nobody to confide in. Nobody only me.

A significant number of male interviewees had no personal social support systems, never having married or being divorced or separated. Lifestyle factors such as drinking or moving around for work played a part in the absence of support systems. A life of hard drinking, living in digs, loss of contact with family at home and increasingly poor health led to virtual social isolation for these men. They had many longstanding acquaintances from the pub but did not consider them supportive relationships, often perceiving other men as having greater need.

Int. M7. There's nobody down there who would understand me so it's best to keep on my own. There's a great lad , he's got a great sense of humour, but he's got his own problems. He's worse than I am.

Some interviewees actively elected to gain their support from statutory or voluntary services because they offered help that family or friends were unable to provide.

Int. F10. I have my social worker who is also my care co-ordinator and I see him on a regular basis. I've got good friends as I say but they find it [mental illness] difficult to cope with.

For a number of interviewees without family or significant social networks the only source of companionship and support was the church or Irish voluntary sector agencies. Church organisations were used less by younger people, whereas Irish advice and welfare agencies were used more by those who were unemployed, homeless or otherwise marginalised. This man, living in a single room identifies the importance of one Irish agency in North London.

Int. M5. Well I come here, Mondays, Wednesdays and Fridays, just to have a cup of tea and a bit of craic with the lads. It's a good place, meet people and feel more relaxed.

There is evidence that those with larger social networks access help more quickly (Radley 1994) and this was evident in the interview data. Having contact with other people and staff in an informal setting may lead to help seeking being "sanctioned" on behalf of the individual. Those approaching voluntary sector agencies even for social reasons, were linked into various statutory services, with staff or volunteers advocating on their behalf and supporting them through the process as required.

7.3.2 Support systems in Ireland

For many participants, the family in Ireland or in other parts of the world was still a source of affective support, with women in particular phoning mothers or sisters frequently, confiding in them and being confided in at times of crisis. This married woman from a large family in both Ireland and England refers to reciprocal support among sisters in both countries.

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Int. F1. What's their troubles is my troubles.

The low cost of travel in recent years not only meant that interviewees were able to go home, but that parents and siblings could also visit London for holidays and family occasions. The telephone was used frequently and regularly to keep in touch with home and family abroad.

Int. F 14. Yes I'm going home next week for three weeks. So I speak to one of them at least every week on the phone. Yes I have sister here but I'm not very close to her, not a close as I am to some of the others who are in Ireland or Australia even.

This had enabled some of the interviewees to resolve family tensions and maintain good relationships with home. This man left home originally because his family had not understood his mental health problem.

Int. M9. I go back regularly, now we phone each other regularly now...Since I went home my mother has said things..... and it's a completely different relationship than I ever had.

Not everybody would confide in the family in Ireland and a number of reasons for this were offered. Some interviewees had been through difficult periods with family because of mental health and other problems, and for some these difficulties had got better but not so for others.

Int. F 10. I think my parents, they have very traditional ideas about mental health. They would been caught up in the whole idea of the stigma of it. And my siblings, I think for them it was just to close to the bone. So you know I've gone through quite hard times with them trying to, I suppose hoping, that they'd accept it as well and come to terms with it. But they haven't, and I have had to find my support elsewhere.

The following narrative echoes the sentiments expressed by a small number of interviewees but may reflect a wider feeling among others with recurrent problems. This widowed mother of five children had regular contact with her family in Ireland, but avoided letting them know of her difficulties.

Int. F8. I deliberately don't phone them. It wouldn't matter how desperate and I have been desperate, I wouldn't phone them. I'm very conscious of being a victim. I have been a victim of circumstances but I am not willing to take the victim role on. I've been in difficulty. I don't [phone] because I feel that they see me as "her", she's got more problems. I've had a lot to deal with in the last few years and I really don't want to be made feel worse or incapable or inadequate in some way.

7.3.3 Reasons for not using social support systems

Although several interviewees had family or close friends to call on, they often chose not to do so or did so only as a last resort. They did this as an active strategy rather than passively opting out as was suggested by some key informant and focus groups. There

were gender differences in reasons for not seeking professional or family help with men attempting to be "macho", while women perceived themselves as incapable or inadequate if they asked for help. Interviewees with family or other support networks often tried to protect them from stress and anxiety, or were reluctant to add to the burdens they already had.

There were practical reasons why people chose to keep their problems to themselves. Friends or family often had little understanding of the problem or experience of similar situations. Not everybody was able to help because of a lack of practical and emotional resources. It was highly probable that those in a position to support were also involved to some extent in the same situation and there is evidence that those who are under stress have fewer resources with which to help others (Sarafino 1990).

People with mental health problems had particular difficulty getting help. Even when they were willing to confide, family, friends and other acquaintances were unable to cope with them. This is not unique to Irish people and there is widespread discomfort in most communities around being with people who have mental illness.

Int. M 9. It wouldn't look good for me to walk up and to start speaking about my illness, speaking up, speaking to you. If I was in pub and if I said I was feeling depressed or feeling insecure they would be thinking " he's a header and I wish he would remove himself from me".

The reality of a mentally ill relative may be too close to bear for somebody already under stress. However it is possible, that some may have been reluctant to identify with a friend or relative's distress because their own memories of cruelty and abuse.

Int. F10. People did find it difficult coming to hospital to hear me say the things I was saying. Sort of about my past, they certainly wouldn't have known the details [of abuse] or hearing me talking about suicide, they wouldn't know how to deal with that. It would have been difficult for them to cope with, I appreciate that. So I won't ring them up when I'm feeling like that. Because I know they find too difficult to handle.

7.3.4 Locus of control and self-efficacy

The literature on locus of control and self-efficacy were relevant to both health behaviour and help seeking. The kernel of self-efficacy is the extent to which people see themselves in control of forces that affect their lives (Pearlin 1981). As discussed in chapter four and five a number of external factors impacted on the lives of Irish people and led them to believe they had no internal control over their lives. According to the key informants, aspects of cultural and religious socialisation damaged Irish people and contributed to a feeling of powerlessness. Childhood and migration experiences had the potential to engender an external "locus of control" and a persistent feeling of not being able to control their everyday lives. In order to take action, the individual needs to believe it will have a favourable outcome and that they have the capacity to perform it. Repeated unsuccessful attempts to achieve a decent standard of living, find adequate housing or access health care impaired perceptions of ability to change behaviour or find appropriate help.

The key informants argued that childrearing practices, authoritarian schooling and religious dogma required children in Ireland to subordinate to others. The interview data largely support this contention and demonstrate that penalties for expression of individuality or any challenge to authority were high. Since personal control is learned in an environment where children experience respect, encouragement and opportunity, a combination of aspects of Irish life will almost certainly have played a part in the development of perceptions of control among Irish people. Only a quarter of the interviewees recall a happy childhood and only two enjoyed their schooldays. One of the recurrent themes in the data is the cold, authoritarian family and the harsh, disciplinarian school and the accounts provide evidence of punitive strictness through to physical and psychological cruelty.

The following interviewee brought up in an authoritarian family and educated by a religious order describes the how it took time and therapy for him to take control of his life.

Int. M2. Speaking for myself it took me three years of therapy to be able to understand that I had control over my life. And it came as a blinding flash and it was very powerful. Suddenly I am in control, I can make decisions which affect everything about me.

The key informants argued that socialisation processes in the home and school left people with a deep sense of insecurity as well as a lack of social skill which impaired peoples' ability to get to know and understand others. Having high self-esteem can encourage people to believe they can influence aspects of their lives (Marks et al 2000). Self-esteem was considered by the key informants and focus group respondents to be an important attribute lacking in some Irish individuals. This led to low expectations, to consider themselves unworthy of help and to believe they were incapable of accessing the services they were entitled to.

Int. F20. Well it[education] wouldn't have been harmful, but it certainly wasn't empowering. It did nothing to help you gain a true sense of yourself ...and it prevented me from being comfortable and natural and easy with people.

One of the male key informants described the way in which clients, educated by religious orders had internalised their powerlessness, regressing in behaviour when they interacted with nuns and priests as adults many years later.

KIYM (Donal) I'm thinking of the people I work with and the way they interface with nuns and priests. They suddenly adopt a character of dependence and disempowering. Yes, childlike, yes. It really pisses you off to see them suddenly change, but the parallel to that is they get some warped sense of security from that. And it's all that kind of pain that we've been talking about but it's one kind of security that they still have.

There is evidence that people who are raised in a caring supportive family are more able to seek help (Marks et al 2000). Help-seeking is learned in a consistent, caring and enabling environment but there was evidence from the informants that these characteristics were often in short supply in the Irish home and school. This interviewee expresses the sentiments of several others from largely unproblematic families.

Int. F20 I don't remember her[mother] or my father saying I don't want to hear [about your problems] but that was the message. What I was getting in terms of being unhappy, was " we don't give in ...pull yourself together, sort yourself out, we don't want to know this". I think their attitude was "we just cope".

The data demonstrate that the unfairness experienced by interviewees had the potential to challenge ideas of self-efficacy. The older generation saw their families struggle against severe poverty while others flourished and the younger people watched while others with lower qualifications got the best jobs. Those who were abused in the family, in relationships or in institutions had little reason to believe they were able to control their own lives, although leaving Ireland and appropriate help and support in London had helped some of them.

7.4 COPING STRATEGIES

The data demonstrate that interviewees adopted a range of self-reliant coping strategies to deal with ill-health and social distress. Like other groups, the interviewees relied on their own resources in the first instance with family and significant others next in line to provide affective and practical support. However several interviewees had limited social support, or for a range of reasons chose not to burden others with their problems. The previous chapter highlights the role of smoking and alcohol as strategies for coping with a range of persistent tensions and conflicts in the lives of the interviewees. Religious beliefs and practices and spirituality are highly significant ways of coping used by all the interviewees and appear to give comfort and enhance health and access to health care.

7.4.1 Religious beliefs and practices

According to the key informants religious beliefs and practices were both seen as causing ill-health and coping with it by Irish people. Younger people with few exceptions tended to see reliance on religious practices and the impact of Catholicism as destructive to health. Older people with some exceptions, saw religious beliefs and practices as important culturally specific coping strategies used by Irish people. Reliance on faith and religious rituals were learned in the home and school and were

intertwined in social customs and traditions in Irish society. Although the majority of interviewees were Catholic, the only Protestant in the sample had experienced similar religious socialisation and her faith was an important part of her life. There was a range of adherence to religious beliefs in the group, with some who were deeply religious and practicing their religion to others who were atheist. What the interview data demonstrate however is the importance of religion or spirituality in the lives of all the interviewees, even those who had rejected religion in all its forms.

Religious observance was a large part of some peoples' lives and a number of the informants relied heavily on faith and prayer for psychological support. Although the following excerpt from a woman in her early forties has more in common with the faith and observance of older people than the younger participants, it highlights the deep devotion of many Irish people.

Int. F13. Every Tuesday I light my candles. I go to Mass every day. I think it's the only thing that's has kept me going Mary. Honestly and truthfully I can say that. And I trust so much in God. I think that's what has helped me through.

The same interviewee highlighted how she had used her faith as an alternative to counselling. She had been given a referral letter for counselling when she was in considerable distress and had not taken it to the appropriate service, but had prayed instead. While her GP might have perceived this unwise, she was very content that prayer had helped her more than any professional help could have done.

Int. F13. That was a year and a half ago cos I thought I'll sort it out myself. And I've still got the letter sitting on the side. I did, I prayed and prayed. I knew it would work and it did.

Not everybody had the consistent and deep faith of the previous interviewee. For others, religion was a background part of their lives which became more important when they were faced with difficulty.

Int. M17. When people are in difficulty, any kind of difficulty, it brings their mind back to God. Religion is not a load to bear, it's there to give people strength and courage.

Although all the participants had been raised in a religious environment many were disillusioned with Catholicism.

Int. F16. I don't believe it's bad to have been brought in a religion, from the point of view of morals, but at the same time I think I had too much of it being shoved down my throat. And it put me off it completely.

Many could not cope with the dogma, whereas others could not reconcile the teachings of Christianity with the lack of concern showed to those in difficulty. This man recounted how his widowed mother was admonished by the parish priest for not making weekly contributions to the Church after the death of his father.

Int. M12. We had no help at all from the Church, no help at all. And Mammy with five children, she gave birth to the fifth after Daddy died……as I say I became an Atheist.

However despite very negative feelings about religion, a number of interviewees found themselves automatically turning to prayer or religious practice when in distress.

Int. M2. I find myself praying but it's not a conscious thing. I find myself praying and I think " what am I doing, this is ridiculous".

Despite the fact that many people turned away from Catholicism it still played a part in the way in which they dealt with illness or distress. It seemed like an automatic response for many but was quickly rejected in some cases.

Int. F16. When I got the cancer I thought what am I going to do. You know I felt maybe this is the situation where prayer might help me, but that feeling didn't last very long.

Although avowed religion was rejected by some, religious rituals still had therapeutic or comfort value for the interviewees and were engaged in not just for the individual but for the sake of other members of the family.

Int. M2. When you are repeating something over and over again like say the Rosary. It can be very soothing and calming. I always light candles.

When one interviewee was mentally ill his religious upbringing came to the fore. It is not clear whether this formed a part of his symptoms or his support structure. The significance of religion in psychiatric symptomatology is recognised in some cultural groups, but there is little written about the experience of Irish people. The following account might easily have been misinterpreted as religious ideation, but was more likely to have been the learned response of a young Irish man in acute distress.

Int. M 9. What I did discover through my psychiatric illness, was that at times it comes back to you unconsciously. I chanted stuff in my head. Yes I would pray 3, 4 or 5 times a day.

A number of people expressed the view that spirituality was more important than religion. This is in keeping with a wider social movement towards secularism and the growth of interest in non-religious philosophies in society today.

Int. M9. Religious not, spiritual yes…… I don't even believe now that a God exists the way we were taught he existed. Yes, I do believe in prayer and the power of prayer. There is something there, but for me its more spirituality than religion.

One woman who had become interested in spiritual healing believed that her religious upbringing had been a strong influence on this. She had rejected the religion forced on her by nuns in school, but had developed a strong spirituality and a belief in her own powers of healing.

Int. F8. So I found this [spiritual healing] interesting because there was no religion attached to it.

Many of the interviewees expressed horror at the institutional abuse revealed in the media in the last three years. Those who had been victims of these abuses had rejected Catholicism and had negative and hostile attitudes to both religion and the clergy. This may have left them without a framework for their lives as well as the absence of a psychological support system in times of need.

However despite the assertions of key informants and some focus group respondents it was clear that religious beliefs or alternatively spirituality were important coping mechanisms for the majority regardless of religious observance. It was striking that interviewees who were in better health were more likely to adopt religious or spiritual ways of coping at least in the first instance. The two interviewees who were most adamant about relying on their own resources and coping alone (despite social networks), had rejected religion twenty years before and did not consider themselves spiritual. All the interviewees describing themselves as either not very healthy or definitely ill eschewed religious beliefs. This may reflect the abuse experienced by half of them at the hands of religious orders. On balance the interview data challenges the assumptions of the key informants and some focus group respondents and suggests that religious or spiritual beliefs may be protective and therapeutic.

7.4.2 A specifically Irish culture of coping ?

Key informants and focus group respondents repeatedly suggested that Irish people chose to cope alone rather than seek professional help or the support of family and friends. It was clear that the majority of interviewees endeavoured to cope alone at first, seeking help only when they couldn't cope and preferring to use Irish organisations rather than professionals or statutory agencies. However the accounts of the interviewees question to what extent this was a free and willing choice made by the participants or whether this independence was a particularly Irish phenomenon. The openness and self -disclosure of the interviewees to a virtual stranger and the evidence they provided, suggest that in the right environment people are willing to express their anxieties and their distress. This man revealed for the first time, the abuse that he had been subjected to in an industrial school.

Int. M7. No it[depression] needs treatment ...it's...it's not very nice, day in day out, down all the time. If I can even get it off my chest. It would depend on the person. Somebody who would understand. I'd talk to somebody like that. Like yourself for instance, I can easily talk to you.

However a general lack of understanding of mental illness or sensitive issues like domestic violence and sexual abuse were likely to push people to keep their problems to themselves. There was an element of choosing not to seek help and preferring to cope alone by some Irish people, but it is difficult to say whether this was a peculiarly Irish phenomenon.

It was clear that the absence of quality and culturally sensitive services drove people to be more self- reliant than may have been in their best interests. Lack of information about existing services meant that some who might have been willing to seek help were forced to find their own ways of coping. Making demands on friends and family who were also in difficult situations encouraged people to do what the following interviewee did when things got bad.

Int. F13. I've told you things that I've never told anyone. I put on my false face, that's what I do. I keep my own counsel.

The key informant data suggest that self-help was a form of opting out which was not necessarily in the best interests of the individual. However the interview data suggest that while it might not always have been the best approach for somebody in poor health, it had other advantages in balancing the negative effects of ill-health. The narratives indicate that multiple factors engendered self-reliant ways of coping with ill-health and distress. Self - reliance was a considered strategy used by people who had lived in and continued to live in very complex and difficult circumstances. For many it had been a tried and tested form of self-efficacy.

Several interviewees coped with extremely difficult situations in their lives and adopted extreme coping strategies in order to survive psychologically. Many engaged in what is described as "emotion focussed coping" where strategies are adopted to minimize the

emotional response to stressful situations (Lazarus and Folkman 1984b). They are used when a situation is perceived as unchangeable but there is a need to limit the effects on the individual. Strategies like repression, denial and detachment may have become effective coping strategies over the years and it may not be easy to adopt a "problem focused" approach to tackling the real issues later in life. This survivor of institutional abuse highlights the slow and painstaking process in learning to trust again.

Int. F3. I really do hurt very, very much. But it's this barrier I put up. I put up layers, but I'm trying to get rid of the layers step by step. But they are hard to break down.

The interviewee accounts reflect expectations that people will not be a burden to others. The narratives are not mere biographical descriptions but allowed the informants to present themselves in a particular way. The accounts presented an image of individuals as virtuous and strong using metaphors of fighting, survival and tenacity which they described as attributes of Irishness. The following interviewee suggests that surviving was part of her being Irish and her narrative reflects her own personal struggle as a child in Ireland and as well as a survivor of the mental health system in England.

Int. F10. I've done this over the years. It's been like a coping strategy for me. When I suffered depression before and I've gone down. I could just pull myself back up again in one way or another. I suppose it's the fighting spirit...it's a part of the Irishness in me. I look on myself as a survivor. A survivor of abuse and of a dreadful mental health system.

The account may well reflect the inability to access effective help from family or professional services reported elsewhere in the study. Aligning personal strength to ethnic identity may also be a feature of the need to portray a positive image of being Irish. This is not unique to Irish people, but such need may be amplified in British society where there is an additional negative dimension to being Irish.

Metaphors of strength and fighting allow people to portray themselves in a positive light, but also enable people to come to terms with illness. They may be particularly important for those who have little material success to boast of, but can take pride in

coping and surviving ill health and other difficulties (Blaxter 1993). Those who had managed to live with severe hardship, illness and disability most effectively had a sense of coherence (Antonovsky 1984). They had worked out the reasons for their poor health, recognising their own lack of blame for their circumstances. They had learned ways of managing their situation and developed coping strategies with made life reasonably predictable. However what was perhaps more significant, was the way in which their lives had meaning and in particular the dignity afforded by being able to cope alone without the shame of being a burden.

7.5 SELF-RELIANCE : A RESPONSE TO INSENSITIVE OR INAPPROPRIATE SERVICES ?

Although the key informants and focus groups emphasise the unwillingness of Irish people to access help and health care, the narratives highlight a range of discriminatory practices and professional ineffectiveness which encouraged the interviewees to rely on their own resources. This fits with Williams (1993a) assertion that although self-reliance is seen as an important social value, the reality of ineffectual medication or incompetent practice is more important in driving people cope alone.

7.5.1 Impact of stereotypes on access

The impact of racist stereotyping on the willingness of interviewees to consult doctors or other practitioners is striking in the data. This is consistent with the high use of pharmacists, social workers, voluntary agency staff and the elevated incidence of hospital admissions reported by Aspinall (2001). Specific barriers include having an Irish accent and the experience or fear being of stereotyped an alcoholic and are causes of offence and anger. They account for avoidance or considerable delay in seeking help as interviewees have little confidence in practitioners who belittle them or make stereotypical assumptions.

Admitting any level of alcohol use proves a barrier for those with mental health problems prior to or having accessed the healthcare system. Several interviewees highlight the role of alcohol in coping with the symptoms of depression and everyday stresses and the potential for misdiagnosis because of this. Focussing on alcohol as the primary problem neglects the treatment of underlying disorders or at best marginalises

the way in which they are treated. The evidence that Irish people are among the highest users of mainstream alcohol services in England, suggests that many mental health problems may be treated primarily as alcohol problems (Kennedy and Brooker 1986, Luce et al 1999). It may also reflect the inability to access appropriate mental health services or the willingness of Irish people to identify an alcohol problem rather than mental ill-health.

The pathologisation of Irish families evident in the data is less widely recognised. Such institutional discrimination is recognised in relation to Black families but the invisibility of Irish people is rarely addressed in the anti-discriminatory discourse which informs social work practice (Garrett 1998). In view of the extent of childhood disability in the sample and in the Irish population in Britain this is worthy of further consideration.

7.5.2 Individual and cultural factors as barriers.

Key informants postulated that one of the reasons why Irish people did not seek help from professionals or family was their reluctance or inability to express emotions. The interview findings challenge this notion, but demonstrate differences in the language available and confidence to express psycho-emotional issues. Despite reluctance initially, people with very painful life stories and distressful lives talked freely and openly and a small number disclosed matters never discussed previously. The biographies of abuse suggest that a major barrier to emotional expression by the interviewees is the fear of not being believed or being blamed for their situation. It is well documented that abused children were not believed in the past, and the experience of speaking out led to further recriminations and punishment (Raftery and O Sullivan 1999). This shapes expectations of being heard and getting help and may be compounded by repression or denial as a way of coping with distress.

The data suggest some interviewees are deterred by a fear or mistrust of professionals or people in authority and cite racism and harassment by police, health professionals and staff in statutory agencies. Older interviewees in particular highlight their socialisation in authoritarian families, disciplinarian schools and their learned subservient to doctors, teachers, priests and others considered their "betters". Younger and educated Irish people are more confident about expressing their feelings, but in an

environment which attaches a number of negative labels to being Irish, the stress of negotiating care and the priority of other aspects of life impact on access to services.

7.5.3 Personal preference or Hobson's choice?

The key informants mostly expressed the belief that emotional illiteracy and the stigma of mental illness prevented people from accessing counselling, therapy and psychiatric help. The data show that although some are deterred by the stigma associated with mental illness, the majority are willing to seek professional help for social and psychological problems. As is the case for the general public there are not enough services to meet demand, and long waiting lists and limited financial means prevent many from getting help early enough. A number of interviewees secured counselling and therapy privately and some eventually accessed it through their GP or the NHS. It is clear that, providing a service is culturally sensitive and the practitioner skilled, even the most vulnerable people are willing to access it. The interviewee accounts show that it is predominantly organisational factors, professional attitudes and practices which account for the reluctance of Irish people to access health care. It is important to recognise that individuals have a choice not to use a service, but in focussing on individual choice, there is a danger of not looking at factors which influence decisions. While there is a preference for Irish services, it is clear that the personal qualities of the practitioner are more important than their ethnicity and that dignity and self respect are central to a positive therapeutic relationship.

7.5.4 Social support and health

Interviewees with support systems, defined themselves as having better health but others had limited opportunities for social support. It is interesting to note that many interviewees rely on the affective and practical support of family in Ireland and elsewhere. Dominant discourses of health emphasise personal responsibility, independence and self-reliance and these discourses are present in the interviewee and lay focus group accounts. The data echo the findings of other studies describing the importance of coping independently and not giving in to illness (Williams 1993a, Williams 1990, Blaxter 1990). A significant difference in this study is the extent of, the multifaceted nature of limiting long-term illness and the low age at which it is experienced by many of the interviewees.

There is evidence that social support buffers people from stress but it depends on the ability of support systems to provide affective material or other tangible forms of aid (Sarafino 1990). Interviewees with support networks are often reluctant to burden family and friends who have problems of their own or who are in no position to offer affective, material or practical support. Whelan (1993) argues that the density of an individual's social network increases the probability of, but does not guarantee social support. This is particularly pertinent for vulnerable male interviewees who mix almost exclusively in public houses in traditionally Irish areas of London, but whose peers are often in similar need.

A number of interviewees have very minimal opportunities for support to buffer the effects of severe or persistent psychosocial stress. Several left Ireland to get away from an oppressive society, but their experiences in Ireland and in England lead them to avoid involvement with the Irish community in London. While this may be therapeutic for some, for others it means a lack of culturally safe opportunities to vent frustrations and an absence of social networks or support systems in times of stress.

7.5.5 Religion and spirituality

The data demonstrate the importance of faith, religious practices and spirituality as coping strategies for the majority of interviewees and those who value either, find comfort and strength and are generally felt able to cope with life. Contrary to the assumption that reliance on religion prevents people from accessing help, the data show they are more likely to be in contact with health and welfare services. This may also reflect their stronger social networks. Two of the healthiest interviewees actively rejected Catholicism twenty years ago and are adamant about relying on their own personal resources. Conversely, those with the poorest health are least likely to rely on religious or spiritual beliefs, but delay getting help or do so only when their health has deteriorated.

There is some evidence that the particular nature of socialisation in Ireland has been damaging. The data suggest that the power of the Church in Ireland deprived some from developing skill and confidence in controlling their own lives. The families of

many and the schooling of the majority appear to lack the caring encouraging and nurturing environment necessary to promote esteem and maximise potential. The interviewees recount a range of factors in the home, school and Church which offered scant encouragement, but instead reinforced negative self-belief and low self-esteem.

Transition into adulthood provides new challenges and sources of information about the self and personal control. Getting a job, being independent, and feeling equal to others offered positive reinforcement to some interviewees for the first time in their lives. This probably enabled them to succeed and have better health while those with poor intellectual and social skills found adult life stressful and less successful. Later in life, working in high effort low control and low reward jobs impacted on perceptions of control over life outside work. Karasek and Theorell (1990) argue that learning accrues over a lifetime of work and the individual's perception of their ability to exert control over the work situation then impacts on broader areas of life. Feeling in control can be health promoting in itself, but is more effective as a buffer since the belief that one can influence one's lot, affords a defence against frustration and hopelessness (Elstad 1998). The repeated failure evident in some of the accounts probably contributes to learned helplessness (Seligman1975) and eventually hopelessness. The data demonstrate that those who had some capacity to control their lives are in better health and endeavour to take at least some measures to protect it.

7.5.6 Self-reliance – an expedient and dignified option

Contrary to the assertions of the key informants and focus group members, self-reliant ways of coping are not necessarily problematic. Self-efficacy for the participants appears to relate more to self-generated ways of coping than seeking help from informal or professional sources. Life both in Ireland and England leads interviewees to adopt different ways of coping which are socially learned, more inward looking, and emotion focused. Despite a number of factors which limit the ability of the interviewees to control their own lives, it is clear that the majority are very much in control, managing their lives as effectively as they know how, but without taking advantage of services which might make life easier. They manage situations they cannot control by limiting the emotional effects (Lazarus and Folkman 1984b) without necessarily dealing with the problems. Although this is disadvantageous at one level, it affords dignity and a sense

of control in their lives to individuals. The tendency to self-generated ways of coping through religion or personal action is a tried and tested response. For many it is less stressful, more effective and expedient than the physical or emotional effort involved in seeking external help. It affords the individual and family a measure of dignity and protects them from the indignity of being seen as scroungers or perceiving themselves as dependent.

Several of the healthier interviewees accounts demonstrate a sense of coherence which enables them to resist the deleterious effects of stress and to manage very poor health and disability. This sense is learned mainly through reliance on personal resources, and in response to the limitations of external provision. They have the motivation and capacity to comprehend their illness and in particular to believe that they can influence it. They are able to rely on their own resources or those at their disposal to manage their health for the most part. What is perhaps more important is that for these individuals, life makes sense emotionally and that their problems are worth investing in. These interviewees are generally higher in intelligence, articulate, in adequate housing but importantly have acquired a sense of being able to control their lives for the most part. They are more confident and have worked at developing a social support system using formal and informal networks. Their sense of coherence enables the interviewees understand their own situation, and use strengths within themselves or their social group to manage difficulties and find meaningfulness and worth in their lives. However although a number of the interviewees have a marked sense of coherence, others have gone some way towards achieving it but are blocked by structural factors. Notwithstanding the real hardships experienced by the majority of interviewees, the data provide evidence of strength, resilience and tenacity which can be promoted and developed in the right health care environment.

PAGE NUMBERING AS ORIGINAL

References.

Abbotts J., Williams R., Ford G., (2001) Morbidity and Irish Catholic descent in Britain : Relating health disadvantage to socio-economic position. Social Science and Medicine, Vol 52, pp 999 – 1005.

Abbotts J., Williams R., Ford G., Hunt K., West P. (1999a) Morbidity and Irish Catholic descent in Britain: Relating health disadvantage to behaviour. Journal of Ethnicity and Health, Vol 4, Issue 1, pp 221-230.

Abbotts J., Williams R., Davey Smith (1999b) Association of medical behavioural and socio-economic factors with elevated mortality in men of Irish heritage in Scotland. Journal of Public Health Medicine, Vol 21, pp 46-54

Acheson D (chair) (1998) Independent inquiry into inequalities in health. London. The Stationery Office

Adelstein A., Marmot M., Dean G., Bradshaw J., (1986) Comparison of mortality of Irish immigrants in England and Wales with that of Irish and British nationals. Irish Medical Journal, Vol 79, pp 185-189.

AGIY (1995) Census briefings. London. Action Group for Irish Youth.

Ahmad W., (1996) The trouble with culture. Chapter 9. D. Kelleher and S. Hillier Researching cultural differences in health. London. Routledge.

ALG (2000) Sick of being excluded : Improving the health of London's black and minority ethnic communities. The Report of the race, health and social exclusion commission. London. Association of London Government.

Aneshensel (1992) Social stress: Theory and research. Annual Review of Sociology, Vol 18, pp 15-38.

Ang-Lydgate M., (1999) Charting the spaces of (un)location : On theorising diaspora. In H. Mirza , (ed) Black British Feminism : A reader . London. Routledge.

Anthias F., Yuval-Davis N. (1992) Racialised boundaries : Race, nation, gender, colour and class and the anti-racist struggle. London. Routledge.

Antonovsky A (1984) The sense of coherence as a determinant of health . In J.P. Matarazzo (ed) Behavioural Health. New York. Wiley.

Aspinall P. (2001) The health status, health services utilization and health related behaviours of adult Irish men in an Inner London Borough : The findings of a population-based Health and Lifestyle Survey. Tunbridge Wells. Centre for Health Services Studies.

University of Kent.

Aspinall P. (1999a) Age standardised rates of limiting long-term illness and permanent sickness in the born in Ireland group. An analysis of local authority variations in Great Britain. London. Guy's, King's and St. Thomas's School of Medicine.

Aspinall P. (1995) Department of Health's requirement for mandatory collection of data on ethnic group of in-patients. British Medical Journal, Vol 311, pp 1006-1009

Badger F., Atkin K., Griffiths R., (1989) Why don't general practitioners refer their disabled patients to district nurses? Health Trends, Vol 21, pp 310-312

Balarajan R., Bulusu L.(1990) Mortality in immigrants in England and Wales 1979-1983 in Britton M.(1990) Mortality and Geography : a review in the mid 1980's. OPCS Series DS, No.9 London.

Bandura A. (1986) Social foundations of thought and action:A social cognitive theory. Englewood Cliffs, NJ. Prentice Hall

Bandura A. (1977) Self-efficacy: Towards a unifying theory of behavioural change. Psychological Review, Vol 84, pp 191-215

Bartley M., Blane D., Davey Smith G. (1998) The sociology of health inequalities. London. Blackwell.

Beale J. (1986) Women in Ireland: Voices of change. London. Macmillan

Ben-Schlomo Y., White I., Marmot M., (1996) Does the variation in the socio-economic characteristics affect mortality? British Medical Journal, Vol 312, pp 1013-1014.

Berkman L., Syme S. (1979) Social networks, host resistance and mortality: A nine year follow-up study of Alameda County residents. American Journal of Epidemiology, Vol 109, pp 186-204

Bernard M. (2000) Promoting health in old age. Buckingham. Open University Press.

Berry J., Poortinga Y., Segall M., Dasen P. (1992) Cross cultural psychology. Cambridge. Cambridge University Press.

Berry J., Kim U. (1988) Acculturation and mental health. In P. Dasen, J. Berry, N. Sartorius. Cross cultural psychology and health : Towards applications. London. Sage.

Blaikie N. (2000) Designing social research. Cambridge. Polity.

Blakemore K. (2000) Health and social care needs in minority ethnic communities: an over-problematised issue? Health and Social Care in the Community, Vol 8, (1), pp 22-30

Blaxter M. (1993). Why do the victims blame themselves? In A. Radley (ed) Worlds of Illness: Biographical and cultural perspectives on health and disease. London. Routledge.

Blaxter M. (1990) Health and lifestyles. London. Routledge

Blaxter M. (1983) The causes of disease: women talking. Social Science and Medicine, Vol 17, (2), p59-69

Blaxter M., Patterson E. (1982) Mothers and daughters: A three generational study health attitudes and behaviour. Oxford. Heinemann

Bosma H., Marmot M., Hemingway H., Nicholson A., Brunner E., Stansfield S. (1997) Low job control and risk of coronary heart disease in Whitehall II (prospective cohort) Study. British Medical Journal, Vol 314, pp 558- 565

Bracken P., Greenslade L., Griffin B., Smyth M. (1998) Mental health and ethnicity : An Irish dimension. British Journal of Psychiatry, Vol 172, pp 103-105 .

Brah A. (1996) Cartographies of diaspora : Contesting identities. London. Routledge.

Brody H. (1973) Iniskillane. London. Allen Lane.

Brunner E., Marmot M. (1999) Social organisation,, stress and health. In M Marmot, R. Wilkinson. Social determinants of Health. Oxford. Oxford University Press.

Buckley M. (1997) Sitting on your politics: The Irish among the British and the women among the Irish. In J. Mac Laughlin (ed) Location and dislocation in contemporary Irish society : Emigration and Irish identities. Cork. Cork University Press.

Burke A. (1976) Attempted suicide among the Irish born population in Birmingham. British Journal of Psychiatry, Vol 128, pp 528-33

Burman E (1994a) Interviewing. In P. Banister, E. Burman, I. Parker, M. Taylor, C. Tindall. Qualitative methods in psychology :A research guide. Buckingham. Open University Press.

Burman E (1994b) Feminist research. In P. Banister, E. Burman, I. Parker, M. Taylor, C. Tindall. Qualitative methods in psychology :A research guide. Buckingham. Open University Press.

Byron M., (1999) The Caribbean -born population in 1990s Britain. Journal of Ethnic and Migration Studies, Vol 25, (2), pp 285 –301.

Cabinet Office (2002) A new commitment to neighbourhood renewal : National strategy action plan. London. The Stationery Office.

Cahill G., Kelleher D. (1999) The health of the Irish: Stress and the negotiation of a contested identity. Paper to British Sociological Association Medical Sociology Conference. September 24-26th, 1999. University of York.

Calnan M. (1987) Health and illness. London. Tavistock

Cameron E., Bernades J., (1998) Gender and disadvantage in health : Men's health for a change. In M. Bartley, D. Blane, G. Davey Smith (eds) The sociology of health inequalities. London. Blackwell.

Castles S., Miller M., (1993) The age of migration : International population movements in the modern world. Basingstoke. Macmillan

Cavelaars A., Kunst A., Mackenbach J., (1997) Socio-economic differences in risk factors for morbidity and mortality in the European Community. Journal of Health Psychology, Vol 2, pp353- 411

Chamberlain K. (1997) Socio-economic health differentials: from structure to experience Journal of Health Psychology, Vol 2, (3) 399-413

Chamberlain K., O Neill D. (1998) Understanding social class differences in health: A qualitative analysis of smokers' health beliefs. Psychology and Health, Vol 13, pp 1105-1119.

Cochrane R. (1983) Social creation of mental illness. London. Longman.

Cochrane R. (1977) Mental illness in immigrants to England and Wales: An analysis of mental hospital admissions, Social Psychiatry, Vol 24, pp 2-11

Cochrane R., Bal S. (1989) Mental hospital admission rates of immigrants to England. A comparison of 1971 and 1981. Social Psychiatry and Psychiatric Epidemiology, Vol 24, pp 2-11

Cohen P. (1988) The perversions of inheritance : Studies in the making of multi-racist Britain. In P. Cohen and H. Bains (eds) Multi-racist Britain. London. Macmillan

Cohen S., Syme S. (1985) Social support and health. London Academic Press

Coldrey B. (1996) "A most unenviable reputation!: the Christian Brothers and school discipline over two centuries. In P. O Sullivan (ed) Religion and identity, Vol 5, The Irish World Wide. Leicester. Leicester University Press.

Cole E., Leavey G., King M., Johnson-Sabine E., Hoare A. (1995) Pathways to care for people with a first episode of psychosis. British Medical Journal, Vol 167, pp 770-776.

Coleman J., Hendry L. (1990) The nature of adolescence. London. Routledge

Commander M., Odell S., Sashidaran S., Surtees P. (1999) Psychiatric morbidity in people born in Ireland. Social Psychiatry and Psychiatric Epidemiology, Vol 34, (11), pp565-9

Connor T. (1987) The London Irish. London Strategic Policy Unit. London. Greater London Council.

Cope H. (2001) Still beyond the Pale ……..? The response of social landlords to the housing and health related needs of London's Irish community. London. Cara Irish Housing Association.

Cornwell J. (1984) Hard earned lives. London. Tavistock.

Crawford R. (1984) A cultural account of "health ": control and release and the social body. In J. Mc Kinlay (ed) Issues in the political economy of health care. New York Tavistock.

Crotty R. (1986) Ireland in Crisis. Dingle. Brandon.

Curtis L. (1984) Nothing but the same old story : The roots of anti Irish racism. London. Information on Ireland.

Dahlgren A. Whitehead M (1991) Policies and strategies to promote social equality in health. Stockholm. Stockholm Institute for Futures Studies.

Dalrymple J., Burke B. (1995) Anti-oppressive practice: Social care and the law. Buckingham. Open University Press.

Davison C., Frankel S., Davey Smith G. (1992) The limits of lifestyle: Reassessing "fatalism " in the popular culture of illness prevention. Social Science and Medicine, Vol 34, pp 675 –685.

DFA (2002) Ireland and the Irish abroad. Report of the Task Force on Policy Regarding Emigrants to the Minister of Foreign Affairs, Mr Brian Cowen T.D. Dublin. Department of Foreign Affairs.

D' Houtard A., Field M. (1984) The image of health: Variations in perception by social class in a French population. Sociology of Health and Illness, Vol 6, pp 30- 60.

Di Matteo M., Kahn K., Berry S. (1993). Narratives of birth and the post partum: Analysis of the focus group responses of new mothers. Birth, Vol 20, (4), pp 204- 211.

DOH (1995) Sensible drinking: The report of an inter-departmental working group. London. Department of Health.

Egan K., Tilki M. (1995) Limited opportunities : Economic disadvantage and access to housing for single Irish women. London. Cara Irish Housing Association.

Elstad J. (1998) The psychosocial perspective on social inequalities in health. In M.Bartley, D. Blane,G.Davey Smith (1998) The sociology of health inequalities. London. Blackwell.

Erens B., Primatesta P., Prior G. (2001) The Health Survey for England 1999. London. The Stationery Office.

Erikson E. (1963) Childhood and society. New York. Norton.

Fanon F. (1986) Black skin, white masks. London. Pluto Classic.

Fernando S. (1988) Race and culture in psychiatry. London. Croom Helm.

Ferrie J. (1997) Labour market status, insecurity and health. Journal of Health Psychology, Vol 2, (3), pp 373-398.

Ferrie J., Shipley M., Marmot M., Stansfield S., Davey Smith G. (1998 a). An uncertain future? The health effects of threats of employment security in white-collar men and women. American Journal of Public Health, Vol 88, pp 1030-1036

Ferrie J., Shipley M., Marmot M., Stansfield S., Davey Smith G. (1995) Health effects of anticipation of job change and non-employment: longitudinal data from the Whitehall II study. British Medical Journal, Vol 311, pp 1264 –9

Fordham S. (1988) Racelessness as a factor in Black students school success: Pragmatic strategy or Pyrrhic victory ? Harvard Educational Review, Vol 58, (1), pp54-58

Foster J., (2003) The Irish alcohol misusers in England : Ill served by research and policy? Some suggestions for future research opportunities. Drugs : Education, Prevention and Policy, Vol 10, (1), pp 57-63

Frankenberg R. (1993) White women, race matters : The social construction of whiteness. London. Routledge.

Freund P., McGuire M. (1999) Health, illness and the social body. New Jersey. Prentice- Hall.

Furnham A. (1994) Explaining health and illness: Lay perceptions on current and future health, the causes of illness and the nature of recovery. Social Science Medicine, Vol 39, (5), pp715- 725

Furnham A., Bockner S. (1986) Culture Shock: Psychological reactions to unfamiliar environments. London. Methuen.

Gaffney M. (1997) Employment and training needs analysis : A report on the vocational guidance, training and employment needs of the Irish population of London. London. Irish Employment and Training Consortium.

Garratt P. (2000) Responding to Irish "invisibility": Anti-discriminatory social work practice and the placement of Irish children in Britain. Adoption and Fostering, Vol 24, (1), pp 23-24

Garratt P. (1998) Notes from the diaspora: Anti- discriminatory social work practice, Irish people and the practice curriculum. Social Work Education, Vol 17, (4), pp 23-33

Gillam S., Jarman B., White P., Law R. (1989) Ethnic differences in consultation rates in urban general practice. British Medical Journal, Vol 299, pp 953- 957

Graham H. (2000)(ed) Understanding health inequalities. Buckingham. Open University Press.

Graham H. (1993a) Hardship and health in women's lives. Hemel Hempstead Harvester Wheatsheaf.

Graham H. (1993b) When life's a drag: women smoking and disadvantage. Department of Health /HMSO. London.

Graham H. (1987) Women, smoking and family health. Social Science Medicine, Vol 25, (1), pp 47 – 56

Greenslade L. (1997). The blackbird calls in grief: Colonialism health and identity among Irish immigrants in Britain. In J. Mac Laughlin (ed) Location and dislocation in contemporary Irish society : Emigration and Irish identities. Cork. Cork University Press.

Greenlslade L. (1995) A good man's fault: Alcohol and Irish people at home and abroad. Alcohol and Alcoholism, Vol 30, (4), pp 407 –417

Greenslade L. (1994) Caoineann an lon dúbh : Towards an Irish dimension in "ethnic" health. Irish Studies Review, Vol 8, pp 2-5

Greenslade L. (1992) White skins, white masks: Psychological distress among the Irish in Britain. P. O Sullivan (1992) The Irish in the new communities. Volume two. The Irish world wide series. Leicester. Leicester University Press.

Greenslade L., Madden M., Pearson M.(1991). Generations of an invisible minority: The health and well being of the Irish in Britain. University of Liverpool Institute of Irish Studies, Occasional Papers Series, No 2, Liverpool. University of Liverpool.

Glynn S. (1981) Irish immigration to Britain 1911-1951: Patterns and policy. Irish economic and social history, Vol 8, pp 50-69

Gross R. (1996) Psychology : The science of mind and behaviour. London. Hodder and Stoughton.

Guba E., Lincoln Y. (1989) Fourth generation evaluation. Newbury Park CA. Sage.

Halpern D. (1993) Minorities and mental health. Social Science Medicine, Vol 36, (5), pp 597-607

Halpern D., Nazroo J. (2000) The ethnic density effect: results from a community survey of England and Wales. International Journal of Psychiatry, Vol 46, (1), pp34-46

Hammersley M. (1993) (ed) Social Research : Philosophy, politics and practice. London. Sage / Open University.

Hammersley M., Atkinson P. (1997) Ethnography : Principles in practice. (2nd ed) London. Routledge.

Hanlon G. (1992) Graduate emigration : A continuation or break with the past. In P. OSullivan (1992) (ed) Patterns of Irish migration. Volume One The Irish World Wide Series. Leicester . Leicester University Press. pp 183-195

Harding S. (1998a) The incidence of cancer among second generation Irish living in England and Wales. British Journal of Cancer, Vol 78, pp 958-961

Harding S. (1998b) Health of the second generation Irish living in England and Wales: Report of a community conference. Federation of Irish Societies. London.

Harding S., Allen E. (1996) Sources and uses of data on cancer patients. British Journal of Cancer, Vol 74, (Supplement xxix), S17-21

Harding S., Balarajan R. (2001) Mortality of third generation Irish people living in England and Wales: Longitudinal Study. British Medical Journal, Vol 322, pp 466- 467

Harding S., Balarajan R. (1996) Patterns of mortality in second generation Irish people living in England and Wales: Longitudinal Study. British Medical Journal, Vol 312, pp 1389-1392

Harding S., Maxwell R. (1997) Differences in mortality of migrants. In F. Drever and M. Whitehead. Health Inequalities. Decennial supplement, No 15, pp 108-21.London. The Stationery Office.

Harding S., Rosato M. (1999) Cancer incidence among first generation Scottish, Irish, West Indian and South Asian migrants living in England and Wales. Ethnicity and Health, Vol 4, (1/2), pp83-92

Harrison L., Carr Hill R. (1992) Alcohol and disadvantage amongst the Irish in England. London. Federation of Irish Societies.

Haskey J. (1996) Mortality among second generation Irish in England and Wales. British Medical Journal, Vol 312, pp 1373

Hazelkorn E. (1990) Irish immigrants today : A socio-economic profile of contemporary Irish emigrants and immigrants in the UK. London. Polytechnic of North London Press.

Helman C. (1990) Culture, health and illness. London. Butterworth Heinemann.

Hemingway H., Marmot M. (1999) Psychosocial factors in the aetiology and prognosis of coronary heart disease : A systematic review of prospective cohort studies. Psychoneuroendocrinology, Vol 22, pp 643-50

Henwood K, Pidgeon N. (1993) Qualitative research and psychological theorizing. In M. Hammersley (1993) (ed) Social Research : Philosophy, politics and practice. London Sage / Open University.

Herzlich C. (1973) Health and illness: A social psychological analysis. London. Academic Press.

Herzlich C., Pierret J. (1987) Illness and self in Society. Baltimore. MD. John Hopkins University Press.

Hickman M. (1995). Religion, class and identity. Aldershot. Avebury.

Hickman M., Walter B. (1997) Discrimination and the Irish community in Britain. London. Commission for Racial Equality.

Hickman M., Walter B. (1995) Deconstructing whiteness: Irish women in Britain. Feminist Review, Summer 1995, pp 5-20

Hillyard P. (1993) Suspect community : Peoples' experience of the Prevention of Terrorism Act in London. London. Pluto.

Holmes C. (ed) (1978) Immigrants and minorities in British society. London. Allen & Unwin.

Hornsby-Smith M. (1987) Roman Catholics in England. Cambridge University Press. Cambridge.

Hornsby-Smith M. Lee R., (1979) Roman Catholic opinion : A study of Roman Catholics in England and Wales in the 1970s. Surrey. University of Surrey.

Hoppe M., Wells E., Wilsdon A., Gilmore M., Morrison D.M. (1994) Children's knowledge and beliefs about AIDS: qualitative data from focus group interviews. Health Education Quarterly, Vol 21, pp 117- 806.

House J., Landis K., Umberson D. (1988) Social relationships and health. Science, Vol 241, pp 540- 545.

Ignatiev N., (1995) How the Irish became white : Race and the making of the American working class. London. Routledge.

Isaakson K. (1989) Unemployment and mental health and the psychological function of work in male welfare clients in Stockholm. Scandinavian Journal of Social Medicine, Vol 17, pp165-9

Jackson J. (1963) The Irish in Britain. London. Routledge / Kegan Paul.

Jenkins R. (1994) Rethinking ethnicity. : identity, categorisation and power. Ethnic and Racial Studies Vol 17, (2), pp197-223

Kandola R., Fullerton J. (1998) Diversity in Action : Managing the mosaic. London. Institute of Personnel and Development.

Karasek R. (1979) Job demands, job decision latitude and mental strain: Implications for job design. Administration Science Quarterly. Vol 24, pp 285-308

Karasek R., Theorell T. (1990) Healthy work : Stress, productivity and the reconstruction of working life. New York. Basic Books.

Karlsen S, Nazroo J., (2002) Agency and structure: The impact of ethnic identity and racism on the health of ethnic minority people. Sociology of Health and Illness. Vol 24, (1), pp 1-20

Karlsen S, Nazroo J. (2000) Identity and structure: Rethinking ethnic inequalities in health. In H. Graham (ed) Understanding health inequalities. Buckingham. Open University.

Kawachi I., Kennedy B., Gupta V., Prothrow-Stith D. (1997) Social capital, income inequality and mortality. American Journal of Public Health., Vol 87, pp 1491-8

Kawachi I., and Kennedy B., Wilkinson R. (1999a) Income inequality and health : A reader. New York. New Press.

Keane J.B. (1993) The contractors : A novel . Cork. Mercier Press.

Kearney R. (1990) (ed) Migrations : The Irish at home and abroad .Dublin. Wolfhound.

Kelleher D. (2001) Problematic identities and health. In M. May, R. Page, E. Brunsden (eds) Understanding social problems. London. Blackwell.

Kelleher D. (1996) The Health of the Irish in England in D. Kelleher, S. Hillier, (1996) (eds) Researching cultural differences in health. London. Routledge.

Kelleher D., Hillier S. (1996) (eds) Researching cultural differences in health. London. Routledge.

Kennedy J., Brooker C., (1986) Irish drinkers in South Camden. Community Psychiatric Nursing Journal, March/April, pp 7-12

Kenny V. (1985) The post colonial personality. The Crane Bag, Vol 4, (1), pp 70-78

Kerr B. (1958) The people of Ship Street. London. Routledge / Kegan Paul.

Kissling E. (1996) Bleeding out loud: Communication about menstruation. Feminism and Psychology, Vol 6, (4), pp 481- 504

Kitsinger J. (1994a) The methodology of focus groups: The importance of interaction between research participants. Sociology of Health and Illness, Vol 16, (1), pp 103 -121

Kowarzik U. (2001) Irish community services: Meeting continuing need. London. Action Group for Irish Youth / Federation of Irish Societies.

Kowarzik U. (2000) Irish community services: Responding to need. London. Action Group for Irish Youth / Federation of Irish Societies.

Krieger N. (2000) Discrimination and health. In L. Berkman and I. Kawachi. Social Epidemiology. Oxford. Oxford University Press.

Krieger N. (1990) Racial and gender discrimination: Risk factors for High Blood Pressure ? Social Science Medicine, Vol 30, (12), pp 1273- 1281

Kreuger R. (1988) Focus groups: A practical guide for applied research. Newbury Park CA. Sage.

Kunst A. (1997) Cross national comparison of socio-economic differentials in mortality. PhD Thesis. Erasmus University Rotterdam cited by M. Shaw, D.Dorling, G. Davey Smith. Poverty, social exclusion, and minorities. In M. Marmot, R. Wilkinson (eds) Social determinants of health .Oxford. Oxford University Press.

Lambert H., Sevak L. (1996) Is cultural difference a useful concept? : perceptions of health and the sources of ill-health among Londoners of South Asian origin. In D. Kelleher, S. Hillier (eds) Researching cultural differences in health. London. Routledge.

Lazarus R., Folkman S. (1984b) Stress, appraisal and coping. New York. Springer.

Leavey G. (1999) Suicide and Irish migrants to Britain: Identity and integration. International Review of Psychiatry, Vol 11, pp 168-172.

Lee. J.J. (1990) Emigration: A contemporary perspective in R. Kearney (1990) (ed) Migrations : The Irish at home and abroad .Dublin. Wolfhound.

Lee R., Fielding N. (1995) User's experience of qualitative data analysis software. In Kelle U., (ed) Computer aided qualitative analysis : Theory methods and practice. London. Sage.

Lennon M., Mc Adam M., O Brien J. (1988) Across the water : Womens' lives in Britain. London. Virago.

Leonard M. (1993) Rape: Myths and reality. In A. Smyth.(ed) Irish women's studies reader. Dublin. Attic Press.

Lorig K. (1993) Self management of chronic illness. : A model for the future. Generations, Vol XVII, (3), pp 11-14

Luce A., Heather N., M Carthy S. (1999) National census of UK alcohol treatment agencies : Characteristics of clients, treatment and treatment providers. Journal of Substance Use, Vol 2, pp112 –120

Lupton D. (1995) The imperative of health : Public health and the regulated body. London. Sage.

Lupton D. (1994) Medicine as culture: Illness, disease and the body in Western Society. London. Sage.

Macintyre S., Hiscock R., Kearns A., Ellaway A. (2000) Housing tenure and health inequalities : A three dimensional perspective on people, homes and neighbourhoods. In H. Graham (ed) Understanding health inequalities. Buckingham. Open University Press.

Macintyre S. (1997) The Black Report and beyond : What are the issues? Social Science Medicine, Vol 44, (6), pp 723- 745

Macken W. (1949) I am alone. London. Pan Books Macmillan.

Mac Amhlaigh D. (1985) Schnitzer O Shea .Dingle. Brandon Press.

Mac an Ghaill M. (2001) British critical theorists: The production of the conceptual invisibility of the Irish diaspora. Social Identities, Vol 7, (2), pp 179-201

Mac Laughlin J. (1994) Historical and recent Irish emigration: A critique of core-periphery and behavioural models. London. University of North London Press.

Mac Laughlin J. (1997)(ed) Location and dislocation in contemporary Irish society : Emigration and Irish identities. Cork. Cork University Press.

Macpherson W. (Chair) (1999) The Stephen Lawrence Inquiry. Report of an inquiry by Sir William Macpherson of Cluny. London. The Stationery Office.

Marcia J. (1980) Identity in adolescence. In J. Adelson Personality development in adolescence. : A cross national and lifespan perspective. London. Routledge.

Marks D., Murray M., Evans B., Willig C. (2000) Health psychology : Theory , Research and practice. London. Sage.

Marmot M., Adelstein A., Bulusu L., (1984b) Immigrant mortality in England and Wales 1970-78 : Causes of death by country of birth. London HMSO.

Marmot M., Adelstien A., Robinson N., Rose G. (1978) The changing social class distribution of heart disease . British Medical Journal, Vol 2, 1109- 1112

Marmot M., Davey Smith G. (1997) Socio-economic differentials in health : The Contribution of the Whitehall Studies. Journal of Health Psychology, Vol 2, (3), pp 275-283

Marmot M., Davey Smith G., Stansfield D., Patel C., North F., Head J., White I., Brunner E., Feeney A. (1991) Health inequalities among British civil servants : The Whitehall II study. Lancet, Vol 337, pp 1387- 1392

Marmot M., Seigrist J., Theorell T., Feeney A. (1999) Health and the psychosocial environment at work. In M. Marmot, and R. Wilkinson. Social determinants of health. Oxford. Oxford University Press.

Marmot M., Shipley M, Rose G. (1984) Inequalities in death –specific explanations for a general pattern. Lancet, Vol 1, pp1003 –6

Marmot M., Wilkinson R.(1999) Social determinants of health. Oxford. Oxford University Press.

Marsh A., McKay S. (1994) Poor Smokers. London Policy Studies Institute.

Mason J. (1996) Qualitative researching. London. Sage.

Mason J. (2002) 2nd ed. Qualitative researching. London. Sage.

Mc Carthy M. (1990a) Early days. Dublin. Kildanore Press.

Mc Carthy M. (1990b) London Years. Dublin. Kildanore Press.

Mc Cluskey D. (1989) Health : People's beliefs and practices. Dublin. The Stationery Office.

Mc Cormick A., Rosenbaum M. (1990) Morbidity statistics from general practice. London HMSO.

Mc Court F.(1996) Angela's ashes : A memoir of a childhood. London. Harper Collins.

Mc Gahern J. (1991) Amongst Women . London. Faber.

Miles R. (1982) Racism and migrant labour. London. Routledge and Kegan Paul.

Miles R. (1993) Racism after race relations. London. Routledge.

Miles M., Huberman A. (1984) Qualitative data analysis : A sourcebook of new methods. Beverly Hills CA Sage.

Miles M., Huberman A. (1994) Qualitative data analysis : An expanded sourcebook. Thousand Oaks CA. Sage.

Modood T., Berthoud R., Lakey J., Nazroo J., Smith P., Vidree S., Beishon S. (1997) Ethnic Minorities in Britain : Diversity and disadvantage. London. Policy Studies Intstitute.

Morgan S. (1997) The contemporary racialisation of the Irish in Britain. An investigation into media representations and the everyday experience of being Irish in Britain. Unpublished PhD thesis. University of North London.

Moore C. (1995) Betrayal of trust: The Father Brendan Smyth affair and the Catholic Church. Dublin. Marino.

Moore D. (1992) Beyond the bottle: Introducing anthropological debate to research into Aboriginal alcohol use. Australian Journal of Social Issues, Vol 27, (3), pp 173-193.

Murray M. (1997) A narrative approach to health psychology: Background and potential. Journal of Health Psychology, Vol 2, (1), pp 9-20

Murray M., Chamberlain K. (1999) Qualitative health psychology : Theories and methods. London. Sage.

Nazroo J. (1999) Ethnic inequalities in health. In D. Gordon, M. Shaw, D. Dorling, G. Davey Smith. Inequalities in health. The evidence presented to the Independent Inquiry into Inequalities in Health chaired by Sir Donald Acheson. The Policy Press.

Nazroo J. (1998) Genetic, cultural or socio-economic vulnerability ? Explaining ethnic inequalities in health. In M. Bartley, D.Blane, G.Davey Smith The sociology of health inequalities. London. Blackwell.

Nazroo J. (1997) The health of Britain's ethnic minorities. London. Policy Studies Institute.

Neeleman J., Mak V., Wessely S. (1997) Suicide by age, ethnic group, coroners verdict and country of birth. British Journal of Psychiatry, Vol 171, pp463- 467.

NIMHE (2003) Inside outside : Improving mental health services for Black and minority ethnic communities in England. Leeds. National Institute for Mental Health / Department of Health.

Ni Nuallain M., O Hare A., Walsh D. (1987) Incidence of schizophrenia in Ireland. Psychological Medicine Vol17, pp943-948

O Carroll I. (1990) Models for movers : Irish women and emigration to America. Dublin. Attic Press.

O Mahoney P., Delanty G. (1998) Rethinking Irish history: Nationalism, identity and ideology. Basingstoke. Macmillan.

Oakley A. (1992) Social support and Motherhood. : The natural history of a research project. Oxford. Basil Blackstone.

Ogden J. (1997) The rhetoric and reality of psychosocial theories of health: A challenge to biomedicine. Journal of Health Psychology, Vol 2, (1), pp 21-30

OPCS (1993). 1991 Census : Ethnic groups and country of birth tables. London. HMSO

Owen D. (1995) Irish born people in Great Britain.: Settlement patterns and socio-economic circumstances. National Ethnic Minority Data Archive. Warwick. University of Warwick.

Papadopoulos I., Tilki M., Taylor G. (1998) Transcultural Care : Issues in for health professionals. Trowbridge. Quay Books.

Parker I. (1996) Qualitative research . In P.Banister , E. Burman, I. Parker, M. Taylor, C. Tindall. Qualitative methods in Psychology : A Research guide . Buckingham. Open University Press.

Patterson D. (1995) Alcoholism – treating the second sex. Irish Journal of Psychological Medicine, Vol 2, pp46-47

Pearlin L. (1981) The sociological study of stress. Journal of Health and Social Behaviour, Vol 30, (3), pp 241- 56.

Pierce M., Armstrong D. (1996) Afro- Caribbean lay beliefs about diabetes. In D. Kelleher, S. Hillier S (eds) Researching cultural differences in health. London Routledge

Pierret J. (1988) What social groups think they can do about health. In R. Anderson, I. Kickbusch, D. Mc Queen, J. Turner (eds) Health behaviour research and health promotion. Oxford. Oxford University Press.

Popay J., Williams G., Thomas C., Gatrell T. (1998) Theorising inequalities in health : the place of lay knowledge. In M.Bartley, D.Blane, G.Davey Smith (eds) The Sociology of health inequalities. London. Blackwell.

Putnam R.D., (1993) Making Democracy Work : Civic Traditions in Modern Italy. Princeton NJ. Princeton University Press

PTAWRA (1987) The Prevention of Terrorism Act : A massive and ongoing breach of civil liberties. Submission to Viscount Colville in conjunction with the Irish Chaplaincy Scheme in Britain and the Irish Commission for Prisoners Overseas. Birmingham. PTA Research and Welfare Association.

Radley A. (1994) Making sense of illness. London. Sage.

Radley A. (1993) (ed) Worlds of Illness : Biographical and cultural perspectives on health and disease. London. Routledge.

Raftery J., Jones D., Rosato M. (1990) The mortality of first and second generation Irish immigrants in the UK. Social Science and Medicine, Vol 31, (5), pp 577- 584

Raftery M., O Sullivan E. (1999) Suffer the little children :The inside story of Ireland's industrial schools. Dublin. New Island.

Raleigh V., Balarajan R. (1992) Suicide levels among immigrants in England and Wales. Health Trends, Vol 24, (3), pp 91-94

Rook K. (1984) The negative side of social interaction : impact on psychological well-being. Journal of Personality and Social Psychology. Vol 46, pp 1097- 1108

Rossiter A. (1993) Bringing the margins into the center: A review of aspects of Irish Womens' emigration. In A. Smyth (ed) Irish women's studies reader. Dublin. Attic Press.

Rossiter A. (1992) Between the devil and the deep blue sea: Irish women, Catholicism and colonialism. In G. Saghal and N. Yuval-Davis (eds) Refusing Holy Orders: Women and fundamentalism in Britain. London. Virago.

Rotter J. (1966) Generalised expectancies for the internal versus the external control of reinforcement. Psychological Monographs, Vol 90, (1), pp 1-28

Ross C., Mirowsky J. (1992) Households, employment and the sense of control. Social Psychology Quarterly, Vol 5, (5), pp 217-235.

Royal Commission (1835) First Report of the Catholic Poor School Committee 1948 (p55), in M. Hickman. Incorporating and denationalising the Irish in England : the role of the Catholic Church in P. O Sullivan P (1996) Religion and identity. Volume 5. The Irish World Wide. Leicester. Leicester University Press.

Rudat K., (1994) Black and minority ethnic groups in England: Health and lifestyles. London. Health Education Authority.

Rudas N., Tondo L., Musio M. (1991) Unemployment and depression : Results of a psychometric evaluation. Minerva Psichiatrica . Vol 32, pp 205-209. In M. Bartley, J. Ferrie, S. Montgomery (2000) In M. Marmot, R. Wilkinson (eds) Social determinants of health .Oxford. Oxford University Press.

Ryan L. (1990) Irish emigration to Britain since World War II. In R. Kearney (ed) Migrations : The Irish at home and abroad.Dublin. Wolfhound.

Sales R. (1997) Women divided : Gender, religion and politics in Northern Ireland. London. Routledge.

Sashidharan S. (2001) Institutional racism in British Psychiatry. Psychiatric Bulletin,Vol 25, pp 244- 247

Sarafino E. (1990) Health psychology : Biopsychosocial interactions. New York. Wiley.

Sapolsky R. (1993) Endocrinology alfresco: Psychoendocrine studies of wild baboons. Recent Progress in Hormonal Research, Vol 48, pp 437- 68

Scheper – Hughes N. (1979) Saints , scholars and schizophrenics : Madness and Badness in the West of Ireland. Berkeley . University of California Press.

Seeman T. (1996) Social ties and health -the benefits of social integration Annals of Epidemiology, Vol 6, pp 442-51

Seidel J., Kelle U. (1995) Different functions of coding in the analysis of textual data. In Kelle U. Computer aided qualitative data analysis : Theory methods and practice . London. Sage.

Seigrist J., Peter R., Cremer P., Seidel D. (1997) Chronic work stress is associated with atherogenic lipids and elevated fibrinogen in middle aged men. Journal International Medicine, Vol 242, pp149-56.

Seligman M. (1975) Helplessness: On depression, development and death. San Francisco. Freeman.

Semmes C. (1996) Racism, health and post-industrialisim : A nation of African-American Health. Westport. CT. Praeger.

Shaukat N., Lear J., Fletcher S., de Bono D., Woods KL (1997) First myocardial infarction in patients of Indian subcontinent and European origin : Comparison of risk factors, management and long term outcome. British Journal of Medicine Vol 309, pp1470-1474

Shaw M., Dorling D., Davey Smith G. (1999) Poverty, social exclusion, and minorities. In M. Marmot, R. Wilkinson (eds) Social determinants of health .Oxford. Oxford University Press. pp 211 –239

Shively C., Clarkson T. (1994) Social status and coronary artery atherosclerosis in female monkeys. Arteriosclerosis and Thrombosis : A Journal of Vascular Biology. Vol 14, pp721 –726

Sidell M. (1995) Health in old age. Myth, mystery and management. Buckingham. Open University Press.

Smaje C. (1995) Health, race and ethnicity : Making sense of the evidence. London. London Kings Fund.

Smith J., Jarman M., Osborn M. (1999) Doing interpretative phenomenological analysis. In M. Murray and K.Chamberlain (eds) Qualitative health psychology: Theories and methods. London. Sage.

Smyth A. (1993) (ed) Irish women's studies reader. Dublin. Attic Press.

SSI (1997) They look after their own, don't they ? : Inspection of community care services for black and older ethnic minority people. London. Social Services Inspectorate/Department of Health.

Spinley B. (1953) The deprived and the priviledged. London. Routledge / Kegan Paul.

Stainton-Rogers W. (1991) Explaining health an illness : An exploration of diversity. Hemel Hempstead. Harvester.

Stansfeld S. (1999) Social support and social cohesion. In M.Marmot, R.Wilkinson (eds) The social determinants of health. Oxford. Oxford University Press.

Storkey M. (1994) London's ethnic minorities. London. London Research Centre

Syme S., Oakes T., Freidman G., Feldman R., Siegelaub A., Collen M. (1974) Social class and racial differences in blood pressure. American Journal of Public Health, Vol 64, p 619

Tilki M. (1996) The health of the Irish in Britain. Federation of Irish Societies Bulletin, No 9, pp-11-14. London. Federation of Irish Societies.

Tilki M., Papadopoulos I., Alleyne J. (1994) Learning from colleagues of different cultures. British Journal of Nursing, Vol 3, (21), pp 1118-1124

Tilki M., Mc Evoy D., (1996) Culturally sensitive reminiscence. Federation of Irish Societies Bulletin, No 10, pp 8-11

Ullah P. (1985) Second Generation Irish youth: Identity and ethnicity. New Community, Vol XII, pp 310-20

Wardle J., Farrell M., Hillsdon M., Jarvis M., Sutton S., Thorogood M. (1999) Smoking, drinking, physical activity and screening uptake and health inequalities. In Gordon D., Shaw M., Dorling D., Davey Smith G.(eds) Inequalities in Health : The evidence presented to the Independent Inquiry into Inequalities in Health Chaired by Sir Donald Acheson. London. The Policy Press.

Walls P. (1996) Researching Irish mental health : Issues and evidence : A study of mental health of the Irish community in Haringey. London. Muintearas.

Walsh J., Mc Grath F. (2000) Identity, coping style and health behavoiur among first generation Irish immigrants in England. Psychology and Health, Vol 15, pp 467-482.

Walter B. (2000) Outsiders inside : Whiteness, place and Irish women. London. Routledge.

Walter B. (1997) Contemporary Irish settlement in London : Women's worlds, men's worlds. In J. Mac Laughlin (ed) Location and dislocation in contemporary Irish society : Emigration and Irish identities. Cork. Cork University Press.

Walter B. (1995) Irishness gender and place. Environment and Planning : Society and Place, Vol 13, pp 35-50

Walter B. (1984) Tradition and ethnic interaction :second wave Irish settlement in Luton and Bolton. In Clarke C., Ley D., Peach C. Geography and ethnic pluralism. London. Allen and Unwin.

Walter B. with Gray B., Almeida Dowling L., Morgan S. (2002) Irish emigrants and Irish communities abroad. : A study of existing sources of information and analysis for the Task Force on Policy regarding Emigrants. Dublin. Department of Foreign Affairs.

Warr P. (1987) Work, unemployment and mental health. Oxford. Oxford University Press.

Wenger C. (1988) Old peoples' health and experience of caring services. London Macmillan.

Whelan C. (1993) The role of social support in mediating the psychological consequences of economic stress. Sociology of Health and Illness, Vol 15, (1), pp 86-101

Wild S., Mc Keigue P. (1997) Cross sectional analysis of mortality by country of birth in England and Wales 1970- 1992 British Medical Journal, Vol 314, pp 705- 710

Wilkinson R. (1999) Putting the picture together : Prosperity , redistribution, health and welfare. In M. Marmot and R. Wilkinson (eds) Social determinants of health. Oxford. Oxford University Press.

Wilkinson R. (1996) Unhealthy Societies : The afflictions of inequality. London. Routledge.

Wilkinson R. (1992) Income distribution and life expectancy. British Medical Journal, Vol 304, pp 165-168

Wilkinson R. (1990) Income distribution and mortality : A natural experiment. Sociology of Health and Illness, Vol12, pp 391-411

Wilkinson R. (1986) Income and mortality. In R. Wilkinson. (ed) Class and health : research and longitudinal data. London. Tavistock.

Williams G. (1993a) Chronic Illness and the pursuit of everyday life. In A. Radley (ed) Worlds of Illness : Biographical and cultural perspectives on health and disease. London. Routledge.

Williams R. (1993b) Religion and illness. In A. Radley (ed) Worlds of Illness : Biographical and cultural perspectives on health and disease. London. Routledge.

Williams R. (1992) The health of the Irish in Britain. In W. Ahmad (ed) The politics of health and race. Bradford . Race Relations Research Unit.

Williams R. (1990) The Protestant Legacy : Attitudes to death and illness among older Aberdonians. Oxford. Oxford University Press.

Williams R. (1983) Concepts of illness : an analysis of lay logic. Sociology, Vol 17, pp185-204

Wilkinson S. (1986) Feminist social psychology: Developing theory and practice. Buckingham. Open University Press.

Wilkinson S. (1998) Focus groups in health research. Journal of Health Psychology, Vol 3, (3), pp 329-348

Woollett A., Marshall H., Nicolson P., Dosanjh N. (1994) Asian women's accounts of ethnic identity: The impact of gender and context in the accounts of women bringing up children in East London. In K.Bhavnani, A.Phoenix (1994) Shifting identities and shifting racisms : An introduction. London. Sage.

Zborowski M., (1952) Cultural components in response to pain. Journal of Social Issues, Vol 8, Fall, pp16-30

Zola I. (1973) Pathways to the doctor: from person to patient. Social Science Medicine, Vol 7, pp 677- 689

Appendix A

Schedule of topics for lay focus groups

What you think good health is ?

Can you be healthy and still have some kind of illness ?

What do you do to keep healthy and stop yourself becoming ill?

What sort of things make you ill?

What sort of things do you do to deal with fairly minor illnesses?

What kind of things would make you go to the doctor?

Do you think that Irish people are particularly prone to poor health ?

Why is that?

Do you always identify as Irish?

If not in what situations?

Appendix B

Schedule of topics for key informant focus groups.

What contributes to the poor health profile of Irish people in Britain ?

What is it about the experience of coming to England or living in England that could be damaging for some?

Why do some Irish people manage to be successful /healthy while others do badly?

In what way if any, does Ireland play a part in generating success or failure for individuals?

What are the particular issues for men/women/older people?

What role do friendships or social networks play in maintaining health or causing illness?

What encourages/prevents people from mixing with English or other people or participating in community events ?

What encourages/prevents people from mixing with Irish people or participating in Irish community events ?

Why are some Irish people reluctant to go to a doctor?

How does religion/faith affect health?

Appendix C.

Schedule of topics for semi-structured interviews.

Tell me about yourself , where you live, how long you've been here

When did you emigrate and why?

What were your memories of home and childhood?

How long did you plan to stay?

What made you change your mind?

What has been the best thing about living here?

What has been the worst thing about living here?

Did you ever feel you were treated unfairly because you were Irish?

Tell me about the place you live, the house, the neighbours, how long you've been there?

Do you feel you belong in the area ?

Do you belong to any local organisations or community groups ?

Do you ever attend Irish social events ? How often ? If not why not ?

Do you always identify yourself as Irish ? Do your children identify as Irish

In what situations have you found it uncomfortable to be Irish?

How much contact do you have with Ireland / family ?holidays

What would you do if you had a serious but not life threatening illness?

If you were depressed or worried who would you confide in?

What stops you confiding in others?

How often do other people confide in you?

Who would help you if you were ill or had an emergency?

How much is religion or prayer part of your life?

Do you ever rely on prayer rather than asking for help or going to the doctor?

How has your religious upbringing affected your life ?

Do you ever feel low or depressed?

What sort of things cause you to feel like this?

Do you ever smoke or drink more when you are feeling low?

What were your experiences with GPs and hospital doctors like?

Do you always follow the treatment the doctor gives you?

Have you ever regretted not going to the doctor sooner?

Do you ever feel lonely and isolated ?

Appendix D

Confidential biographical details – interviewees

Date of birth: .....**Are you** :Male.....Female .....

Are you : Single.....Married.....Living as a couple.....
Divorced/Separated .....Widowed .....

Were you born in : Irish Republic .....Northern Ireland .....

What year did you come to Britain .....

What level of education did you attend : Primary.....Secondary.....
Technical.....University.....Other (please state .....

What is your occupation/former occupation .....

What is your housing tenure : Owner.....Local Authority.....
Housing Association.....Private rented.....Tied.....
Other (please state) .....

Do you have access to a car: Yes.....No.....

Tick the statement that best describes you :

I am very healthy .....

I am reasonably healthy .....

I am not very healthy .....

I am definitely ill.....

How much do you smoke per day.....

How many units of alcohol do you consume in one week .....

Are you currently having any treatment for illness : Yes.....No.....

If yes, are you willing to identify the illness/illnesses .....
.....

Is the treatment you are receiving : NHS.....Private doctor of hospital.....
Complementary therapist .....Other (please state).....

Thank you for giving your time to help the Irish community in London.

Appendix E

Letter to management committees

Dear

I am currently undertaking research on the health of Irish people in London as part of my doctoral studies with Middlesex University. I hope to undertake a number of focus groups to identify key issues for further exploration in individual interviews. I would like to involve 6-8 participants who are either staff or committee members and anticipate that the exercise will take 45 minutes to an hour. I would like with the groups permission to record the focus groups for purposes of analysis.

Any organisation or individual is free to refuse or to withdraw without explanation at any time during the study. Strict confidentiality will be maintained and only myself and my academic supervisors would have access to the data. The findings of the research will be published in my thesis and possibly in articles or books in time. Quotes from individual participants will be used for illustrative purposes and numbers or pseudonyms will be used to protect the identity of contributors.

It is anticipated that the final research report will not be available for two to three years but a summary of the findings will be sent to participating organisations.

I am happy to arrange a suitable venue but would be very grateful if it were possible to hold the focus group in your premises. In the interests of using time efficiently the focus group could be part of or added on to an existing meeting. I would be grateful if you were to suggest one or two possible dates.

Please do not hesitate to ring me if you need any more information.

Yours sincerely

Mary Tilki

Appendix F

Information letter to interview participants

Dear .....

Thank you for agreeing to discuss the possibility of participating in my research. I am researching the health of Irish people as part of a doctoral degree with Middlesex University. The interview would take approximately one hour and it could be arranged at a time and venue suitable to you. I would like to record the interview with your permission and any information you gave would be treated in confidence. Your name will not be used or your identity in any way disclosed and the interview material would only be seen by me and my supervisors. You are free to refuse or to withdraw at any time during the research without any questions being asked.

The findings of my research will be published in a thesis which will be publicly available through the university library in two to three years time. Quotes from your interview may be used for illustrative purposes but your identity will be protected by the use of a code number. I anticipate that in time, the research will also be publicised through journal articles, books and conferences but again without disclosing the identity of any participant.

I am a registered nurse with considerable experience of dealing with sensitive health related issues and being an Irish woman I am familiar with many of the issues which affect Irish people in London.

I do hope you will able to participate and I am happy to answer any questions you may have before you make a decision. I will also provide you with a summary of the research report when it is complete if you would like this.

Yours sincerely

Mary Tilki

Appendix G **Analytic categories in qualitative data**

First order analysis	Second order analysis
Early childhood/schooling	Life in Ireland
Early life experience /family life	
Reasons for migration	Migration experience
Arrival experiences	
Settling down	
Discrimination and racism	Feeling disadvantaged / excluded
Sense of belonging	
Perceptions of area	
Participation in Irish activities	Ethnic identity
Irish identity	
Identity of children	
Self concept	Learned behaviour
Health beliefs/behaviour	
Professional help seeking	
Expression of emotions	
Health care experiences	Insensitivity /incompetence / racism
Compliance with medication	
Significant life events	Extreme hardship
Impact of ill-health	
Health problems	
Faith and prayer	Coping styles /strategies
Social support network	