

Public Pressure, Private Protest: Illness Narratives of West Indian Immigrants in Montreal with Medically Unexplained Symptoms.

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**Public Pressure, Private Protest: Illness Narratives of West Indian Immigrants in Montreal
with Medically Unexplained Symptoms [ABSTRACT]**

Some evidence suggests that West Indian immigrants in Canada are a marginalized and over-burdened group. However, little attention has been given to examining health status and beliefs. We partly redress this gap by investigating health beliefs of West Indian immigrants in Montreal with somatic, emotional or medically unexplained symptoms. The overall aim was to elicit and explore illness narratives, explanatory models, symptom-attribution and help-seeking in the community. A sample of 15 West Indian immigrants took part in semi-structured interviews. We found that participants overwhelmingly ascribed their symptoms to post-migratory experience. They particularly highlighted the importance of two related factors: chronic over-work since migration and irregular patterns of daily living. Many worked long-hours, including over-time and moonlighting. Participants related their irregular patterns of daily living to disturbances of bodily functions (e.g. sleeping, eating) as well as to social functions (e.g. family-life). These themes reflected elements of ethno-physiological beliefs common in the West Indies, as well as North American illness models. Attributing medically unexplained symptoms to overwork and irregularity in personal and social realms may be a socially acceptable way of critiquing perceived injustices in participants' work, social and interpersonal situations. This is especially so because the dominant discourse regarding race and ethnicity in Canada tends to emphasise positive aspects of multiculturalism- only reluctantly acknowledging conflict and inequality. Narratives could be interpreted as an oblique criticism of Canadian society's apparent indifference to participants' ongoing marginalisation.

Public Pressure, Private Protest: Illness narratives of West Indian Immigrants in Montreal with Medically Unexplained Symptoms.

Introduction

In this paper we examine the illness narratives of West Indian¹ immigrants in Montreal, Canada with medically unexplained symptoms or emotional distress. Exploring the illness narratives of this group is of particular interest for several reasons. Senior figures at Health Canada (the federal agency that addresses health policy) have recently noted that “knowledge of the unique patterns of health and health care needs of immigrants is somewhat limited in Canada” (Gold and DesMeules 2004). The health of certain immigrant groups in Canada has been the subject of some scrutiny, most notably South-East Asians (e.g. Beiser, Turner and Ganesan 1989, Beiser, Cargo and Woodbury 1994, Hyman and Dussault 2000). However there is a relative lack of knowledge regarding the health status and health beliefs of the West Indian population in Canada (Lashley 2000).

Converging qualitative and quantitative evidence suggests that West Indians in Montreal and elsewhere in Canada tend to experience disproportionate socio-economic hardships when compared to similarly educated white Canadians and other immigrants (Torczyner and Springer 2001, Lautard and Guppy 1999, Richmond 1990). Statistics Canada (2003) reports that low-income rates amongst Caribbean immigrants (37.5%) are

¹ We use the term “West Indian” to refer to people from the islands and territories in the Commonwealth Caribbean (including Guyana). Community groups in Montreal frequently employ this term and we believe it is preferable to the term “Caribbean”, as the latter term by definition includes peoples from other islands (e.g. Cuba and Haiti) with different histories, languages, and cultures, not included in the present study

significantly higher than both the host population and most other immigrant groups. In addition to economic hardships, qualitative evidence suggests that the social context of wider Canadian life may act against the well-being of Caribbean immigrants. Henry (1994), conducting qualitative research in Toronto with this group, found that “racism is the single most important issue that members of this group encounter” (p14). Though Canada is noted for its absence of inner-city ghettos or race riots of the type occasionally seen in Europe and the USA, the evidence indicates that West Indians are a vulnerable and over-burdened group, who must deal with socio-economic marginalisation and disadvantage. These inequalities are likely to impact on overall health and well-being.

Taking all this into account, we set out to explore the illness narratives and explanatory models of West Indian immigrants in Montreal, Canada with medically unexplained symptoms. Illness narratives may reflect aspects of not only individual experience, but also wider social and cultural processes that affect the group in question (Kirmayer and Young 1998). Illness narratives usually include participants’ accounts of factors underlying aetiology and perpetuation of their symptoms. Common themes between and within participants’ narratives can be grouped together as explanatory models (Kleinman, 1980). In the development of these models, sufferers draw on individual and collective background knowledge and experience.

A further aim of our study was to examine how far illness narratives of West Indian immigrants in Montreal reflect retention of health beliefs and models common in the West Indies. Based on ethnographic fieldwork conducted in Jamaica, Sobo argued that “Jamaicans see the body as an open system that must stay ‘equalised’” (1990, p29). Others have also remarked on the importance of equilibrium in West-Indian folk

medicine (Laguerre 1987). These beliefs are usually anchored in bodily processes. For example not eating on time may be linked to “gas”, changes in temperature can threaten the free flow of blood (leading to fever) and infrequent sexual activity can lead to the build up of toxic substances in the body (Sobo 1990, 1992, 1993, Groleau 1988). In the present study, we examined the extent to which respondents retained elements of this ethno-physiological knowledge system and used it to provide cultural explanations for medically unexplained symptoms.

The present study relies on a community, rather than a clinical sample, the latter being used in most previous research on medically unexplained symptoms. Studies based on clinical samples may be subject to a number of limitations, for example participants may apply a higher degree of self-censure so as not to threaten continuity of care. Through use of a community sample, we overcome some of the limitations of a clinical sample, as well as giving voice to those not using health services for their ailment, a group of obvious public health importance.

Method

We conducted 15 in-depth interviews with West Indian immigrants in Montreal with medically unexplained symptoms or emotional distress. Participants were sampled from a larger cross-sectional community survey (n=2 241) investigating health care utilisation amongst different ethno-cultural groups in an inner city neighbourhood in Montreal (Kirmayer et al 1996). A total of 268 West Indians participated in the larger community survey and approximately 60% agreed to a follow-up telephone interview. Respondents

who reported four or more somatic, emotional or medically unexplained symptoms were invited to take part in a third stage face-to-face illness narrative interview. Of the twenty who agreed to participate, 15 completed the interview providing useable transcripts. Relevant socio-demographic characteristics of participants can be seen in Table 1.

The interviews followed the McGill Illness Narrative Interview (Groleau and Kirmayer 2004) that systematically attempts to elucidate comprehensive illness narratives from participants including information on illness prototypes, idioms of distress and explanatory models. Interviews lasted between one to two hours and were held at a local general hospital. They were recorded onto audio-cassette and transcribed for analysis. The transcriptions were imported into the ETHNOGRAPH software package, where data was systematically examined in order to discover common explanatory models. Validity of the findings is strengthened by the fact that, though playing complementary roles in the research process, the authors agreed on the principal results of the study based on their close connection with the raw data. All names used in the results are pseudonyms; some identifying characteristics have been deliberately clouded to protect anonymity.

Results

Upon analysis, we found that most of the participants' interviews were centred on two related factors. Firstly, medically unexplained symptoms were ascribed to the chronic effect of overwork since arrival in Canada. Secondly, symptoms were ascribed to lack of routine and irregular patterns of daily living.

Almost all of the participants described their symptoms and distress as resulting primarily from overwork. More specifically, they saw their illness as the culmination of a difficult and stressful post-migratory experience. Specific factors frequently mentioned by participants as leading to their symptoms included overwork through long hours, the need to engage in overtime to make ends meet, the disruptive effects of shift-work and the physical consequences of work that often involved hard manual labour. Related to these factors centred on work-activity, participants also implicated ongoing chronic and acute difficulties regarding money in the development of their symptoms. Negative socio-economic context was thus implicated in symptom formation.

Many participants also ascribed the development and continuation of symptoms to lack of routine and regularity in their everyday lives (often as a consequence of factors previously mentioned e.g. shift-work and overtime). Lack of routine, structure and predictability was especially mentioned as it affected two sets of factors: those intrinsic to the body and those more externally orientated. With regard to the body, irregularity in eating, sleeping, bowel movements, physical exercise and the menstrual cycle were all implicated as precipitating or perpetuating factors in participants' narratives. With regard to factors more external to the body, irregularity due to unpredictable public transportation, uncertain sources of income, and unreliable activities of third-parties (most notably that of absentee fathers) were also implicated as pathologically disruptive. The themes were consistent across most participants, but for the purposes of brevity we present three cases that are representative of our findings.

Miss Smith

Miss Smith is a woman in her 50s originally from the Leeward Islands who has lived in Canada for around 25 years. She has several grown children, some still living at home, whom she brought up alone. In the initial survey, she reported a range of medically unexplained symptoms including back pain, dizziness and belly pain. Like some other participants, she has spent most of her life working with elderly people in an institution. When asked for her own explanation of her symptoms, Miss Smith repeatedly brought up over-work, stress and the lack of a routine in her life as principal factors. This can be seen in the extracts below. When asked what caused her problems, she said:

“I mean the whole general routine life. You see, like I'm the master of everything. You see? I'm a single person with a family, and I have to see to it that everything is well set-out for them. So I tend to believe that half of the aches and pains that I have is the pressure that I put myself into, or actually, the pressure that is placed upon me...I - I love my work. And I cannot complain about the work that I do, but I know the work that I do sometimes, it has a heavy reaction ... on my body, on my mind and, you know, on everything”

Like many other women participants, Miss Smith mentions that she is a single-mother, and bemoans the lack of support from her children's absentee father. While this lack of support also may have occurred in the Caribbean it appeared to be especially severe with regards to impact in Montreal. All of the single parents in our sample lamented the absence of a wide local familial and/or social network that could compensate for the

absence of children's father— a network that can generally be relied upon to provide instrumental support in the West Indies itself (Lashley 2000, Gopaul-McNicol 1993).

Miss Smith returned to the theme of the negative impact of a heavy workload throughout her interview, amplified by the absence of compensatory social networks. In the next extract, she further ascribes her symptoms to long hours, lack of free time and lack of routine. This was related to the fact that her work schedule was intermittent:

“Either I am tired from work, I have too many long days, or without break, or something like that, that brings on tension to anybody...physical and mental, yeah. You know, if I don't have work to do, I will feel it. I'm staying too long idling. I want to work and I want a break. I want a happy medium. You know, you work, you get a break, time out, time to attend to the home front, you know? And then personally, then myself. But you try not to keep going without having a little time to myself, a little time for the home, and everything has to be rushing, I feel at one point that I will die before I live. You understand? I would like to live before I die...”

As mentioned earlier, the desire for routine and regularity and the supposed health promoting benefits accruing to this were not only mentioned by participants with regards to the work and social realm. They were also frequently brought up as applying to bodily functions such as sleep, eating and physical exercise. In the next extract, Miss Smith argues that irregular bowel movements often lead to the onset of her symptoms.

“Sometimes it's because you might need a bowel movement. After a bowel movement, all the pain is gone. He [the Doctor] didn't tell me that, but I have watched, noticed this, time and time. When it comes, it's a griping pain here and a griping pain there, and then, if you keep a regular time, like either morning time, or night-time or bedtime, and then you keep it constantly that way, then everything is fine. I noticed that if I have no problem in the morning my day is fine. I don't have to think about it...It happens at sometimes that you're in a rush. You go without it, and then you become incapable during the day, then you feel the cramps... You know, you are what you eat, if you eat right you will be right”

Like most of the other participants, Miss Smith retained certain West Indian ethno-physiological beliefs regarding the importance of balance in maintaining healthy bodily functioning. However she also held that lack of equilibrium in the work and social world contributed to her symptoms. While repeated by many other participants in our sample, this is not commonly reported in the literature on the West Indies itself.

Miss Jones

Miss Jones was a woman from Jamaica in her mid-forties. She had lived in Canada for over 20 years and was experiencing a range of medically unexplained symptoms including dizziness, nausea and fatigue. The themes that emerged from her interview were very similar to those of Miss Smith, and emblematic of the wider data set. Again interruptions to bodily and daily routines were given as causal explanations for

symptoms. In this first extract, Miss Jones mentions the problem of “gas”, a problem frequently mentioned by the majority of participants. This problem is explicitly linked to lack of regularity in eating habits:

“It's according to the body, people don't eat properly, because sometime, if I don't eat properly, it will happen. It's because sometimes according to how you eat you get it, because I'm not- I don't eat on time, so sometimes the gas happens, but if I eat on time then it don't.”

As well as talking about the health damaging effects of lack of routine in bodily functions such as eating (the menstrual cycle was also mentioned), Miss Jones talked about how the balance of daily activities could determine whether symptoms were experienced or not. Below she explains this in answer to a question regarding what determines onset:

“The way you perform the day according to how much you do, how much you work, it happens. It's just off and on. It's according to how your day - you perform at work, according to how much activities you do, it just happen, because it's not always tiring. Sometime it is, sometime it's not.”

Like many other participants Miss Jones worked long, irregular hours. At the time of interview, she was the nanny to a child whose parents worked long hours, so sometimes she worked from very early in the morning until late at night. Unresolved tensions between Miss Jones' overwork, consequent lack of free time and unmet desire for

relaxation repeatedly emerged in her interview. Miss Jones acknowledged that this conflict over control of time was often difficult to resolve, and (similar to the second extract from Miss Smith) she consciously tried to manage her life so that it was not purely centred on work. Like many participants, involvement in a church provided some protective social activity, acting as a modest replacement for the absent extended family:

“Then you have to relax too, eh, because I realize you're a bit, you know, you got to relax but...I'm always on the go. I'm very active. [laughs] I'm never at home. I go - like most of the time I reach home at eleven at night, 'cause like after work I go home, I have a shower. I go to church. I go to church a lot. The only - you see, I go to church at least four days a week. So I go home after work, I shower, I run back out. I'm always - I've very active, always on the go.”

Miss Thomas

Miss Thomas was a single mother in her forties from Jamaica with grown children who had lived in Canada since the 1980s. She had a range of medically unexplained symptoms including fatigue, joint pain and tension. Like other participants she stated that symptoms were due to the impact of her work life. In the first extract she describes how her job as a nurse's aide is irregular, unreliable and sometimes demands that she sleep over at work. This means there is no predictability with regards to income and structure:

“Some they call one week, they don't call you following two, three weeks, so how you going to survive? It's very hard.... sometimes they want you to sleep in...I can't take that.”

Miss Thomas also talks about the impact of this stress arising from lack of regular work and ongoing financial difficulties. Like many of the other participants she speaks about the relationship between sleeping, eating, routine and stress.

“Most time when you are stressed, they tend to say you get light-headed, you know, you don't sleep well or something like that. That could be...because most of my problem is stress...Maybe the stress caused me to have it, stress can give you anything, any kind of disease, you know...caused everything. Sure, because you don't sleep well, you don't eat well, you don't - and you're thinking all the time and nothing working your way, what is that, you know?”

Finally, Miss Thomas explicitly states that her aspirations underlying her relocation to Canada have not been met. Throughout her narrative, she links this aspiration-achievement discrepancy to her symptoms. In this final extract, she ruefully muses over her situation, recounting problems encountered in her life in Canada. Like many other women participants, she also links symptoms to the lack of support from her children's father, actively comparing her own difficult situation with that of her male sibling:

“My brother came here, he didn't have no problems, so he is living good and he has no - I mean, he is not rich, but he is comfortable. You know, he has a job, sixteen years at one place and, you know, he has no kids, so he live his life. It's what I came here that I would have a career and live my life. But my kid came and everything got messed up. And father was no good, so that make it worse...yeah, so and it's only me - Its only me struggling and struggling, struggling against the odds, you know, to reach where I reaching now, you know, I'm on my own just with my kid...”

Discussion

Overall, the results are consonant with our earlier work on explanations for medically unexplained symptoms in the community. This suggests that while many somatic symptoms may be medically unexplained, respondents typically have social or cultural explanations that they may think are inappropriate to bring to the clinician's attention (Groleau and Kirmayer, 2004, Kirmayer, Groleau, Looper and Dao, 2004, Kirmayer and Young 1998). However in contrast to the responses of Vietnamese immigrants in our wider study (Groleau and Kirmayer 2004), whose illness narratives implicated pre-migration stresses as the most significant contributor to current distress, West Indian immigrants ascribed their symptoms almost exclusively to post-migratory factors. This difference in emphasis may be a function of the underlying events leading to migration. Refugees who have suffered severe oppression, injustice, violence, trauma and loss in their country of origin may link their present symptoms, with good reason, to these past

events. In contrast, economic immigrants, who consciously chose to migrate in search of a better life, may link their illnesses to events and processes occurring post-migration, especially when their achievements have failed to match their aspirations. This seemed to be the case in the present study. None of the West Indian immigrants were refugees and none mentioned pre-migratory injustice, trauma or even hardship due to socio-economic conditions as a significant factor contributing to their illness. In contrast, the difficult post-migration experience was consistently highlighted as the key aetiological period in their life course. This finding corresponds with the work of others (e.g. Lashley 2000, Henry 1994) who discuss the negative social and emotional consequences arising from the wide discrepancy between migration-related expectations and post-migration reality experienced by many West Indian immigrants in Canada.

Our findings also concur with other studies mentioned in the introduction, which have indicated that Caribbean immigrants experience disproportionate socio-economic disadvantage in Montreal and Canada more generally (Torczyner and Springer 2001, Lautard and Guppy 1999, Richmond 1990). The issue of unmet expectations (related to ongoing economic hardship) that surfaced continuously in participants' narratives thus appears to reflect real socio-economic disparities. Interestingly, participants did not highlight inter-personal conflict or intra-psychic dilemmas as significant factors, these being common explanations for unexplained symptoms in the general population in North America (Katon et al. 1982).

Overwork

Of the chronic ongoing problems discussed, the theme of overwork stood out as a frequent explanatory model. Many of the participants worked very hard in order to provide for themselves, their families in Montreal, and sometimes for their families in the West Indies as well. This involved shift-work, long hours, over-time and moonlighting. The work often involved demanding physical labour, such as moving patients in a hospital, factory-work or looking after children. Participants stated that this work wore them down, consequently manifesting itself in a variety of bodily symptoms. Interestingly, this emphasis on overwork as a prominent theme does not feature in any of the ethnographic studies of health and illness in the West Indies itself (e.g. Sobo 1990, 1992, 1993). This could reflect different patterns of employment or suggest some level of acculturation and internalisation of explanatory models prevalent in North America. Certainly, ascribing symptoms to overwork and “stress” is a common and fairly acceptable explanatory model in North America (Young 1980), allowing relatively safe, unstigmatised participation in the sick role.

Lack of Equilibrium in Bodily Functions

The other significant theme to emerge strongly from the data was the importance ascribed by participants to a lack of equilibrium or regularity. Participants reported how irregular patterns in their daily lives regarding bodily functions and personal social activity, had negative effects on their health. This causal model, especially regarding the health damaging effect of lack of routine in bodily functions, indicates an element of retention of ethno-physiological beliefs common in the West Indies. As stated in the introduction,

ethnographers of health and illness in the Caribbean have noted that West Indians tend to conceptualise the body as a system that must stay 'equalised'. This conceptualisation emerged strongly from our own data, whether with regards to sleep, eating habits, physical exercise, bowel movements, sexual activity or menstrual cycles. A lot of this discourse centred on the health-damaging role of "gas", believed by participants to arise from irregular eating habits and bowel movements. Sobo (1993) reports that gas is a common idiom of distress in the West Indies. Interestingly, recent research suggests that rates of constipation and irritable bowel syndrome are significantly elevated in black populations in the U.S. (Kang 2005, Gralnek et al 2004). Due to differences in diet or other unidentified factors, gas could be an idiom of distress grounded in physiological processes, though ascribing causation to irregular bodily habits may be another example of the importance of regularity and routine in West Indian concepts of health and illness.

Lack of Equilibrium in Social and Personal Life

Lack of equilibrium with regard to bodily functions as an explanatory model probably indicates the persistence of some elements of ethno-physiological beliefs common in the West Indies. In contrast our finding that participants also tended to attribute their symptoms to lack of balance, equilibrium, routine and regularity in their social and personal lives is not reflected in the ethnographic literature on the West Indies. The reason that this is an explanatory narrative in West Indians in Canada, though not clearly present in the West Indies, may be due to changes in family, social and work life consequent upon migration. Factors often invoked with regard to lack of equilibrium at

the social or personal level included a dependence on unreliable public transport, shift-work, unpredictable activities of third-parties (e.g. baby-sitters) and most notably the errant behaviour of absentee fathers (or in one case from the study, an absentee-mother). Many of our participants lamented absentee-fathers' lack of economic and instrumental involvement in mother and child's lives. In the West Indies, the extended family is usually willing and able to compensate for an absentee-father's absence (Sobo 1990, Gopaul-McNicol 1993). However in Canada, the impact of the absence of the baby-father and extended family appears to be significantly amplified as there are no parallel structures that give the single parent the support necessary to diminish multiple role-strain². For example, a single-mother in the West Indies will normally be able to unproblematically "shift" her children to other family members whilst she goes to work and carries out her life routine (Potter et al 2004, Lashley 2000). In contrast, West Indians in Canada must find cheap and trustworthy baby-sitters, who are willing to work nights and weekends - a very challenging task.

Interviewer Effect

There is clear evidence that the personal characteristics of the interviewer influence the responses of participants in qualitative research (Britten 1995). Whilst all three of the interviewers in the present study were well trained and experienced in the conduct of ethnographic interviews, all were white Canadian professionals. It has been noted that black people in Canada are often circumspect in deciding what to reveal and what to keep

² One notable exception in this regard in the present study is the Church, which acted as a surrogate extended family for participants, many reporting they relied upon this for material and emotional support

to themselves in interactions with white people (Kelly 1998). It could certainly be the case that participants self-censored certain feelings and opinions and gave answers they considered acceptable to people who may have been perceived as representatives of the white Canadian 'establishment'. For example, none of the participants mentioned "duppy (ghost) attacks" or "bad blood"; both important aspects of concepts of health and illness in the West Indies (Sobo 1990, Gopaul-McNicol 1993). This could indicate either acculturation or self-censorship of socially undesirable answers. Similarly though participants obliquely criticised the social system which demands that they work long, hard, arduous hours with minimal rewards or hope of change (by ascribing symptoms to overwork or irregular lifestyles), they very rarely openly challenged structural factors as a whole or invoked racism as an explanatory model. Again this could reflect either an unwillingness to discuss these issues with a white Canadian interviewer or an assessment that these issues are not central to their illness. Future research contrasting responses of black respondents to white interviewers and black respondents to black interviewers in Canada may shed further light on this matter.

Overall Interpretation

The development of medically unexplained symptoms and emotional distress, linked by participants to overwork and lack of routine in their daily life could be a bodily or psychological manifestation of internalised or suppressed frustration at being unable to achieve the regular, balanced lifestyles imagined to be enjoyed by most Canadians. Being alone (more than half of the participants were single parents) appeared to contribute to

this sense of overwork and dis-equilibrium, because in Montreal, in contrast to the situation on their islands of origin, participants could not rely on extended family to fill the instrumental and emotional lacunae left by the absent partner. The bodily distress and subsequent explanatory narratives may provide a safe channel for anger, frustration and sense of injustice to manifest itself, without engendering the social and personal danger associated with directly confronting failure to succeed, broken dreams, ongoing socio-economic marginalisation and the apparent indifference of the host society.

This semiotic interpretation posits that the body becomes a site of protest; a private protest against the perceived injustices (transformed to discourse about “imbalance”) in individual and communal socio-economic and familial situations (Turner 1992, Ong 1987). These ailments in themselves could be seen as an expression of opprobrium against existing socio-economic marginalisation. This transformation may be especially marked in individuals who lack agency or in groups marginal to the political system. As frequently mentioned, West Indian immigrants do appear to suffer systematic disadvantages in Canada when compared to white Canadians. Similarly as a group, West Indians in Montreal may not have acquired any great political leverage, due to the relatively small size of their community and their anglophone background (Torczyner and Springer 2001). Thus the individual, when consciously reflecting on bodily symptoms, ascribes causation to safe and acceptable explanations such as overwork and lack of routine. Interestingly, Kelly (1998) has noted that while Canada is generally portrayed as a conflict-free multicultural society, “Canadian society is more reluctant than the UK to openly recognise conflict” (p. 12), a general belief echoed by other writers on race and ethnicity in Canada (e.g. Li 1999, Henry 1994). It could be that in refusing to

openly invoke racism or discrimination as an explanatory model, participants have internalised the dominant discourse of Canada being an egalitarian, conflict-free society. This benign self-image may contribute to a form of ‘repressive tolerance’ that silences or elides criticism (Wolf, Moore & Marcuse, 1969).

To conclude, this study has shed light on the illness narratives and health beliefs of a sample of predominantly low-income West Indian immigrants in Montreal, Canada—a group that has hitherto been under-researched in this regard. The study suggests a syncretic fusion between persistent elements of traditional West Indian ethno-physiological models and North American models of health beliefs. Individual illness narratives tended to reflect the wider “Canadian experience” of West Indians in Canada, saturated as they were with stories of overwork, low-pay, lack of support and indifference from the host society. Our study suggests further research is necessary to investigate the wider impact of these factors on overall health and well-being amongst West Indian immigrants in Canada.

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Table 1: Socio-demographic Characteristics of the Sample

Participant	Age	Gender	Employment	Marital Status	Number of children at home	Years in Canada
01	54	Woman	Nurse's Aid	Never married	0	25
02	Not given	Woman	Health Attendant	Never Married	1	31
03	67	Woman	Retired	Widowed	0	25
04	31	Woman	General Worked	Divorced	0	7
05	54	Woman	Seamstress	Never married	0	22
06	44	Woman	Animator	Married	3	23
07	26	Woman	Domestic Worker	Never married	0	4
08	48	Woman	Unemployed	Divorced	1	16
09	69	Man	Retired	Married	0	17
10	21	Woman	Student	Never married	1	11
11	42	Man	Unemployed	Separated	1	13

12	43	Woman	Domestic worker	Married	2	24
13	46	Man	Welder	Never married	0	27
14	51	Man	General helper	Divorced	0	4
15	37	Woman	Homemaker	Married	2	7
Mean (SD)/ Aggregate	45.21 (13.8)	11 women/ 4 men		10 single/ 4 married	0.79 (0.975)	17.07 (8.96)