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SOCIOLOGICAL CONTRIBUTIONS TO THE COMMUNITY MENTAL HEALTH MOVEMENT: A REFORMULATION

A Thesis

Presented to

The Faculty of the Department of Sociology

The College of William and Mary in Virginia

In Partial Fulfillment

Of the Requirements for the Degree of

Master of Arts

By

Richard Drury Morrison

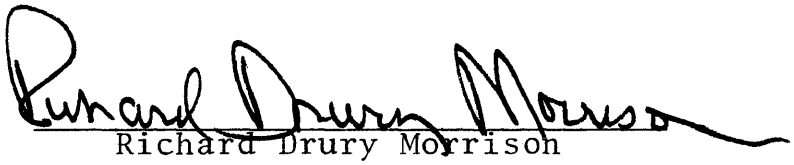
1981

APPROVAL SHEET

This thesis is submitted in partial fulfillment

of the requirements for the degree of

Master of Arts



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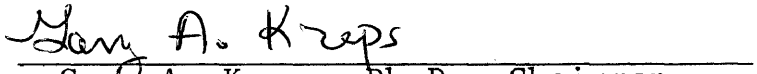

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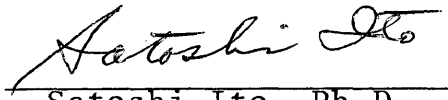

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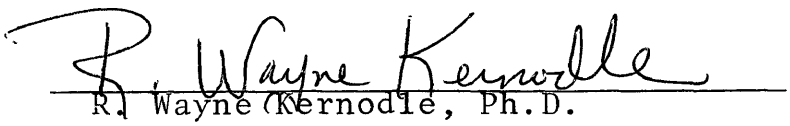

R. Wayne Kernodle, Ph.D.

To Alphonsero, Sylvester, Barbara

and the many others . .

. . and, of course, to Lea

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I gratefully acknowledge the patient but potent guidance received from my thesis advisors throughout this very long process. At times they have appeared to be the embodiments of the paradigmatic divisions within the discipline that are reviewed in this product. The value in their contributions, however, lies in their willingness to bridge attachments to these paradigms and their encouragement of my belabored effort to do the same.

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Lest my mentors of record feel embarrassed by this attribution of influence, I hasten to spread both gratitude

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Finally, of course, I am indebted to the people and institutions of the Eastern Shore of Virginia. I shall not easily forget the joy and the pain of interaction with

them. I believe firmly that these interactions were of mutual benefit and I look forward to continuing the many friendships that developed during my years of residence in that unique and fascinating area.

Important as the influence of academicians, mentors, consultants, colleagues and friends has been, it is necessary to note that these advisors bear no liability for the positions and opinions expressed here. None of my helpful friends would have ruminated, catalogued and reported in exactly the manner I have. I accept--with respect--responsibility for the following pages. Every attempt has been made to separate academic observations from personal advocacy positions, but the distinction is sometimes blurred. I, alone, am responsible for any confusions which may remain.

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ABSTRACT

Applied field research into mental health services needs in a set of rural Virginia communities is used as a case study for surrounding discussions of the sociology of mental disorder and the emerging sociology of community mental health. The paradigmatic divisions that characterize the general body of sociological endeavor also characterize the applied field. These divisions are discussed and illustrated by a review of the literature of both general sociology and the sociology of mental disorder.

It is argued that overconcentration in the applied field on research and theory from a single paradigm (social factist) has resulted in a reification of the medical metaphor for the explanation of an essentially social phenomenon. Labeling theory provides a powerful conceptual tool for the understanding of the social processes involved in defining, treating and disposing of those labeled mentally disordered, however, the theory has not been especially useful in generating research into the new system of mental health services provision. Instead, social epidemiological models have arisen to explain these processes. These models result in the unfortunate concentration on the social attributes of those who have come to be labeled to the exclusion of the social functions served to the dominant social order in the process of labeling.

The field case study is employed to illustrate the contributions to comprehensive understanding of these social processes through triangulated use of theory and appropriate research methods. Combining work from the social fact, social definition and social behavior paradigms results in understandings of mental health services as flows of public utility controlled by community organizations for the purpose of ensuring access to a docile, pliable secondary laborforce. These findings are then employed to critique theoretical approaches to the study of mental disorder now dominant in the applied field. Finally, a set of linked propositions relating to mental disorder as residual deviance and to the social purposes served in labeling and treating these deviances as a part of the community social control systems is posited. The theoretical underpinnings of these propositions are exposed and network analysis of community organizations is proposed as an appropriate methodology for analyzing the mediating effect served by community mental health services boards between population characteristics and risk prediction models and mental health services as output measures. Some observations of appropriate sociological involvement in policy research related to community mental health programming close the work.

SOCIOLOGICAL CONTRIBUTIONS TO THE COMMUNITY MENTAL HEALTH MOVEMENT: A REFORMULATION

CHAPTER I

DEFINING THE PROBLEM

Introduction

The purpose of this work is to place within a framework of sociological analysis and understanding a set of applied research and partisan experiences of the author related to the assumptions and objectives of public policies subsumed under the rubric "community mental health."

A primary outcome of the present effort has been the resolution of intellectual and ethical concerns experienced in the conduct of applied social research and public policy studies over the past several years. This resolution has been accomplished by: (1) critical analysis of the several competing sociological theories, conceptualizations and research practices which have undergirded the rationale and rhetoric of the community mental health "movement"; (2) a re-evaluation of the assumptions and practices of the movement itself and of the legitimate function of basic and applied sociological research related to public mental health policy; and (3) a formulation and statement of a number of logical propositions which accomodate the several sociological perspectives pertinent to the policies under study and explain not only the "successes" of the movement but illuminate the

resistance encountered by this federal attempt to alter existing policies and practices related to the social control of deviance.

A second purpose is implicit and important. In the course of the critical analysis and discussions which follow, the partisan position of the author will be apparent and is acknowledged. The amelioration of human suffering continues as an important personal and scientific commitment. It is a commitment legitimated by a tradition within sociology, especially in the sociology of deviance and social control, as articulated by Becker (1966) in his Presidential Address to the Society for the Study of Social Problems. The tradition is particularly evident in the applied works of sociologists concerned with public policy, as Gouldner (1968) correctly states in his polemic retort to the Becker position. Partisan identification with the "underdog" (deviant actor) against oppression by agents of enforcement of social control policy is neither inherently an illegitimate or unethical activity for the social scientist but according to Gouldner, may lead to alliances between the social scientist and a federal elite who formulate policies of social control the actual enforcement of which the sociologist-cum-civil libertarian will subsequently find repugnant. This uncomfortable, but often profitable, coalition may persist only so long as the applied sociologist remains committed to theoretical perspectives which are less than

comprehensive in explanatory power and leaves unchallenged the motives, ideologies and technical assumptions of the policymakers. Stated simply, the sociologist motivated to ameliorate human suffering and prevent human oppression, may uncritically accept and foster ideological aspects of social policies which, on more careful and rigorous sociological examination, provide the state with unintended tools for the coercion and control of at least some portion of its citizenry. The argument will be illustrated amply in the discussions and analyses which follow. It is stated here without embellishment in the hope that it may both anchor the exposition and remind the reader of an implicit but urgent intent.

Organization of the Material

Since this thesis attempts critically to evaluate previous applied research undertaken by the author and to place this prior work into a framework of sociological understanding, some deviation from the traditional organizational format for theses which present and defend original research is required. The purposes above are served through the critical evaluation of the prior research methods and findings as these methods attach to or deviate from several "classical" sociological theories and methodological approaches related to the sociology of mental disorder. Diversity in theoretical orientation and research practices in the applied field, in turn, derives from differing theoretical perspectives and

related methods within general sociology which must also be understood. The earlier applied research to be employed illustratively here was undertaken in support of the assumptions and practices of the community mental health movement. The present work seeks to locate these assumptions and practices within relevant theories of mental disorder and social control. The exposition and sociological analysis of the assumptions of community mental health are, therefore, critical. Finally, this thesis seeks to provide a set of logical propositions comprehensive enough to accommodate anomalies encountered both in the earlier research and in the present critical evaluation of that work.

The following format will be employed. The balance of Chapter I discusses briefly the objectives, methods and findings of the prior research augmented by recent personal experiences in partisan activity directed toward the influence of federal public policy related to mental health. This narrative assists in formulating a "statement of the problem" which concludes the chapter.

Chapter II recounts the diverse and contradictory assumptions and technical and ideological beliefs of the community mental health movement and attempts to place these assumptions and beliefs within the perspective of prior sociological and social psychological formulations related to mental disorder.

In Chapter III, the major sociological perspectives relevant to mental disorder are explored and related

to the multiple paradigms of general sociology delineated and discussed by Ritzer (1975). A critique of the prevalent conceptualizations and methodological practices within the sociology of mental disorder forms an integral part of this presentation.

With these discussions complete, Chapter IV returns to the applied research experience to illustrate the need for a more comprehensive theoretical and methodological approach to applied work in the field of concern.

Chapter V presents a set of propositions which encompass and account for anomalies arising from the application of single theoretical perspectives and/or research methodologies to the study of the sociology of mental disorder. Policy implications and recommendations related to further sociological involvement in the field are also presented.

The Illustrative Case

In the years that have intervened between the fulfillment of academic course requirements for the Master of Arts in sociology degree and the completion of this thesis, the author has engaged in applied research related to the sociology of mental disorder and in local, state and federal forums pertaining to the design, redesign and implementation of public policy related to mental disorder. For one and one-half years following completion of academic coursework, the author and Professor R. Wayne Kernodle co-directed an investigation of

mental health service needs and mental health policies and practices on the Eastern Shore of Virginia. The findings emanating from this research resulted in the author's appointment as member and recorder to one of the thirty-five citizen task panels of the President's Commission on Mental Health charged with advising the Commission, the President, the Executive Branch and the Congress regarding public policy affecting prevention and treatment of mental illness and other mental disorders. The field research in Virginia and the reporting of findings of those studies took place from May, 1975 through November, 1976. The President's Commission on Mental Health was established by Executive Order of the President in February, 1977. Task panels appointed by the Commission functioned from the summer of that year through the presentation of panel reports to the Commission and the final Commission report submitted to President Carter on July 1, 1978. The recommendations of the Commission, in turn, influenced the content of the federal administration's proposal for revised law and policy governing mental health embraced within the draft legislation, "The Mental Health Systems Act of 1980," now before the Congress of the United States.

The field research which constitutes illustrative material for the present work was funded by the Virginia Department of Mental Health and Mental Retardation to accomplish the following objectives:

1. Using appropriate social research methods, assess and project the public sector mental health service needs of the resident and migrant labor populations of the Eastern Shore of Virginia, an isolated rural land peninsula with a predominantly agricultural economy. The peninsula includes Northampton and Accomack Counties, is populated by approximately 44,000 persons and employs approximately 5,000 itinerant farmworkers during the peak vegetable crop harvesting season each summer. The area is characterized by widespread poverty, low levels of educational attainment, high rates of seasonal unemployment and year-round underemployment, and generally disadvantaged status for the majority of the population.

2. Study the present system of public mental health service delivery on the Eastern Shore of Virginia and analyze the extent to which these services are accessible and acceptable to the resident and migrant populations and conform to the philosophies and intents of the Community Mental Health Centers Act of 1964 and the policies of federal and state agencies responsible for implementing the Act. Subsumed under this objective was the identification of structural and cultural barriers to the delivery of optimal preventive and therapeutic mental health services.

3. Based upon these findings, recommend a model for the delivery of optimal preventive and therapeutic mental health services in rural areas.

Results of studies implementing these objectives are reported in a series of working papers (Kernodle and Morrison, 1976) and in a Digest of the Report of the Eastern Shore Mental Health Study (Morrison, 1976). Methods used in the field research were varied as appropriate to the separate tasks. Secondary data, especially the Mental Health Demographic Profile System (MHDPS)--a "risk prediction/needs assessment" model using selected

social, economic, employment, housing, family structure and household composition and other social indicators derived from the 1970 Census of the Population and Housing--were employed to estimate potential need for mental health and other public services. Clinical records of institutionalized and outpatient clients receiving public mental health services were analyzed and compared with estimates of need. Survey research in the form of structured and unstructured personal interviews and mailed questionnaires was undertaken to study community experiences, attitudes, values and beliefs related to mental health need and mental health services.

In addition, the author resided in an Eastern Shore community during the field research and engaged daily in participant observation of both structured and unstructured forms. A network of trusted local informants was established to augment the research staff. The qualitative information gained through these processes and in daily immersion in the life of the community contributed importantly to the understanding of the structures and processes of community decision making, particularly those related to policies affecting the dependent poor. Finally, a "natural experiment" was undertaken in the establishment of a local interagency council of human services delivery agents. Under the aegis of this council, a new service was inaugurated to provide temporary shelter, protection, nourishment, counseling, transportation

and referral for a variety of indigent persons with emergency needs.

Methods and findings of the research are discussed in more detail in Chapter IV. Findings addressing the formal objectives may be summarized as follows:

1. The demographic profile of the Eastern Shore reveals a large, dispersed population with urgent need for stable income maintenance, employment, health services and mechanisms to ensure their full participation in decisions affecting their own and community life. The resources available to the community mental health system should be used to advocate for increased participation in human services delivery programs for which this vulnerable population is eligible while avoiding diagnoses or labels of mental disorder except in those instances in which there is clear functional impairment and a technology to address the impairment.

2. The present system of mental health services delivery is highly centralized, relies upon the "medical model" to the exclusion of other approaches and tends to serve the needs of the population differentially. Outpatient services are made available (and accepted by) young, white, minimally impaired clients preferentially. Uneducated, impoverished and minority client needs are not well served by outpatient services. This population segment is over-represented in the census of institutionalized inpatients.

   The chief proximate barrier to reorganization of mental health service delivery is the community mental health services board of directors and the employees of this citizen board. The board and employees represent and articulate the needs of a power structure which is unresponsive to the human services needs of the majority of the population including the poor, undereducated, and black sub-populations.

3. A model system for rural mental health services delivery ought be decentralized, geographically dispersed, and provide a continuum of services ranging from advocacy

> (to connect vulnerable populations with employment, income maintenance, health and other human services) through the provision of short-term psychiatric hospitalization in community facilities. The use of stigmatizing mental disorder diagnoses should be avoided except in clearly defined instances of impairment for which a resorative technology exists.
>
> Staffing of mental health services should reflect the general characteristics of the population to ensure acceptability of these services. Governance of program activities should be placed in a citizen board sensitive to the economic, social and cultural characteristics of the rural area and committed to upgrading the quality of life for all citizens.

These recommendations reflect the fusion of a theoretical perspective--labeling theory--and the accumulated evidence of social epidemiological studies of the covariation of certain social and economic characteristics of populations and sub-populations and defined (labeled) mental disorder. In this formulation the study of population characteristics lead to the identification of segments of a rural population possessing characteristics known to be highly correlated with high rates of diagnosed mental disorder elsewhere. That is, one could infer that these segments of the studied population were "at risk" or vulnerable <u>to having the label of mental disorder successfully applied</u>.

An "anomaly" discovered in field research was that the characteristics known to covary directly with rates of diagnosed mental disorder were not correlated in the direction or with the expected strength with rates under

treatment in the communities studied. In terms of the potential for stigma arising from the successful application of the label mental disorder, this anomaly presented little consternation at the time. The identified characteristics--poverty, poor housing, high youth and aged dependency ratios, "weakened" family structure, etc.--were asserted to be amenable to melioration targeted directly to those factors of "risk" without application of the label mental disorder with its associated potential for stigmatization.

The field studies of the communities, however, revealed a power structure opposed to melioration of these indicators of disadvantage and powerlessness. This structure exercises control not only over the flow of public utility from welfare, health, housing and social services programs but from the community mental health system as well. Low rates of use of public mental health services and the inverse relationship of "need" for and use of these services as inferred by the social epidemiological model were paralleled in the communities we studied with the "underutilization" of other public services programs: income maintenance, public health services, public housing subsidies, employment services, etc.

The structure of community organizations and decision making governing public services and the lack of relationship (or often the inverse relationship) between "need" as indicated by the study of population characteristics

and use of services are sociologically understandable by reference to the division of labor which preserves the status quo within the communities studied. In these communities, the social and economic advantage of a small agribusiness elite is dependent upon the existence of a large pool of unskilled, docile and pliable members of the secondary labor force. The anomaly between needs and services is explained by reference to the ideological commitment of the elite that provision of public services to the dependent poor would undermine the availability of cheap unskilled labor--chiefly farm labor--this population provides. That is, a systematic analysis of the community explains both the manner in which the members of the communities are differentiated (in terms of wealth, income, and control over land, jobs and wages) and the manner by which the communities are integrated (through the use of public services as instruments of social control). Control over both the differentiation axis and the integration axis lies within the influence of the same elite.

Subsequent involvement in a citizen panel of the President's Commission on Mental Health brought awareness of a prevalent, improper use of the socioepidemiological model of estimating needs for mental health services when this model is dissociated from the theoretical perspective it supports. Many of the citizen panels (including the one on which the author served) represented advocates for minority groups. Minorities represented

by separate task panels included age groupings (infants and children, adolescents, the elderly), racial or ethnic groups (Asian/Pacific Americans, blacks, Hispanics, American Indians and Alaskans), and other "underserved" groups (rural residents, women, Vietnam-era veterans and migrant farmworkers). Each advocacy panel argued that the sub-population it represented was urgently in need of additional mental health services. The arguments were frequently legitimated by reference to socioepidemiological studies "proving" that human populations sharing characteristics with the sub-population in question experience high rates of mental disorder. These arguments were not dissuaded in light of evidence attesting to a wide range in rates of diagnosed mental disorder according to the population characteristics(s) shared by the "underserved" population in previous studies of the social correlates of defined mental disorder.

Powerful incentives exist for advocating the extension of diagnoses or labels of mental disorder to persons and groups not now served within the public mental health system. These are familiar from the work of Parsons (1951) and others: acquisition of the sick role excuses the incumbent (and frequently other members of the primary group of the incumbent) from participation in the work tasks of the social order and provides additional secondary gains. Under the community mental health system, these secondary gains may be particularly salient.

Access to other public services (specialized health care, income maintenance, social and recreational services, public housing, etc.) may be obtained through the successful application of a label of disability in the form of a diagnosis of mental disorder for some portion of the population barred from eligibility for these services on the basis of income alone.

Many citizen panelists believed there to be within the minority populations they represented high levels of undiagnosed mental disorder for which some effective mental health treatment exists. Moreover, panelists seemed convinced that extension of secondary gains to this undiagnosed population would outweigh any undesired effects of labeling and would, in effect, "prevent" the exacerbation of "incipient" mental illness within that population. Whether or not this be the case, little attention was directed to the fact that minority populations typically do not control the allocation of secondary gains in the public service sector. Their participation in these gains is at the pleasure of that audience which defines their disability and erects the systems of reward and punishment associated with these definitions.

The chief thrust of the arguments made by citizen panels remained: (1) disadvantaged status has been demonstrated to be highly correlated with mental disorder; (2) the population represented shares in certain indicators of disadvantaged status; (3) some unspecified

number within the population represented, therefore, may be inferred to "have" mental disorder and there is evidence that neither treatment nor secondary gains associated with treatment are being provided to this unspecified number; and (4) the solution to the problem lies in convincing the community leadership of the existence of these undiagnosed mental disorders and providing services to the presently unserved population.

This argument, undissected, appears rational. Illumination of the argument from a more complete sociological perspective, however, reveals certain limitations not only in the logical form of the argument, but in the implications for policy it contains.

Statement of the Problem

There is agreement among sociologists and other social and health scientists that the complex of behaviors labeled mental disorder represents a form of "residual deviance" which arises from fundamentally diverse sources (Scheff, 1968: 10). Certain types of mental disorder are demonstrably the result of organic causes and have genetic, biochemical or physiological origins. Other types appear to arise from non-organic sources and to have their origin in the social environment and social fabric. Rates of both organic and non-organic forms and types of diagnosed mental disorder have been demonstrated to covary in accordance with aggregate social and economic characteristics of the diagnosed population. The strengths

of these reported relationships, however, vary widely. Because mental disorders having organic origins have been demonstrated to have sociodemographic correlates, and particularly because mental disorders without clear organic origins are essentially "social definitions" the study of mental disorder is properly of sociological interest.

The contemporary community mental health movement draws much legitimation from applied sociological studies of patterns of distribution of labeled mental disorder. The earlier and inefficient medical model of explanation of the origins of mental disorder with its related treatment regimens has given way to more complex notions regarding etiology and treatment. The replacement of the medical or disease model as the sole metaphor accounting for the phenomenon, however, is far from complete. At least in part, this may be seen as the ironic result of sociological studies which simultaneously challenge the efficiency of medical model and disease metaphor, and, inadvertently, reify the assumptions inherent in the model. That is, studies aimed at demonstrating the <u>variability</u> in rates in accordance with social and economic characteristics of those diagnosed as mentally disordered have been employed to imply the existence of the (undiagnosed) "disease" in populations with low treatment rates but possessing social or economic characteristics correlated with high rates of (diagnosed) mental disorder.

This use of empirical studies is methodologically

suspect but represents conceptual confusion that inheres in important ways in the studies proper. That is, social epidemiological studies have generally been undertaken from the public health perspective in which the causes of disease form a trilogy: (1) host factors include all those characteristics in the human individual that increase/decrease probability of disease; (2) environmental factors deterring or aiding development of disease; and (3) agent factors present in the disease-causing object or process itself which determine its ability to produce the disease state. (Suchman, 1963:96). These studies have demonstrated accurately that genetic and biological factors alone do not account for that which is labeled mental illness. Studies of the environmental (social and economic) correlates of defined mental disorder, however, have been taken as "social indicators" of the phenomenon itself or as "risk" for mental disorder.

Alternatively, it is the variation in strength of reported relationships that may be of critical sociological interest. If the disease metaphor is discounted in favor of one accommodating social and environmental origins of the phenomenon, the processes and patterns of definition itself are of sociological interest and clearly lie within the domain of policy analysis. Lemert (1964) and Friedson (1970) are among those asserting that the norms providing criteria for social definition and the agents making such definitions are proper subjects of

sociological concern. Becker (1963, 1973) and Erikson (1962) also concur in viewing non-organic forms of mental disorder as social deviance. Erikson (1962:308) asserts that "deviance is not a property inherent in certain forms of behavior; it is a property conferred upon those forms by the audiences which directly or indirectly witness them. Sociologically, then, the critical variable in the study of social deviance is the social audience rather than the individual person, since it is the audience which eventually decides whether or not any given action or actions will become a visible case of deviation." Becker's (1963:9) central thesis that "the deviant is one to whom that label has successfully been applied" supports the notion that the labeler is a proper focus of sociological inquiry.

Unfortunately, the labeling perspective which views non-organic (and some organic) mental disorder as a form of residual deviance the occurrence of which is dependent upon the norms, motives and processes of whose controlling the definition has not engendered a body of empirical studies making the perspective useful for policy purposes. While the variation in correlative studies undertaken in the social epidemiological mode of investigation provides prima facie evidence of the operation of social processes involving both "residual deviants" and labelers, there is no evidence that a confluence of perspectives has, in fact, taken place.

Marx, Ellison and Reiker (1974) argue that sociology has unwittingly contributed to individualistic concepts of mental disorder and to the perseverance of the medical disease model of causation and treatment. In so doing, they invoke Blau's (1969) distinction between a focus on the determinants and a focus on the consequences of social organization. That is, prior sociological investigations have focused on social conditions (population characteristics) as independent variables to account for patterns of dysfunctional behavior (rates of mental disorder) of individuals and groups. A more macrostructural formulation would view characteristics of social structure as dependent variables to be explained by antecedent factors. That is, characteristics of the population and the division of labor within communities would be seen as dependent variables to be sociologically explained by constructs accounting not only for these indicators of social differentiation but processes of integration as well. Population characteristics in the social epidemiological model and the structure, processes and experiences of institutions of social control (such as community mental health services) are explained by reference to antecedent factors which determine the characteristics both of social structures and social institutions.

That an overarching sociological theory embracing the labeling perspective and accounting for the range of reported associations between social characteristics of

the population and the social definition of deviance as mental disorder has not arisen is seen in the present work as resulting at least partially from the paradigms which guide and divide the discipline of sociology and its applied studies. More fundamentally, the problems to be discussed are persistently problems of conceptualization and measurement identified by Blalock in the 1979 Presidential Address before the American Sociological Association (Blalock, 1979:881-84).

Impetus for clarifying conceptual problems and for delineating and properly using appropriate tools for measurement in the field of social deviance and social control is provided by the proliferation of public policies affecting "community" crime and correction systems, welfare and social services, community public health programs, and most focally mental health services. In each of these social problem areas models have been promulgated by the federal government which purport to measure "need for services" by reference to population characteristics. These models appear likely to define increasing numbers of economic and social structural problems of inequality in terms of the personal pathologies these inequalities are purported to produce. The models legitimate the address of "pathological" outcomes by increased provision of taxpayer-funded, governmentally supervised services. Clients of these services form an increasingly large proportion of the population--a proportion led to accept redefinition of social structural problems in terms of

their own behavioral or psychological deficits.

The sociological study of mental disorder seems particularly suitable as a mechanism for illuminating social control processes. As distinguished from other social processes having more clearly recognizable outcomes (physical diseases, for example) the outcomes of the community mental health system may be seen as "sensitizing" concepts.

It is assumed that readers of this work are familiar with the general problems of nosology which characterize the diagnoses of mental disorder. The lack of consensus and clarity in defining the content of specific forms of mental disorder make Blumer's (1969) distinction between definitive and sensitizing concepts adroit. That is, lacking precise identification of the characteristics common to a class of objects (defined mental disorders) the use of these same concepts as "sensitizing" rather than definitive opens a new and illuminating perspective.

Advocates of social epidemiological models have been frustrated by their inability to predict mental health outcomes (rates of defined disorder) from population data. These advocates tend to ignore that which may be of core sociological interest: variability in outcome in community mental health programming sensitizes the analyst to social processes and dynamics within communities that affect the definitional process in important ways. These processes, as this work will attempt to document, are not unrelated to other important community dynamics, but they

are related in complex ways that are not illuminated by reference to social epidemiological models alone.

Given reasonably similar "inputs" in terms of population characteristics, the actions taken by community power structures affect and mediate "outputs" in terms of rates of defined mental disorder. Rates under treatment, viewed as sensitizing concepts enhance the ability to understand mediating social processes and the correlates and reasons for these processes in a way that these same materials viewed as definitional concepts do not.

The community mental health movement provides other opportunities for sociological study. The movement established a system for local political control over the processes of defining and treating mental disorders. Local citizen boards responsible to elected public officials make and interpret mental health policies, replacing the previous pattern of "individualistic" practice in which physicians and/or psychiatrists were alone responsible for diagnosis and treatment of individual "patients." Thus, we now approach a system in which population data (input) is processed by a human group (citizen board) in a manner which results in aggregate data (output or rates under treatment) that permits structural analysis and comparative study of community processes. Variations in the relationships between input and output data serve to sensitize the social analyst to the need for analysis of the structural mediator--the

community and its citizen board--that explains or interprets the variation. At minimum such a formulation permits inferences to be made regarding the social purposes served by variation across communities.

This work, stimulated by earlier efforts to understand community processes through application of multiple theoretical constructs and research practices, seeks to explore this potential for structural analysis.

CHAPTER II

DIMENSIONS, ASSUMPTIONS AND SOCIOLOGICAL IMPLICATIONS OF THE COMMUNITY MENTAL HEALTH MOVEMENT

Dimensions and Assumptions

In 1963, President John F. Kennedy delivered a special message to the Congress outlining a "bold new approach" to public policy related to mental health and mental disorder. In that message he specified three objectives for this new approach.

> 1. We must seek out the causes of mental illness and mental retardation and eradicate them. . .for prevention is far more desirable for all concerned. . . prevention will require both selected specific programs directed especially at known causes, and the general strengthening of our fundamental community, social welfare, and educational programs which can do much to eliminate or correct the harsh environmental conditions which are often associated with mental retardation and mental illness.
>
> 2. We must strengthen the underlying resources of knowledge and, above all, of skilled manpower which are necessary to mount and sustain our attack on mental disability for many years to come.
>
> 3. We must strengthen and improve the programs and facilities serving the mentally ill. To do this we must construct community mental health centers, staff them, etc. (Kennedy, 1963:2).

To implement these objectives, Congress passed the

Community Mental Health Centers Act of 1964 (P.L. 88-164), a set of laws and policies which simultaneously increased the federal role in provision of public mental health services--previously almost the exclusive domain of the several states--and established a decentralized mechanism for local control of these services in accordance with broad federal guidelines.

The community mental health movement grew rapidly and was widely hailed for its central thrust--deinstitutionalization of mental patients from dehumanizing custodial care in state hospitals to more humane care within their own communities and commitment to prevention of inappropriate and expensive hospitalization in massive institutions in the future.

By the mid-1970's the new ideology dominated public programming of mental health services. The nation had been divided into more than 2,000 "catchments" purporting to reflect the values, attitudes and beliefs of "communities" but more precisely reflecting geographic or political sub-divisions with lower (75,000) and upper (200,000) population limits. Mental health programming in each catchment was governed by elected or appointed citizen boards which interpret the mental health service needs of the community, administer federal and other public funds for provision of preventive and therapeutic services, supervise administrative and direct service staff and, in general, plan and operate programs in compliance

with federal and state guidelines and mandates (Ozarin, 1977). The average daily census in state mental hospitals had been reduced from one-half million in 1955 to 200,000 in 1975. Of all mental patients in treatment, the proportion in institutional care (nursing homes, state hospitals) decreased from three in four in 1955 to one in four in 1975.

During this same period, however, the direct annual public cost of mental health services increased ten-fold from $1.7 billion to $17 billion year, and more than 50 per cent of this cost continued to support institutional care. Even so, advocates of the new ideology claimed that 10 to 15 per cent of the population needed care while fewer than 5 per cent were in treatment (President's Commission on Mental Health, 1978).

The need to re-examine the experience of the movement has been based largely on considerations of ballooning cost, but there is evidence that the dimensions and assumptions of the movement should also be systematically addressed. Criticism in the recent past has been largely limited to problems in operationalizing the ideology but there is increasing evidence of public challenge of the diffuse assumptions and dimensions of the movement itself (Dunham, 1974; Trice & Roman, 1974).

Bloom (1973) asserts that, as the term suggests, community mental health refers to all activities undertaken in the community in the name of mental health. The

dimensions of the field are broad and unclear but recognizable, in the main, insofar as they differ from the dimensions of the more traditional medical/psychiatric model. He posits these dimensions to be:

1. Community mental health is distinguished from traditional, clinically oriented activities in its emphasis on practice in the community as opposed to practice in institutional settings.

2. The emphasis is on the total community or total defined population rather than on individual patients.

3. Community mental health emphasis is on preventive services as distinguished from therapeutic services.

4. Community mental health emphasizes indirect as opposed to direct services; this dimension is operationalized in an emphasis on "consultation and education" and the involvement of diverse community agents such as the clergy, public health nurses, etc.

5. Community mental health emphasizes innovative clinical strategies that have potential for meeting needs of larger numbers of people more promptly than has ordinarily been possible; operationally this dimension includes crisis intervention, group therapeutic approaches, etc.

6. The field is characterized by a rational planning process in decision-making regarding programs through use of demographic analyses, specification of unmet mental health needs, identification of special high risk populations, etc.

7. Community mental health is characterized by the use of innovative resources of manpower including paraprofessionals and indigenous mental health workers.

8. Community mental health is commited to "community control"; the mental health professional is not the sole source of expertise regarding mental health needs

and services

9. Community mental health is oriented to the identification of sources of stress within the community; that is, the ideology views the community as having counterproductive, stress-inducing properties as opposed to assuming that psychopathology is wholly within the internal psychological state of the individual patient (Bloom, 1973:1-2).

Within the breadth of the community mental health ideology with its implied attack upon both the philosophical and technical bases of past social efforts to control and treat mental disorder, there is ample latitude for conflicting viewpoints and, resultingly, little consensus has emerged. In discussing the meanings ascribed to the Congressional Act which brought legitimacy to the movement, Ozarin (1977) specifies a range of interpretations. At the conservative end of a continuum is Kolb's (1971:283-293) view that "community mental health was intended to focus the energy of the community on the treatment and rehabilitation of people suffering from severely impairing psychiatric disabilities--the psychoses." In opposition to this interpretation is Ewalt's (1970:XI) position that the purpose of community mental health is "to coordinate efforts to improve the community in ways that will enhance mental well-being, decrease to bearable limits the occurrence of personal and social stress, relieve troubled persons, prevent mental illness when possible and treat and rehabilitate those who become ill or disturbed."

The potential for conflicting notions may be illustrated further through juxtaposition of a statement of

ethical and technical ideologies formulated by Zusman with a list of relevant facts regarding mental illness posited by Dunham and Trice and Roman's list of underlying assumptions of community mental health programs which have yet to be empirically validated.

Zusman (1977) posits the ethical beliefs of community mental health to be: (1) good mental health services should be available to all those who need them regardless of any other personal characteristics including ability to pay, location of residence, age, etc.; (2) each person should control his destiny to the greatest extent possible; (3) close, long-term relationships, particularly those within small groups, are valuable and to be fostered; (4) the strength which comes from humans banding together in social groups is to be prized and utilized.

Technical beliefs which support the ideology include: (1) the method of service delivery--the manner in which the patient and the therapeutic agent are brought together--is as important as the nature of the service itself in determining outcome; (2) the nature and frequency of occurrence of mental illness are dependent upon current environment; (3) in therapy, as in all goal-directed interaction, the nature and quality of the relationship are far more important than the technical skills of the individuals involved; (4) mental illness is in large part--if not totally--synonymous with social deviance, and both are in turn closely related to all that is "bad" or unpleasant in life; (5) mental hospitalization is "bad";

(6) human beings, when operating in a bureaucracy, are fallible and not to be trusted (Zusman, 1977:21-34).

By contrast, Dunham (1974) documents the following facts: (1) evidence increases that psychoses in the middle age groups have not increased in the United States over the past two or three generations, despite increasing "stress"; (2) there is mounting evidence that the major mental disease, schizophrenia, is found in every culture of the world and at every social level within these cultures; (3) individuals with manic depressive psychosis have, for the most part, been removed from hospitals and are being managed in the community due to the increase of office psychiatric practice; (4) there is evidence that some kind of genetic defect is operative in the etiology of the psychoses, certain kinds of mental deficiency, and certain psycho-physiological disorders; (5) epidemiological evidence demonstrates that psychopathic, situational, and personality disturbances are highly concentrated in the culturally and economically impoverished areas of our communities; (6) it is clearly recognized that certain types of environment reinforce various kinds of mental symptoms; (7) mounting evidence indicates that the outcome of various psychotherapeutic techniques is extremely uncertain; (8) the detection and treatment of schizophrenia during childhood has not prevented this disorder from recurring or continuing into adulthood (Dunham, 1974:41-50).

Trice and Roman (1974) also challenge assumptions

commonly made by proponents of the community mental health movement. Assumptions lacking sufficient empirical support include: (1) programs can actually reach target populations and, in so doing raise the level of mental health to the benefit of the community at large; (2) many community mental health assumptions are an extension of the concept of personal, individual pathology; in short, they define more and more structural problems in mental health terms without evidence of "disease" (3) a "catchment area" is synonymous with a "community"' (4) minor emotional disturbances are on a continuum with severe chronic psychoses, and so severe disorders will be prevented if minor disorders are promptly treated; (5) immediate intervention will minimize chronicity and the lengthy hospitalization of patients; (6) remaining in community life is more constructive for the mentally ill than hospitalization; (7) mentally ill persons receive appropriate treatment and care within the community; (8) it is viable for community programs actively to seek out emotionally disturbed persons for treatment and, in so doing, both protect the community and relieve those who suffer; (9) the goals of various types of prevention are realistic, and their achievement can be reasonably expected as a consequence of the community mental health movement; (10) the community mental health worker knows how to reorganize a community in order to increase the mental health of its population; (11) there has been some working resolution

of the etiological debate between those who argue genetic causation and those who prefer sociogenic interpretations (Trice and Roman, 1974:136-139).

In short, public policy in mental health is characterized by ideological debate. The very aspects of the field which make it more amenable to study as a sensitizing concept rather than a definitional one also make it difficult to document or repudiate ideological beliefs and assumptions with empirical evidence.

Sociological Implications

The rhetoric of the movement includes frequent reference to sociological studies and findings. Advocates for more extensive provision of public services make frequent reference to social epidemiological studies. The fact of covariation between measures of social and economic disadvantage and rates of mental disorder is well established in the literature; however, the range of these associations is wide. This range in reported levels of association is influenced significantly by both antecedent and intervening variables that interpret or explain strengths or weaknesses in the relationships. Faris and Dunham's ecological studies of mental disorder in Chicago (1939) and Hollingshead and Redlich's (1958) analysis of the influence of social factors in the individual and at the community level on the definition and disposition of mental disorder in New Haven formed important cornerstones

in a movement that expanded the unit of analysis from earlier concentration on the individual actor thought to possess "psychopathology" to the influence of membership in social groups and social classes on individuals whose behavior comes to be defined by others as mentally ill.

Sociology has further influenced the community mental health movement in identifying important therapeutic keys to the resocialization of those defined as mentally ill (or in preventing the occurrence of the definition) which lie in the nature of relationships between individuals and primary groups (Sullivan, 1938; Becker, 1962). The movement toward group and milieu therapy, the establishment of "therapeutic communities," and the notion of "community as client" incorporate important contributions from sociological theory and inquiry.

These contributions are humanistically "positive" in the sense that the use of stigmatizing, dehumanizing and inefficacious treatment within "total institutions" (Goffman, 1958) has decreased. There is evidence, however, that contemporary attempts to reduce complex sociological analyses and findings to convenient demographic models for the prediction of rates of mental disorder from social indicators, for locating "populations at risk" and for adjusting therapeutic practices may be misleading and may unintentionally "blame the victim."

In its more elemental form, the social definition of an individual as mentally disordered requires knowledge

not only of the behavior of that individual but of the values, attitudes, intents and motives of social agents making such definitions. Scheff (1963) posits a set of central propositions related to mental illness. He asserts that the causes of the initiation, maintenance and termination of what is called mental illness are part of the social system in which it occurs, and one can account for mental illness by mechanisms other than those internal to the psyche of the individual. Mental illness is a label given to diverse kinds of deviations which do not fit under any other explicit labels. Mental illness can thus be viewed as a type of "residual deviance". His propositions include: (1) residual deviance arises from fundamentally diverse sources, and (2) relative to the rate of treated mental illness, the rate of unrecorded residual deviance is extremely high (Scheff, 1963:10-11).

Mechanic (1969:68-69) in a set of complementary assertions sees <u>all</u> illness as defined because the person directly concerned or others become aware that some deviation from the normal state has taken place. Psychiatric conditions differ from ordinary medical conditions, from the perspective of the public, insofar as they partake in dimensions related to the visibility, recognizability or perceptual salience of the deviant signs and symptoms, the extent to which the person perceives the symptoms as serious, the extent to which these symptoms disrupt family, work and other social activity, frequency and

persistence of symptoms, the tolerance of those who are exposed to and evaluate the symptoms, the information available to, knowledge of and cultural assumptions and understandings of the evaluator and other dimensions clearly connected to social processes. These are complex conceptualizations of social processes that submit only with difficulty to measurement.

It is significant that the present public and professional controversy regarding the goals and achievements of the community mental health movement is focused typically upon the phenomenon of "deinstitutionalization." Brown (1975) operationalizes this term to include three components: (1) the prevention of inappropriate mental hospital admission through provision of community alternatives for treatment; (2) the release to the community of all institutional patients who have been given adequate preparation for such change; and (3) the establishment and maintenance of community support systems for non-institutionalized persons receiving mental health services in the community.

Bachrach (1976) views this statement of operational goals as an "anticipatory definition" the accomplishment of which is impossible without reference to larger sociological concepts. She calls attention to latent meanings of the term, which has come to be symbolic of the entire community mental health movement. Recalling Davis' (1949) definition of an institution as a "set of

interwoven folkways, mores, and laws built around one or more functions" as opposed to the equation of institution and mental hospital, she asserts

> . . .an institution may be viewed in two different ways: as an established place, such as a long-term care mental hospital, or as an established set of social patterns, such as the totality of artifacts and practices society has adopted for the care of its mentally disabled population. It is in the latter sense that the term deinstitutionalization, used in reference to the mentally ill, has greatest value. It implies the breakdown of a social system, of established patterns of social control which determine how the mentally ill should be viewed, what their status (position) in society is, what rights and obligation society has in reference to them, and what rights and obligations they have in reference to society (Bachrach, 1976:2).

In short, while the concentration in the literature tends to focus on concrete measurements of social facts related to the etiology of mental disorders, and on the distribution of the labeled disordered among the various levels of "institutions" (institutionalized mental patients, deinstitutionalized mental patients, pre-institutional services, etc.), the "real" dimension of the movement will be realized only through the adjustment of deeply entrenched social norms, values and beliefs which are identical to the full conceptual meaning of the term social institution.

A general theoretical model by which this process may be understood, and which might reorient future research

is Parsons' (1951) concept of the "sick role" and secondary gain, coupled with the derivative constructs of Becker (1963, 1973) and Erikson (1962) relevant to the labeling of social deviance. In each of these formulations, however, it becomes necessary to redirect or expand the units of analysis from concentration on how an individual becomes legitimated in the sick role in a labeling process involving other individual actors to the more embracing question of how and why communities come to define members as mentally disordered in non-randomly distributed quantities which are correlated with other social characteristics and attributes.

In Parsons' formulation, the person in the sick role is at least partially influenced by the secondary gains to be experienced through exemption from normal social roles and responsibilities. Except as noted below, this concept has not guided research into the sociology of mental disorder, and it is important to emphasize that Parsons' concept concentrated upon secondary gains available to the person in the sick role, rather than on the motives for regulating the flow of secondary gains.

Becker and Erikson, as earlier noted, see social deviance as residing almost exclusively in the eyes of the beholder and direct attention to the social audience, rather than the deviant, as a focus of sociological study.

The Dohrenwends (1969:174-5) in social-psychological construct of the social etiology of mental disorder are

clearly influenced by Parsons' concept of secondary gain, which they see as differentially experienced according to position in social class and membership in ethnic groups and cultures. Their observations are coupled with a set of propositions incorporating the central position of self-perceived and objective "stress" as the underlying phenomenon which makes the secondary gains to be secured through acquisition of the label of mental disorder differentially desirable. The model lacks sociological purity in failing to acknowledge the fact that the administration of secondary gain lies within the sphere of influence of the agent or collectivity providing the label, and not primarily within the sphere of influence of the actor. Since these authors are psychologists, their focus on salience of secondary gain for the individual within social groups is legitimate.

Unfortunately, sociological studies of the processes of labeling mental disorder have also focused on the behaviors of individuals (as representatives of social groups and social classes) and the differential outcomes according to aggregated attributes of the individual to the virtual exclusion of analysis of social system variables that define the "meaning" of these social attributes in particular social systems from the perspective of these social systems. The logic of the community mental health movement suggests that a reformulation which focuses upon the structures and processes by which communities

distribute secondary gains differentially to "beneficiaries" is appropriate. The key to understanding this "inequitable" process lies in the analysis of gain to the community or identifiable segments of the community in the structuring of differential access to the sick role, rather than focusing upon the behaviors of individuals in their "pursuit" of secondary gains associated with the sick role. These latter behaviors can be readily explained by reference to the concept of economic man, rationally seeking to maximize public utility flow while minimizing energy investment (Downs, 1957).

Marx, Ellison and Reiker's (1974:10) earlier cited argument that sociology has inadvertently reified individualistic concepts and the medical-disease model of mental disorder is again pertinent. The authors assert that "sociological involvement in the mental health field should: (1) examine socially organized collectivities in the mental health field and treat them as dependent variables; (2) eschew the individually oriented concepts of mental health and mental illness and replace them by the sociological perspective; and (3) establish meaningful, operational measures and empirical indices of social system variables and community concepts that can be used for comparing various communities and community processes relevant to mental health." It is an argument that has gone largely unheeded for there is currently no agreed upon template by which measures of "community" and

community processes can be analyzed to explain or interpret the wide range of reported relationships between social epidemiological variables and defined mental disorder.

It seems especially ironic that sociological theory and research originally intended to confront the "individually oriented concepts of mental health and mental illness" and replace the medical model as the sole metaphoric construct accounting for the origin and disposition of mental disorder have been involved and exploited in the extension of these concepts and models. Even this unintended use of social research, however, is sociologically understandable.

While the community mental health movement has greatly increased the numbers and roles of mental health service providers, it has only partially reoriented the practices of this expanded service industry which remains under the control of physicians and psychiatrists as legitimated agents of social control. The ideological diffuseness and array of assumptions of the movement make it possible to absorb even contradictory information in arguing for expansion of its sphere of influence and control. While sociological theories and findings have not been directly contradictory, "the sociological perspective" which Marx, Ellison and Rieker seek to replace individually oriented concepts of mental disorder does not exist. Rather there are several perspectives in the sociology of mental disorder. Theory and research have developed

somewhat independently within these perspectives, as they have in general sociology. Rates of progress have differed according to resources available to support empirical investigations and intellectual speculation. As will be demonstrated, social epidemiological approaches have provided policy makers with the greatest quantitative research inputs. This is due both to an earlier fascination with quantitative studies, particularly of bivariate relationships, and the state-of-the-art in the ability to operationalize and measure complex but relevant conceptual materials. It may also be because research in the epidemiological tradition is more readily interpretable as supportive of the intents of funding agencies and their constituencies in the quest for expansion of their domains of influence.

Arguments related to purely mechanical limitations dissipate in light of methodological and statistical tools now available. A continuing problem, however, appears to rest in the parochialism of applied sociologists working within the confines of a single theoretical perspective of research paradigm. For example, the major concluding plea of many social epidemiological investigations is for a more definitive nosology of mental disorders or nomological net to resolve "anomalies" in their findings that discover a wide range in reported associations between social and demographic characteristics of a population and defined mental disorder (Dohrenwend and Dohrenwend, 1969:175).

A more fruitful approach might be not only to accept the lack of definitional clarity in outcome measures but embrace this "confusion" as an additional indicator of the sensitizing, rather than definitional character of the concepts and processes at hand. That is, a goal of sociological investigation might be explaining variation in reported relationships rather seeking definitions that confirm their stability. The social indicator then becomes the variation and relevant sociological questions might include study of why and how this diffuseness in outcome measures is enabled by social systems, in whom does the power to define in the "loose" system reside (and who or what confers this authority) and, finally, to what larger purposes or use is this power directed?

Before addressing these questions, however, it is helpful to understand divisions within the applied field of the sociology of mental disorder, to speculate on reasons why particular paradigms have dominated the field at particular times and to locate this discussion in the larger context of divisions that prevail within the general body of sociological inquiry.

CHAPTER III

PARADIGMS OF SOCIOLOGICAL INQUIRY AND IMPLICATIONS FOR A SOCIOLOGY OF COMMUNITY MENTAL HEALTH

In this chapter attention will focus on the foundations of the sociology of mental disorder as influenced by the several theoretical perspectives and associated research traditions within general sociology. The intent is to identify the reciprocal effects of attachment to a particular theoretical perspective and use of research methods and tools historically related to that perspective. The argument developed is two-fold: (1) methods have frequently been employed for expediency that are incongruent with theoretical premises they are employed to support; (2) the emergence of community mental health movement and the abundant data the movement has accumulated provides an opportunity to bring research methods and theoretical propositions into closer alignment. In this argument the thrust is to reverse a tendency to permit available research tools and analytic methods to "drive" a conceptual model.

The Multiple Paradigms of Sociological Inquiry

Ritzer (1975) analyzes the paradigms which have guided general sociology using Kuhn's (1962; 1970) model

for the development of a science. Within that model, a paradigm gains pre-eminence in a science and is refined and extended during a period of normal science investigations. Inevitably, research efforts guided by this paradign encounter anomalies that resist explanation by the paradigm. As anomalies increase, a crisis ensues, the paradigm itself is questioned, attacked, and if the scientific crisis is sufficient, a new paradigm emerges to explain both previous findings and the anomalies the previous paradigm failed to explain. Since the discussions which follow are anchored by reference to the paradigms suggested by Ritzer, his definition is essential:

> A paradigm is a fundamental image of the subject matter within a science. It serves to define what should be studied, what questions should be asked, and what rules should be followed in interpreting the answers obtained. The paradigm is the broadest unit of consensus within a science and serves to differentiate one scientific community (or sub-community) from another. It subsumes, defines and interrelates the exemplars, theories, and methods and tools that exist within it (Ritzer, 1975:7).

In Ritzer's analysis, there are three paradigms in contemporary sociology, each rooted in sociological tradition and accompanied by preferred research methods. These are: (1) the social fact paradigm; (2) the paradigm of social definition; and (3) the social behavior paradigm. Each finds its most pristine expression within an exemplary work, is guided by an image of scientific endeavor and by past and present theoretical constructions, and

incorporates methods and tools considered to be appropriate.

The works of Durkheim form the exemplar of the social fact paradigm. In The Rules of Sociological Method (1895) Durkheim argued that the basic subject matter of sociology is the social fact. This contention was empirically demonstrated in Suicide (1897) in which the concept of the social fact is used to distinguish the newly developing discipline of sociology from the competing fields of psychology and philosophy. Within Durkheim's formulation, a social fact is treated as a thing external to the scientist and "coercive on him." Although Durkheim was not prepared to endow social facts with ontological status, contemporary works within the paradigm tend to ignore equivocations within the work of Durkheim and to imply that social facts are not merely treated as things, they are things.

Blau (1960) elaborates that two types of social facts exist: social structures and social institutions. The social factist focuses on the nature of these structures and institutions and their interrelationships and sees social behavior and social definition as more or less determined by social structures and institutions. This point illustrates the encroachment of each paradigm upon the realms of the others.

Theories encompassed within the social fact paradigm include structural-functional theory which tends to

see social facts as highly interrelated, conflict theory which emphasizes the coercive forces which maintain order or create disorder in social relations, systems theory, and macrosociology. Of these, structural-functionalism and conflict theory are those which have encouraged the bulk of normal science investigations and have been explicated in great detail. Ritzer analyzes contemporary works of Merton (1968) and Dahrendorf (1959) and successfully demonstrates that, when these works are submitted to close analysis, the structural-functionalism of the former is illuminated by the conflict theories of the latter. Conversely, conflict theory can be better understood primarily by reference to the "larger" paradigm of functionalism. Concrete efforts toward integration and reconciliation of the two perspectives are found in the works of van den Berghe (1963), Coser (1956) and Coleman (1971).

The methods and tools of the social fact paradigm are generally the interview and the questionnaire. Historical and comparative studies, such as Weber's analysis of religion and capitalism are also important illustrations of the paradigm, although contemporary sociology, according to Ritzer, avoids these methods as too time consuming and expensive.

Since the social fact paradigm attempts to interrelate social structures and social institutions it is ironic to Ritzer that responses of <u>individuals</u> to formulated interviews or questionnaires provide the methods

of normal social fact investigations. That is, in the attempt to describe and explain the relational dynamics of social structures and social institutions, the use of aggregated individual expressions falls short of reflecting the fundamental image of the subject matter embraced by social factists. Further, the reification of indices which provide an investigatory tool within the paradigm in attempting to reflect larger conceptual issues leads to a lack of interpretive understanding or verstehen.

A second major paradigm in sociology is social definitionism and, according to Ritzer, the exemplar for the social definitionist is Weber's (1961) work on social action. This work may be distinguished from the other works of Weber in that its focus is on the subjective meaning individuals attach to their action.

In this paradigm, the focus of analysis replaces macroscopic social facts (such as social structures and institutions) with a more microscopic examination of intra-subjective and intersubjective states of mind that characterize social behavior. It is within this analytic framework that Weber argues for the use of interpretive understanding or verstehen. The substance of social definition is invisible. To the social definitionist, man as individual and as collectivity is in certain respects the creator of his own social reality.

Within this paradigm, three major theoretical perspectives are subsumed: action theory, symbolic

interactionism, and phenomenological sociology. Action theory, according to Ritzer, is exemplified by Parson's concept of voluntarism within the larger framework of The Structure of Social Action (1937). The exemplar, in turn, was influenced by the action orientation of Pareto, some aspects of the work of Durkheim, and most importantly, Weber.

Hinkle (1963) provides the following set of fundamental assumptions of action theory: (1) men's social activities arise from their consciousness of themselves (as subjects) and of others and the external situations (as objects); (2) as subjects, men act to achieve their (subjective) intentions, purposes, aims, ends, objectives, or goals; (3) they use appropriate means, techniques, procedures, methods, and instruments; (4) their courses of action are limited by unmodifiable conditions or circumstances; (5) exercising will or judgment, they choose, assess, and evaluate what they will do, are doing, and have done; (6) standards, rules, or moral principles are invoked in arriving at decisions; (7) any study of social relationships requires the researcher to use subjective investigative techniques such as their verstehen, imaginative or sympathetic reconstruction, or vicarious experience (Hinkle, 1973:706-7).

These overarching assumptions apply not only to action theory but also to symbolic interactionism and, perhaps, to phenomenological sociology. Ritzer is

intrigued that both Parsons and Weber abandoned social action theory during their later works and moved from analysis of the acts of individuals to the analysis of social systems and social structures. Because social action theory was "abandoned" by its founders, it has not developed as fully as other theories within the social definitionist paradigm.

Symbolic interactionism both as a theoretical construct and as a body of empirical research has been more fully developed. Subsumed here are the works of Cooley, Thomas and Mead and the later works of the Chicago school epitomized by Park and Burgess. Of the several schools subsumed under the paradigm of social definition, symbolic interactionism is the most difficult to summarize. The key to the symbolic interactionist position lies in the process of interpretation that mediates between stimulus and response, a focus separating this paradigm from the social behaviorist.

Blumer (1962) is viewed as the dominant contemporary exponent of symbolic interactionism, defining the field as:

> the peculiar and distinctive character of interaction as it takes place between human beings. The peculiarity consists in the fact that human beings interpret or 'define' each other's actions instead of merely reacting to each other's actions. Their response is not made directly to the actions of one another, but instead is based on the meaning which they attach to such actions. Thus, human interaction is mediated by the use of symbols, by interpretation,

> or by ascertaining the meaning of one another's action. This mediation is equivalent to inserting a process of interpretation between stimulus and response in the case of human behavior (Blumer, 1962:180).

Within the paradigm and the theoretical school, there is a disinclination to deal with society as if it were a set of "real structures" distinct from people. Social facts are not things that control or coerce but are little more than a framework within which the dynamic aspects of society takes place. There is no need to reify society. Symbolic interactionism is thus distinguished from social behaviorism, and from social factism.

From the perspective of phenomenological sociology, the relationship between the social construction of reality and action is the object of study, as it is both with the action theorist and the symbolic interactionist. Phenomenologists are distinguished from other theorists by their more intense focus on the "taken for granted world" of everyday life. Some are distinguished by their use of methods to disrupt social situations in order that the "taken for granted world" can be studied.

The methodological tool of choice of the social definitionist is observation. Since the invisible quality of "minding" prevents direct observation, it can be captured only through inference. Participant observation permits the social definitionist to examine natural processes over time in a natural setting.

Using observational techniques, the cumulation of knowledge is difficult but not impossible. Discrete hypotheses are frequently derived from observational studies and can be interrelated toward the construction of general theory. That this course has not been frequently undertaken is in part attributable to the bias of the perspective against "scientism" and pseudo-scientism which are imputed to characterize the work of the social factist and social behaviorist. Verstehen--that level of understanding passionately sought by definitionists--cannot be gained through the "harder" scientific methods of the other paradigms, and may in fact be destroyed by the use of statistical indices and methods.

The final paradigm is social behaviorism and the exemplars of the paradigm are the works of Skinner (1971) in psychological behaviorism and Homans (1961) in sociology. The focus of the behaviorist is the behavior of individuals that operates on the environment in such way as to produce some consequence or change in it which, in turn, modifies subsequent performances of that behavior. Behaviorists reject the definitionists' notion that there is a voluntaristic mind that intervenes between the contingencies of reinforcement and behavior and regard such entities as metaphysical constructs. Negative views are also taken of the social factists' concentration on structures and institutions. If behavior is the focal concern, concepts such as mind, social structure, or social institution serve only to distract or distort the focus.

The exchange theories of Homans have tended toward microscopic levels of analysis. Blau (1964) has attempted to extend exchange theory to the macroscopic level. In that endeavor, through a union of social behaviorism and social factism, Blau sees a sequence leading from interpersonal exchange through social structure to social change. At step one within the sequence, Blau and Homan are united in examining personal exchange transactions between people and the exchange contingencies which govern these transactions. These interactions give rise to a differentiation of status and power (step two) leading to legitimation and organization (step three) which inseminates opposition and leads to social change (step four) (Blau, 1964:2).

While Ritzer asserts that survey research or observation research could be used by social behaviorists, adherents tend to avoid both. Invariably, the behaviorist uses the experimental method. Studies may be either field experiments or laboratory experiments and are generally quasi-experimental in design.

Ritzer believes there to be both positive and negative consequences of paradigm differences within sociology. Positive consequences are to be found in the bridging of the paradigms and in their separate or collective invocation in efforts to triangulate research. Insight from each is necessary for the full explanation of social reality. While it is possible to characterize the works

of any sociologist according to a single paradigm, the most influential works (Durkheim, Weber, Marx, Parsons) clearly bridge two or more paradigms. While efforts such as those of Berger and Luckmann (1966) seek to reconcile social factism and social definitionism, and Blau's (1964) work seeks to reconcile social factism and social behaviorism total reconciliation of the paradigms has not been achieved. The "best" sociology, according to Ritzer, consists of efforts to triangulate and verify knowledge gained from any paradigm with arguments obtained from others.

Negative consequences lie in the polemic nature of the political arguments of theoreticians and researchers attached to single paradigms. Much of the polemic and political quality of arguments emanating from any theoretical construct is targeted toward "straw men" and tends to exaggerate the positions of both the polemicist/politician and his opponent. These arguments are dysfunctional to the general discipline of sociology, especially when warring positions are placed in open view of the consumers of sociological knowledge.

Ritzer's argument that triangulation and paradigm bridging are necessary for a full understanding of social reality supports the concern and the major conclusions of the present work.

The sociology of mental disorder is a form of investigation derivative of the normal science works of general sociology. Since several paradigms operate within general

sociology, the derivative work is also characterized by a lack of bridge building or triangulation. This lack of completeness in analytic reconstruction of social reality has made some consumers of derivative sociology suspicious of the utility of sociology in general. Since contemporary efforts in the sociology of mental disorder have arisen from general sociological theories and research methods rooted in one or more of the paradigms, it is necessary first to examine historic sources and their differences before proceeding to discuss contemporary efforts and applications.

Foundations of the Sociology of Mental Disorder

The contemporary French sociologist Bastide (1972) surveys the foundations of the sociology of mental disorder and distinguishes between the early and continuing tradition of European sociology with its emphasis on theoretical constructs and the American tradition of atheoretical empiricism. With respect to historic foundations, he imputes paternity both of Western sociology and the sociology of mental disorder to Comte. Other early contributors to the field of general theoretical sociology whose works have impacted contemporary sociology of mental disorder are Durkheim and Marx. Although the theoretical constructs of Comte, Durkheim and Marx transcend Ritzer's types, Comte and Durkheim may be categorized as belonging predominantly to the social fact paradigm and Marx to the paradigm of social definition. The focus of the former

two was on the relationship between occurrence of social phenomena and accompanying characteristics of social structure while the focus of the latter was upon the dynamic content of these relationships.

In Comte's formulation, insanity represented the mind in a state of "selfishness", the revolt of the individual against objective (social) reality and the surrender of the individual to "subjective" reality. Such surrender characterizes certain historic periods and the rate of surrender varies in accordance with the form and level of social organization of the time. Increases in the incidence of insanity are related to the passing from "organic" into "crisis" periods of social history and develop alongside and for the same reasons as "individualism."

The work of Durkheim refines and empirically validates Comte's notions regarding the relationship between insanity and characteristics of the social order. The formulations of Durkheim specify the types of solidarity (and not the absence of this solidarity) which result in characteristic forms and rates of individual and collective behavior. While the earlier formulation of the gemeinschaft/gesellschaft typology of social orders of Toennies is useful in positing ideal types, the work of Durkheim is more heuristic in specifying not only a more complete typology of social orders to be found in a continuum, but the forms of "individualistic" behaviors which accompany each category of social order.

It is in Suicide that the typology of social order and associated types of individualistic behaviors that Durkheim proves most valuable to the sociologist of mental disorder. The irony of his contribution is that in analyzing the relationship between suicide and "social integration", Durkheim disproves the previously held notion that suicide represents a form of "insane" behavior. That is, the relationship between types of social order and rates of suicide obtains even when the equation is controlled for the variable "insanity."

According to Bastide, the forms of social solidarity specified by Durkheim in The Division of Labor in Society, as these are explicated in their association with rates and forms of suicide behavior in Suicide, could provide a framework for the understanding of mental disorder and explain the variance both in the rate and the form of these disorders as well. That is, the state (and level) of "mechanical solidarity" within a society explains and predicts the rate and form--altruistic--of suicide and, by inference, rates and forms of mental disorder. The state and level of "organic solidarity" which explains and predicts egoistic suicide, and the presence and degree of social anomia which explains and predicts anomic suicide might also explain and predict forms of mental disorder. Unfortunately, in the fourth type of social order--enforced solidarity--characteristic of colonial and slave-owning societies with its associated phenomenon of

fatalistic suicide, Durkheim's explication is incomplete. Little information was collected in societies characterized by enforced solidarity and even fewer data existed regarding the rates of suicide behavior associated with this form of social order. Further, Bastide's speculations regarding the ability of the typology to explain rates and forms of mental disorder as well as suicide ignores basic distinctions between suicide as a social fact and mental disorder as, predominately, a social definition. It is a frequently made mistake with serious consequences.

The positivism and "social physics" of Comte are clearly evident in the Durkheim formulation in which social facts are explained by reference to other social facts. Levels of association between sets of social facts vary, but are explained by reference to the constructs themselves.

It is to Marx that one must turn for explanation of the dynamics occurring within these constructs and typologies. Marx's concepts of class struggle and alienation illuminate the pathogenic effects of economic and social conditions. According to Bastide, however, the explanation of mental disorder by reference to indicators of social disorganization (slums, low wages, unemployment) alone fails as a Marxist conceptualization. Although the direct effects of the kind and level of social order on disordered behavior is undeniable, the creation of causal links between these factors represents an oversimplification

and a form of manipulated false consciousness in which the individual exploited by the social order is held responsible even for his own alienation.

Social influences for Marx must be understood within the broader contradictions of capitalist society as these impact on individual consciousness. Environmental influences may be observed, but they do not explain relationships between deleterious contexts and mental disorder. Rather, the explanation is to be found in the divisions and contradictions of society. Explanations do not lie in social "accidents" such as war, revolution, and disruption, but in the technical, material and spiritual transformations which create problems for man. The presence of pathogenic conflicts in the individual simply resonate the general conflicts of capitalist society. The first task of "therapy" is to change the social order to excise the contradictions within capitalist economic and social structures. The social change agent needs to understand not only the relations of production and conflict between the forces of production, although these are fundamental, but the attendant contradictions of an ideological, political and cultural nature. This last aspect clearly identifies the attachment of Marxist formulations to the social definition paradigm.

Although Durkheim reflects upon the nature of the "conscious collective" and in the consideration of that dynamic bridges the paradigms of social fact and social

definition, the dimension of the "collective conscience" as expressed in the form of ideology, politics and cultural variables is a new addition to the explanatory landscape. Marx's insertion of culture and class conflict into the equation between social order and personal behavior sets a stage for the dissection and explanation of differences in amount and kind of behavioral disorder according to the social meaning of the position held within the social order (class, status, etc.).

The parallel developments of Marxian theory and doctrine and those of psychoanalysis has been subjected to study both by social psychiatrists (Rosen, 1968) and psychiatric sociologists (Bastide). Freud, particularly, in Civilization and Its Discontents (1962) acknowledged the conflict between the id (instinct) and the super-ego (the constraint of the social order) which is integrated through successful socialization of the ego as a mediating psychic structure. Freud, contrary to the Marxists, discounted the deterministic role of socioeconomic factors and class struggle and gave primary etiological significance to the role of biology. The essential distinction to be made, however, lies not so much in denying parallels in the constructs of Freud and Marx, but in the objects of their study. Freud's attention was focused upon amelioration of intrapsychic pain, particularly the neurosis of middle-class Viennese women. The object of Marx's attention was clearly the social structures

associated at a causal level with the struggle of economic and social classes and the representation of collective pain within the fact of class consciousness. They are united in their study of conflict. This affinity marks them as bed fellows, but the objects of their affection are clearly distinct.

Placement of Durkheim (and Comte, Toennies and Weber) into the paradigm of social fact and Marx into the paradigm of social definition is perhaps too facile. Durkheim, Toennies and Weber were obviously able to bridge social fact and social definition. Durkheim, who coined the term "social fact", included within this rubric both material and non-material social phenomena. Weber's concern with the relationship between structural variables and the rise of a certain economic "mentality", his discussion of "the spirit of capitalism" and the "spirit" of social structure (such as the Indian caste system) confirms his ability to bridge the paradigms. The delineation of social facts which accompany the gemeinschaft/gesellschaft typology of Toennies is not simply an enumeration but an attempt to characterize dynamic qualities within these ideal constructs.

The coercive quality of social facts and their mediation in class consciousness, however, is more clearly revealed in the dynamic relationships of social fact that social definition that form the dialectical character of Marxist thinking. In providing the mediating variable of

power between the independent variable of social structure and the dependent variable of behavior the works of Marx have had enormous ramifications. Today, the sociology of mental disorder is divided into at least two camps, the first of which studies the empirical associations of social indicators with mental disorder and seeks to ameliorate the disorder and the second which seeks to explain these associations by reference by dynamic variables and to change the dynamic. These mediating dynamics are to be found within social class formation and maintenance as, for example, in the dynamic by which the dominant social order within the community defines and disposes of the phenomenon of mental disorder. The mediating variable of power is also to be found in the dynamic structure of the family, within the power relationships both explicit and implicit within indicators of marital status, and in the dynamics of domination and subjugation according to sex. At least as significant as membership in social collectivity is consciousness of this membership. This consciousness of membership includes reference to power which is unequally distributed across and within collectivities.

Social behaviorism, since it arose as a sociological paradigm in the mid-twentieth century has had little influence upon the sociology of mental disorder. The paradigm is historically linked to Pavlovian constructs, self-consciously associated with Marxism, and has found its expression in mental health in therapy to control or

change noxious personal behaviors. The macrostructural exchange propositions identified by Blau (1964), however, have relevance to community organizational and interorganizational areas of mental health concern as these institutions and structures affect and effect social change.

Bastide's imputation that American sociologists have been solely concerned only with social factist empiricism and the atheoretical explication of socio-economic and socio-demographic correlates of mental disorder is incorrect. In the discussion which follows, two sociological classics in the American literature are examined, both clearly concerned with the dynamic relationships that exist within constructs that relate amounts and kinds of mental disorder to social structure. The recent proliferation of atheoretical studies and demographic risk prediction models may indeed be an embarrassment to social theorists and is undeniably an expression of Whitehead's "fallacy of misplaced concreteness." The social factist nature of many unconnected demonstrations of associations between "race and mental illness," "sex and mental illness," "age and mental illness," "marital status and mental illness" emanated nonetheless from earlier, more profound attempts to display both the structure and dynamic of social reality.

In the section that follows attention is diverted from the foundations of the general derivative body of sociology of mental disorder to the more specific concerns

of a sociology of community mental health.

Sociology of Community Mental Health

Although community mental health was not to become a rubric until the 1960's, the classic sociological studies of mental disorders were concerned almost totally with community, seeking to discover how American communities and sub-communities were similar or different in the distribution of mental disorders and how these communities responded to mental disorders and other forms of social deviance.

A caveat is in order before proceeding to examine several of these classics. Labeling theory was not then influential in the field; the major metaphor guiding intellectual thought in the field was medical/psychiatric. Mental "illness" was taken to be a social fact, and sociological fascination was with its differential occurrence as a concrete concomitant of other social arrangements. That is, few if any students before the mid-twentieth century doubted its definitional status; thus the association of the phenomenon with other social facts was vested with near-ontological status.

Any effort to understand the present position of the sociology of community mental health must include reference not only to the classic demonstration by Faris and Dunham (1934) of the spatial distribution of mental disorder in Chicago, but to the school of sociological

thought which fostered the genre of investigation known as urban or human ecology--the study of social relationships as these are influenced by the physical environment. A central concern of this sub-discipline is the notion of segregation or localization of urban population in separate areas as a result of competition (Bastide, 1972:15, emphasis added).

In 1925, Park, Burgess and McKenzie of the University of Chicago put forth their concentric zone model of urban spatial structure. Within this model, urban areas are arranged in a series of concentric zones with the predominant land use changing from commercial through industrial to increasingly higher cost residential areas proceeding from the center of the city to its periphery. Human populations were seen as moving successively outward from the inner city where immigrants were first assimilated, into more costly residential areas as their social mobility increased reflecting improved economic status. This dynamic view of the social/spatial geography of cities was influenced by analogy to plant ecology and embodied the notion of the invasion of natural areas inhabited by one group by a competing group leading to succession and dominance of the area by the new group.

The human ecology model spawned a number of empirical studies of Chicago, among which were Faris and Dunham's study of the spatial distribution of mental disorders and Shaw and McKay's (1942) study of juvenile delinquency.

Michelson (1970:8-9) summarizes the approach:

> They typically studied a phenomenon--usually a pathology--at an aggregate level, having divided the city into a number of sub-areas corresponding as much as possible to natural areas. They explained the existence of the phenomenon by referring to the homogeneous social organization to be found within the sub-area, which in turn was dependent on the spatial relations of that place to surrounding sub-areas. Since the people or use of an area often changed, the character of a natural area at any point of time would be a function of the constant competition for space and hierarchy of dominance; therefore the pathologies usually found their explanation in an unalterable cause with strong economic overtones.

A relevant finding of early works was that any number of pathologies (crime, sexual deviance, mental disorder) could be found to deposit differentially within areal zones of the city. Instead of explaining this finding by reference to the power variables implicit in the theories of Park, Burgess and McKenzie, however, new sets of hypotheses arose which attempted to explain rates of deviance in terms of "social disorganization." Little note was taken that the explanation of specific indices of social disorganization (mental disorder, for example) was made by reference to other aspects of social disorganization (family instability, social isolation, etc.) and that this reasoning was at best circular.

Faris and Dunham were confident that they had discovered a universal rule. Regularities in the distribution of mental disorder could not be attributed to

poverty, since their counts of the mentally disordered included first admissions to expensive nursing homes and other institutions with high costs. Furthermore, if poverty were responsible, they asserted that a similar distribution for all disorders would be found. Instead, they found that different types of mental disorders predominated in different areas. Faris and Dunham also controlled for transience and mobility. Noting that high levels of transience existed within the zones with the greatest "social disorder" they demonstrated that rates of mental disorder in these areas remain high even when controlled for transient populations. In so doing, Faris and Dunham attempted to refute the "drift hypothesis" which asserts that already mentally disturbed individuals move into areas of social disorganization to escape into anonymity and isolation. The authors did not agree, first because manic depressive psychotics were not found in this zone and, secondly, because the age distribution in the zone demonstrated a higher concentration of young than old persons with mental disorders. Personality disorders were instead asserted to be caused by the living conditions in certain areas, the breaking up of family ties, loneliness, disappearance of all social control and all opportunities for social interaction.

Despite serious flaws in methodology (for example aggregating pathologies in accordance with pre-zoned, artificial areal units and the more serious problems of

both the ecological fallacy and the individualistic fallacy [Timms, 1971:37]) and criticisms related to the failure of the biological analogy to accommodate such complex issues as "culture" and "social class" within these zones, the findings of Faris and Dunham are of interest. Not only did rates of first admission for treatment of mental disorder vary in highly regular patterns, the "kind" of mental disorder varied as well.

Studies replicating these methods were undertaken in Providence, Rhode Island (Faris and Dunham, 1939); Austin, Texas (Belknap and Jaco, 1953); Luton, England (Timms, 1965) and elsewhere and confirmed regularities. In these formulations, however, it was as if the areal unit produced differing rates of mental illness and further defined the content of the aberration.

Faris and Dunham attempted to explain this relationship in terms of dynamic variables--social isolation and social mobility--and found association between measures of these phenomena and specific diagnostic categories of mental disorder. In replications in other cities, these patterns were somewhat altered but associations remained strong (Belknap, 1954; Jaco, 1954; Tietze, 1950). In addition, replications attempting to explicate further the association between physical space and mental disorders found strong "intervening variables" to be income, marital status, religious affiliation and other indicators of social relevance. The reporting of these findings

provided impetus for further studies of the relationships of these indices of membership in collectivity and mental disorder. Regrettably, just as Faris and Dunham seemed to have misplaced the underlying dynamic of urban spatial differentiation--competition and dominance--in their analysis of physical space and mental disorder, later studies of indices appear, in the main, to have lost the concept (membership) these indices purport to measure. Although both scientific and lay literature abound with these descriptions of "the culture of poverty," "the black culture," and allusions to the socio-cultural characteristics of sexual identity, later sociological (as opposed to the social anthropological) literature appears to have concentrated on measuring the associations of mental disorder and indices of collectivity.

Some tantalizing leads to important questions regarding the nature of membership in collectivity and the relationships between these social groups appear in Faris and Dunham's work:

> It is significant that although the rate for Negroes in area nine, the apartment house district, is extremely low as compared to the rate for Negroes in other areas of the city, the rates for the native White or native percentage and the foreign-born Whites for this area are the highest within these classifications as compared to any other areas of the city. It is apparent that the schizophrenic rate is significantly higher for those races residing in areas not primarily populated by members of their own group. (Faris and Dunham, 1934:54).

Marx, Rieker and Ellison (1974) cite similar findings in migration studies. Chinese immigrants to Vancouver, where there exists a large Chinese population had low rates of mental disorders; immigrants to Ontario where there are but few isolated Chinese, have high rates of mental disorder. Of interest are both the characteristics of the "receiving population" and the nature or dynamic of the relationships between collectivities.

It is important to distinguish that the work of Faris and Dunham and the subsequent replications of their work were at best derivative of the body of ecological theory, a theoretical construct which has been replaced by "neo-ecology" in the works of Hawley (1950) and Duncan and Schnor (1959, 1960). Reissman (1970) traces the evolution of neo-ecology from earlier theoretical constructs and decides that while of obvious interest to those studying either community or social pathology, the constructs are not adequate bases for a fully developed urban social theory.

Of importance to this discussion, urban ecology fostered empiric investigations of the association of mental disorder with "community" variables. These studies largely ignored the cultural characteristics of the areal units they attempted to survey and the dynamic of power relationships between and among these areal units. Replications have, in the majority, simply demonstrated geographic concentration of mental disorders, spatial differentiation

in the types of disorders, and investigation of census variables with amounts and kinds of mental disorder. The work of Faris and Dunham and their replicators clearly belong within the paradigm of social fact.

A fuller conceptualization of the meaning of membership within collectivity and the relationships between collectivities with reference to patterns of associated mental disorder awaited the work of Hollingshead and Redlich (1954). The work of these authors, Social Class and Mental Illness: A Community Study, was preceded historically by efforts to understand the relationship between occupational groups in industrial society and mental disorder as an interim step from the analysis of spatial distribution to the fuller realization of the socio-cultural meaning of class membership and its impact on behavior defined as disordered.

Early efforts to ascribe causation to the actual position in the industrial/occupational hierarchy were confounded by conflicting findings. Some studies found professional workers more prone to neurotic disorders than manual workers. Other studies appeared to reverse these findings, particularly when investigations were directed toward both diagnosed and undiagnosed symptomotology. One interpretation of these findings (Clark, 1953) speculated that the statistical differences in the occupational distribution of disordered behavior could be found to result from three factors (in addition to the physical

effort of the work itself): (1) differential attractiveness and desirability of various occupation; (2) the difference in prestige which these occupations have in the view of society; and (3) problems created by income level and the cost of housing. Of these, prestige was found to be more influential than income.(Clark, 1953:335-340).

When occupations were stratified by prestige, Ruesch (1948) demonstrated that higher rates of psychiatric symptomatology were associated with middle occupational groupings reflecting "conformist tendencies of this class," traumatic disorders characterized the lower groupings "related to the class struggle" and the neuroses were associated with higher prestige occupational groups reflecting "their overbearing super-ego and cultural traditions." (Bastide, 1974:111).

Rennie (1957) discovered that psychoses vary in inverse relation to a scale of occupational social stratification and neuroses vary in direct relationship to this scale. These efforts were flawed by unidimensional (occupational) characterization of the concept of stratification. The principal work examining the relationship between psychiatric data and multi-dimensional aspects of social class membership remains the New Haven study of Hollingshead and Redlich.

The work of the Lynds (1924, 1935) formed the first classic community study to analyze the power structure of communities, and disabused Americans of the notion of a

classless society. Myrdal (1944) had analyzed the disparity between public expressions of a "classless society" and private behavior revealing clear social class stratification. The studies of Mills (1956), of Hunter (1953) and, particularly of Dahl (1961) whose work was focused on New Haven, were contemporary with the work of Hollingshead and Redlich. Further, the City of New Haven with its major university resources had served as a laboratory for repeated analyses of social structure, both historically and within the work of Dahl. Psychiatric census data were becoming increasingly more complete, and the 1950 Census of the Population provided current information regarding social characteristics of areal subdivisions of the city. The stage was thus set for a work that attempted to integrate many previous findings by reference to the previously ephemeral conceptualization of social class.

The New Haven study has had a marked influence on the sociology of community mental health and, perhaps, an even more profound influence on technical attempts to operationalize measures of social class. Because of the relevance of the New Haven study to the present purposes, it is useful to discuss both technical and substantive aspects of the work.

Substantively, the study involved two research questions: (1) Is mental illness related to social class in American society? and; (2) Does a psychiatric patient's position in the status system affect how he is treated

for his illness? In the authors' terms:

> The first query is related to the etiology of mental illness. The psycho-dynamic concept of unconscious conflict between instinctual forces and the demands of the environment is crucial for any attempts at explanation of most neurotic and psychotic illness. Knowing that the different social classes exhibit different ways of life, we conjectured that emotional illnesses might be related to patterns of life characteristic of class positions. . .The second question is focused on treatment. . .our observations and experiences with psychiatric treatment lead us to think that the kind of treatment a patient receives is not a function solely of the state of medical knowledge which is embodied in the art and science of making a diagnosis and prescribing treatment. Subtle and powerful psychological and social processes appear to be important determinants in the choice of treatment and its implementation. We are interested particularly in finding out whether various psychiatric treatment patients receive are affected by class status (1954:10).

The research questions generated the following five hypotheses:

> The prevalence of treated mental illness is related significantly to an individual's position in the class structure;
>
> The types of diagnosed psychiatric disorders are connected significantly to the class structure.
>
> The kind of psychiatric treatment administered by psychiatrists is associated with the patient's position in the class structure.
>
> Social and psycho-dynamic factors in the development of psychiatric disorders are correlative to an individual's position in the class structure.
>
> Mobility in the class structure is associated with the development of psychiatric difficulties.

> In turn, these hypotheses rest upon underlying assumptions which include: (1) the social structure of American society is characterized by a system of stratification; (2) individuals living in a given class are subjected to problems of living that are expressed in emotional and psychological reactions and disorders different in quantity and quality from those expressed by persons in other classes; (3) psychiatrists who are responsible for diagnosing and treating mental illness are controlled, as members of the society, by its value system; (4) the working rules of psychiatry are practiced in ways that are connected implicitly with class status; (5) mental illness is defined socially; that is whatever a psychiatrist treats or is expected to treat must be viewed as mental illness; (6) the class status of individuals in the society is viewed as the independent or antecedent variable; the diagnosis of a patient's illness and the treatment prescribed for him by a psychiatrist are considered to be dependent or consequent variables (1954:11-12).

Technically, the New Haven study drew a five per cent random sample of the population adjusted for deficiencies in the source from which this sample was drawn (City Directory). The resulting sample was checked against a variety of other sources to determine representativeness. Interviewers trained by the principals conducted formal interviews of each resident in the sample household (with systematic replacement for those households unavailable for interview). A total of 3,559 formal interview responses formed the sampled population. Interviewing schedules recorded biological and social data including age, race, sex, occupation, education, marital status, religion, and relationship to the head of household.

Additional data collected included family income, whether the dwelling was owned or rented, magazines and newspapers entering the household regularly, and other items of interest in understanding the stratification of the community.

Since New Haven had been studied by historians, psychologists and sociologists for a number of years, there was general agreement among social scientists that the social structure was differentiated both horizontally and vertically. Vertical differentiation includes reference to racial, ethnic and religious factors; horizontal differentiation is formed by a series of economic strata or classes based on income and/or wealth (1954:388).

From the initial interview sample, a cross-sectional sub-sample of 552 households was drawn. Household members in the sub-sample were interviewed in the home with a 200-question schedule designed to furnish detailed data on ethnicity, religious affiliation, economic, educational social and residential background. Information regarding respondents' values, attitudes, aspirations, standards of living, hopes for the future, frustrations, desires, and fears were also included in the schedule. From the completed interviews of the sub-sample, the principal investigators, who were life-long residents of the area determined that the New Haven community could be divided into five classes or social levels. Assignment to these social classes of the surveyed respondents was made <u>subjectively</u> based on independent review of completed interviews.

Interjudge reliability was assessed following assignment. Retrospective analysis was made independently of the principals regarding those criteria by which subjective judgments were made. There was agreement that primary consideration in this assignment process was given to: (a) where a family lived, (b) the way it made its living, and (c) its tastes, its cultural orientation, and the way it spent its leisure time (1954:389-90).

The next step was to abstract from interview schedules specific indicators of class position: family address and occupation of the head of household, and the years of school completed. Residential location was scaled according to a scale developed over a 25-year span from studies of the New Haven community. Occupational scaling was a modification of the Edwards' system of classification used by the United States Bureau of the Census resulting in seven levels of occupation. An educational scale of seven levels was developed on the premise that similar education tends to produce individuals of similar tastes, attitudes and behaviors. Through multiple correlation and regression, these scales were tested for internal validity and compared to subjective assignment to class status. Intercorrelations between judged class position, area of residence, education and occupation provided confidence in the use of the scales as independent measures of subjective judgments.

From these intercorrelations between judged class

position, area of residence, education and occupation in the sub-sample, weights of 6, 5, and 9, respectively were assigned to residence, education and occupation. From the resulting continuum of scores achieved in this "index of social position score" cutting points were established to differentiate among the classes of the community's social system. That is, homogeneity within score range and heterogeneity between ranges was assessed. For the time, the method used for class status assignment was considered quite sophisticated; but it is emphasized that the author's anchor point for validation of the scaled indices was subjective knowledge of the New Haven community. Within the text, no inference is made that the index might be considered equally valid elsewhere. No commentary is provided regarding reliability of the index for generalization to other areas.

The larger sampled population was then assigned to membership in one of five social classes, and this assignment was compared with a psychiatric census of both incidence and prevalence of treated "mental illness." These analyses permitted inferences to be drawn within stated confidence levels regarding the relationship of "social class" with treated mental illness. Pertinent to the present discussion is the rich description of the cultural characteristics, behaviors, habits, values and beliefs of the class system as it operated both historically and at the time the initial subjective

assignment to a five class system was made. These descriptions reveal much more with regard to intraclass and interclass dynamics than is reflected in the contrived index. Further, neither the indicators used in the composite index nor the composite index were intended to supplant the need for an understanding either of the concept of social class or the dynamics of class relationships in New Haven.

The use of the composite index and its three subscales has nonetheless had a profound influence on the development of social indicators used in lieu of subjective data since the publication of the study. Succinctly, social facts as expressed in concrete and discrete indicators and composite measures have, regrettably, come to stand for the more dynamic concept of social class membership. Social facts came to stand for social definitions in a manner that can only be considered as unintended by the authors.

Incontrovertibly, the author's first three hypotheses were supported. The prevalence of treated mental illness was found to be related significantly to position within the class structure. The types of diagnosed psychiatric disorders were connected significantly to position within class structure. The kind of psychiatric treatment administered was associated with the position of the patient in the class structure. The fourth and fifth hypotheses were not reported in the major work emanating from the study although these were analyzed

separately by social psychologists. In later reports the notion that social and psychodynamic factors in the development of psychiatric disorders were correlated to position in the class structure was confirmed and mobility within class structures was found to be weakly associated with the development of psychiatric difficulties. (Myers and Roberts, 1959).

A minor difficulty with the study has arisen concerning conclusions reached regarding the working hypotheses. Miller and Mishler (1959) underscore that the findings related to the first working hypotheses--that the prevalence of treated mental illness is related significantly to an individual's position in the class structure--while undeniably supported by the data has resulted in a stereotypic notion that a purely inverse relationship exists between social class and mental illness. Detailed analysis of the data presented within the study do not support this position since there are at least minor anomalies within the data requiring more sophisticated statements. For example, Class III, the "middle class," and not Class IV, the "upper middle class" registers a lower prevalence score.

Another level of criticism of the study reported in the literature was its failure to address the matter of untreated mental disorder. By definition, the methods used permitted no assessment of residual disorders not accounted for within the psychiatric census. This gap

in the literature, coupled with the notion that discrete indicators could be used with confidence outside the New Haven setting led to at least one major study of both treated and untreated mental illness.

Srole and Langner (1962) studied a nearly universal sample of individuals and families residing in a specific geographic sub-area of mid-town Manhattan. A total of 1660 residents aged 20-59 were assessed as to "severity of symptoms and associated psychiatric impairment" by trained psychiatric interviewers. Respondents were categorized by symptomotology on a seven point scale ranging from "well" to "incapacitated." Attempts to relate residual mental disorder to "socioeconomic level" (on a six point scale) tended to support the findings of Hollingshead and Redlich although the "scale of socioeconomic status" differs from "the index of social position" used by Hollingshead and Redlich. Further, mid-town Manhattan can be assumed to be substantially different in history, "character" and class dynamic from New Haven.

Despite a number of methodological difficulties, the Manhattan study received wide notoriety, chiefly with regard to its finding that less than one-fifth of the population of mid-town Manhattan could be considered psychiatrically well. Interpretation of their data led to popular notions regarding the distribution of untreated mental illness as this assumed phenomenon is associated with indicators included in SES scales. Questions of the

validity of measurements conducted within the study and of reliability notwithstanding, the following decade was characterized by an ever-increasing number of studies relating treated (both incidence and prevalence) and untreated or residual mental disorder to discrete indicators of age, race, sex, income, education, occupation and such other aggregate data as are readily available through reports of the U.S. Bureau of the Census.

An exemplar of the process of reification of social indicators (social fact) as social dynamic (at the conceptual level) can be found within the work of Jaco (1960). Studying the correlates of incidence of treated mental disorder in Texas, this work resulted in the atheoretical reporting of mental disorders by age, sex, "subcultural" differentials (race and ethnicity), migration, spatial distribution, rural/urban residence, marital status, occupation and education. Notably, the study included only incidence (within one calendar year) for diagnoses of certain categories of the psychoses. Major hypotheses investigated (stated in the null) were: (1) the probability of acquiring a psychosis is random for all individuals; (2) inhabitants of different areas exhibit the same incidence rates of psychoses; (3) persons with different social attributes or affiliations have the same incidence rates of psychosis.

The null hypotheses were uniformly rejected (sic) with results reported to include:

(1) incidence rates increase with advancing

> age; (2) females exhibit a significantly higher incidence of total psychoses than males; (3) 'Anglo-Americans' demonstrate the highest incidence rates with non-White and Spanish Americans rates descending in that order; (4) significant differences were not found between rates of interstate migrants and native born Texans; (5) rates adjusted for differentials in age, sex and 'subculture' were significantly different among economic subregions within the area, and no significant correlations were found between adjusted rates for these ecological areas and available psychiatric facilities; (6) urban areas exhibited a consistently higher incidence rate than rural areas; (7) in terms of marital status, highest rates were found for divorced, followed by the single, the separated, the widowed, and the married; (8) incidence rates were highest among the unemployed followed by professionals and semi-professionals, service, manual, clerical, and sales, agricultural, and managerial, official, and proprietary workers in that order; highest rates were found for those having no education, followed by those with some college training, those with 5-8 years, 9-12 years, and 1-4 years of schooling in that order; (9) many significant differences were exhibited for each factor when other factors were controlled (Jaco, 1960:177-87, emphasis added).

This last finding, reported with minimal emphasis, might have provided guidance for more sophisticated multivariant analysis of social factors and mental disorder. No evidence of this direction is found within the available literature. On the contrary, a proliferation of studies arose to test those associations found within Srole and Langner, Hollingshead and Redlich, and Jaco in an apparent attempt to establish or confirm universal relationships between presumed independent social variables

and the dependent variable of mental disorder (however that phenomenon is defined).

The body of literature emanating from these studies is characterized by a lack of unifying theme or guiding theoretical construct and has included normal science investigations in diverse communities and places with conflicting results. In large part, the wide range of "social facts" reported in these correlative studies is due to non-uniform use of indicants purporting to measure dynamic variables such as social class, familism, life style, and residential and social mobility. Insofar as these normal science investigations of social facts display uneven results and diverse findings, are not referenced to larger theoretical constructs and insofar as the studies, taken together, fail to account for wide variation in the dependent variable, social epidemiology has failed to establish as a method for explanation, much less prediction, of social fact relationships. Evidence for this conclusion may be found in Appendix A in which a review of socioepidemiological studies of mental disorder is presented.

It is emphasized here that studies originally descriptive of community dynamics in terms of recognition and disposition of defined or labeled mental disorder gave way to studies of population characteristics and covariation of these characteristics with the socially defined phenomenon of mental disorder. When differences in the manner

in which the "meaning" of indices of disadvantaged status and power differences are omitted as mediating variables between population data and outcomes of social definition, one is left with a body of correlations that confirm the existence of social processes but do not explain these processes.

As empirical studies of community social dynamics such as Hollingshead and Redlich's gave way to atheoretical correlative studies of population data the importance of "community" as mediating variable was lost or de-emphasized. The substitution of "catchment" for "community" in community mental health programming mirrors the misdirected or sociologically incomplete conceptualizations of these later correlative studies. Availability of population data per "artificial" catchment continues to influence and perpetuate notions that mental disorder "resides" in individuals, in social collectivities, social groups and social classes. The use and misuse of secondary data (the accumulation of studies of individuals) illustrates Ritzer's and other's concern for the lack of fit between social fact theories and the methods used in the erection and validation of these theories.

Labeling theory and its application to the sociology of mental disorder arose in the social definitionist paradigm during the mid-twentieth centry, parallel with, but disconnected from, social factist studies. The concentration

in the labeling literature, has been with evidence that definitions of mental disorder reflect the social position of both the labeler and the actor whose behavior is labeled. This evidence, while illuminating, was accumulated in a historic time in which the "doctor" and the "deviant" were the principal actors in the social process. The non-quantitative bias of these micro-level observations has provided little to guide macro-level policy makers.

By extension, however, it seems plausible that explanatory and predictive models in a sociology of community mental health could be erected which account for the variation in outcome (labeled mental disorder) in accordance with: (1) population characteristics as indices of differential distributions of power, knowledge and resources in addition to their reflection of "division of labor", and; (2) community characteristics at the macro-level which reflect processes of social integration and social control. These latter community characteristics might include reference to the economic structure and function of the community and the sub-populations it embraces, historic indicators of community receptivity to social change, and indicators of both the dominant ideology and "culture" of the community leadership and the degree of congruence between these dominant ideologies and those of the populations and sub-populations controlled by this leadership. Finally, as community mental health programming is but one public

utility under the control of community leadership structures which regulate the flow of these utilities, mental health outcomes (rates of mental disorders) might be viewed in their relation to other outcomes of the regulation of public utility flow (participation in public health, welfare and other "social" services).

Failure to merge social fact studies with social definitionist theory represents but one aspect of failure to bridge paradigms in the applied field. The thrust of federal policies to alter (increase) the flow of mental health services has encountered substantial resistance at the community level, as will be demonstrated in the next chapter. Ability to "deinstitutionalize" services rests upon an understanding of those structural conditions within community that are supportive of/in conflict with the ideological movement and the adoption of policy to permit governance of public utility flow predominantly by those committed to the ideology. That is, the social behaviorists' macro-level propositions related to social change must be understood and these understandings incorporated into policy "regulating the regulators." There is no evidence that this perspective has been incorporated into federal policy governing community mental health programming. Rather, communities have been permitted to incorporate the delegation of control over this programming into the overall political process of leadership identification with

predictable results.

Summary

The sociology of community mental health is derivative of the body of conceptualizations and studies of the sociology of mental disorder which, in turn, relate to paradigms and divisions within the discipline of sociology, generally. With some limitations (see, for example, Eckberg and Hill, 1979:925-937) Ritzer's dissection of the dominant paradigms of sociological inquiry provide a heuristic device for analysis of why a sociology of community mental health has not established as a conceptually adequate (comprehensive) body of explanation and prediction of an essentially social process.

Panzetta (1972:1-22) has characterized studies of "community" as the "short circuit" in the community mental health movement. The insertion of the mediating variable "community" in the equation between population characteristics and mental health outcomes--particularly as "community" may be analyzed by reference to delegated agents of the community who govern mental health services--provides a new ability to analyze structurally the process of social definition. These analyses, not yet undertaken, may explain differences in the processes of social definition (and public utility flow) across communities leading to the ability to alter the structures identified and, thus, influence the "social behavior" of communities.

Failure adequately to express a comprehensive sociology of community mental health may be a result of non-aligned theoretical perspectives and research practices and failure to "triangulate" these perspectives and practices. Alternatively, it may well be that a not-fully-conceptualized sociology of community mental health reflects a less-than-total commitment of sponsors of empirical research to understand the social processes involved. In either event, an equifinal outcome is the continued and expanded ability to interpret problems of social structure and of inequality and powerlessness in terms of individual (and collective) personal defect and "failure". Such a formulation is not only sociologically incomplete, but imbues a social definition process with ontological status and detracts from the clearer (more comprehensive and economical) intellectual understandings available when the concepts are employed to "sensitize" rather than concretely "define".

The following chapter illustrates the need not only for triangulation of research practices and conceptualizations but for intellectual effort in interpreting the relative influence of "input", "output" and mediating variables in any effort to understand complex social processes.

CHAPTER IV

FIELD RESEARCH ON THE EASTERN SHORE OF VIRGINIA

In this chapter the field research methods and findings previously reported in terms of the applied research objectives (Kernodle and Morrison, 1976; Morrison, 1976) are recast in terms of Ritzer's (1974) paradigms and reinterpreted in terms of Blumer's (1969) suggestion for use of certain concepts as sensitizing rather than definitional. In previous reporting the disparity between predicted mental health service needs and use of services was viewed as an "anomaly" to be "fixed" by putting appropriate, accessible and effective services in place. In the present perspective the anomaly is, in itself, a finding useful for understanding the social structure of the communities we studied.

The field research may thus be viewed as three inter-related components: (1) the use of secondary data and survey research in the social fact tradition, generally guided by social-epidemological principles; (2) the use of participant observation, key informants and other methods seeking an interpretive understanding of community structures and processes from the social definitionist perspective; and (3) the use of a natural experiment seeking to alter organizational and interorganizational

practices, an experience which may be viewed from Blau's model of exchange, potentially leading from interpersonal interchange to structural change from the macrolevel social behaviorist perspective.

SOCIAL FACTS AND SOCIAL EPIDEMIOLOGY

Geography and Economy

The peninsula extending from the Maryland/Virginia border on the north to the Chesapeake Bay Bridge Tunnel on the south comprises two rural Virginia counties (Accomack and Northampton) and is commonly referred to as the Eastern Shore of Virginia. The peninsula is bordered on the east by the Atlantic Ocean and on the west by the Chesapeake Bay. It is approximately 70 miles in length and varies from 10 to 20 miles in width.

The area was originally known as the "Kingdom of Accawmacke" and was first explored by Captain John Smith in 1608, settled in 1614, and in 1663 was divided into the present two counties. The land area of the peninsula is 696 square miles and the water area 263 square miles. The land and climate are particularly suited to crop cultivation with an average temperature of 40° F. in January and 78° F. in July. The water area surrounding the mainland is deservedly renowned for the abundant shellfish, finfish and other seafoods which are exploited for profit and pleasure. On the ocean side, barrier islands enclose ecologically valuable wet lands. On the bayside,

Tangier Island, considered a part of the Eastern Shore, is inhabited by approximately 800 persons and is accessible only by water and air.

The area is geographically isolated from the Commonwealth. It is accessible by car or bus by the Chesapeake Bay Bridge Tunnel System (built and operated by a private commission chaired by an Eastern Shore grower) from the south or by a more circuitous route from the north through the state of Maryland. The bridge tunnel system is the longest in the world with one-way toll of $6.00 (at the time of the study, since raised to $8.00) for the passage of an automobile. No commercial airlines provide services and the community airport is adequate only for small aircraft. There is commercial bus service into the area from the mainland, but regulations prohibit the use of these buses for intrastate travel. Public transportation on the Eastern Shore exists only in the form of several privately operated taxicabs.

The peninsula is bisected in the north-south direction by a high speed four lane highway connecting the industrial cities of the north with the mainland of Virginia to the south. State and county roads criss-cross the peninsula and are adequately maintained. Small creeks and inlets intrude from both shorelines and make transportation in the north-south direction circuitous except by use of the major arterial highway. Residents without private transportation are virtually immobilized and must

depend upon relatives or friends for transportation or use the limited transportation services operated by human service delivery agencies. The mental health delivery system maintained no such transportation system at the time of our studies.

Agriculture is the dominant enterprise of the Eastern Shore. Croplands constitute 25-30 per cent of the land area in the two counties. Major crops are potatoes (white and sweet), green beans, tomatoes, sweet corn, asparagus, strawberries, melons, squash, cucumbers and a variety of other vegetables. Farm income exceeded $29 million in 1970, although slight decreases in numbers of farms and in overall farm acreage are occurring. There is a trend from small or medium sized privately owned farms to absentee owned agribusinesses employing resident managers. Poultry and poultry products are commercially processed by two highly automated facilities that are increasingly dominant employers in Accomack County. These facilities process one-half million chickens on peak work days and employ nearly 2,000 persons, largely in unskilled or semi-skilled assembly line jobs. Employees work at the minimum wage with minimal opportunity for higher wages. Many former agricultural workers are now employed within the poultry industry. Managers are concerned that they have fully exploited the local supply of willing laborers and sometimes resort to importing domestic and alien workers. The work is considered hard, monotonous and distasteful

by many local employables relative to wages offered.

The resident population of the Eastern Shore was 43,446 in 1970 and has declined steadily since 1939. Tables 4.1-4.3 indicate the distribution of the population by race, age grouping and income in 1970.

A disproportionate segment of the population is dependent, either under the age of majority or past retirement age. Of the wage earning population, most residents are unskilled farmworkers or other laborers or operatives as indicated in Table 4.4. Estimates of the local Planning District Commission indicate a civilian work force of 18,337 persons in 1971 (41 per cent of the population) with 21 per cent of the population employed in agriculture, 18 per cent in manufacturing and the remainder in construction, transportation, wholesale and retail and other service industries or self-employed.

By virtue of the seasonal nature of agriculture, unemployment on the Eastern Shore fluctuates widely, ranging from an average 9 per cent to seasonal unemployment of more than 18 per cent. Seasonal variation in employment also affects the commercial fishing industry and entrepreneurial watermen. About 3,000 watermen harvest seafood resources (oysters, hard clams, soft clams, crab and finfish in 15 commercial varieties), although their number is estimated to be dwindling.

The physical health of the resident population of the Eastern Shore was studied in 1973. Rates of infant

Table 4.1: 1970 Population of Eastern Shore of Virginia, By Race

County	Total Population	White Population		Black Population		Other	
		Number	Per cent	Number	Per cent	Number	Per Cent
Accomack	29,004	18,111	62.4	10,853	37.4	40	.2
Northampton	14,442	6,861	48.1	7,555	51.5	26	.4
Total	43,446	24,972	---	18,408	---	66	

Source: Accomack-Northampton Planning District Commission Land Use Report, June, 1973.

Table 4.2: 1970 Population of Eastern Shore of Virginia, By Age

Age Group	Number	Per cent	Virginia	Per cent
Under 18	14,378	33.1		34.4
18-64	22,519	51.8		57.7
65 and Over	6,549	15.1		7.9
Total	43,446	100.0		100.0

Source: Accomack-Northampton Planning District Commission, Land Use Report, June, 1973.

Table 4.3: 1970 Eastern Shore Population, By Income

Area	Median Family and Individual Income (1970), in Dollars			
	White Family	Black Family	White Individual	Black Individual
Accomack County	6,736	4,015	1,518	1,459
Northampton County	5,996	3,633	2,171	1,475
Median, All U.S. Rural Counties	7,224	4,231	1,767	1,214

Sources: Virginia Division of State Planning and Community Affairs Fact Book: Accomac and Northampton Counties, January, 1972. National Institute of Mental Health, Mental Health Demographic Profile System, 1975.

Table 4.4: 1970 Occupations of Employed Persons; Eastern Shore and Virginia

Occupation	Per cent Accomack County	Per cent Northampton County	Per cent Virginia
Professional, technical	7.8	7.8	16.0
Nonfarm managers & administrators	8.7	8.7	8.5
Sales workers	5.0	5.0	6.5
Clerical workers	8.7	8.7	17.9
Craftsmen, foremen & related	11.9	11.9	14.2
Operatives, except transport	17.3	17.3	13.2
Transport equipment operatives	5.1	5.1	4.1
Nonfarm laborers	10.1	10.1	4.8
Service workers	8.9	8.9	9.9
Private household workers	3.6	3.6	2.2
Farmworkers	13.0	13.0	2.7

Source: Estimates from Virginia Division of State Planning and Community Affairs; July 3, 1975. The identical estimates for both Eastern Shore counties are those of the Division and are obviously insensitive to local differences known from other sources to exist.

mortality, immature birth (less than 5.5 pounds at birth), illegitimacy, overall death, accidental death, tuberculosis, syphillis incidence and salmonellosis incidence were the highest in the state. The fetal death rate was the fifth highest in the state (MacStravic et al., 1973).

The agricultural industry imports 3,500-5,000 migrant farmworkers during each summer season to complement the locally available secondary labor force. The need for these laborers is diminishing and the demography of the migrant labor population is changing. The earliest available record (1955) recorded the presence of more than 10,000 migrants, the majority of whom were black single males. At the time of our study, 3,400 migrant workers were present on one day during the peak harvesting season. Of this number, approximately 50 per cent were black, 40 per cent were Spanish-speaking and 10 per cent were white. Nearly 400 of the migrant workers present in mid-1975 were children under the age of 14.

In short, the Eastern Shore of Virginia is an isolated rural area economically dependent upon crops from the land and sea, inhabited by a population that is by national and state standards unhealthy, undereducated, hindered from available resources by an inadequate transportation system, relatively impoverished, and reliant upon the caprices of nature and those who control the land and access to labor for employment and income. The maintenance of the established economic order is dependent

upon a ready supply of unskilled labor. Mechanization of land and sea harvests require fewer unskilled workers than in the past. Despite decreases in overall need for unskilled laborers, however, it remains an economic necessity to import itinerant workers to supplement a local supply depleted by changes in birth and death rates, out-migration, and rising expectation.

The Human Geography of the Eastern Shore

The aggregate population characteristics sketched above were subjected to microanalysis in our studies through the use of the Mental Health Demographic Profile System (MHDPS). This system was developed and promulgated by the National Institute of Mental Health (NIMH) in an attempt to provide mental health planners with an analytic model for the prediction of risk among populations and subpopulations in accordance with social and economic characteristics of these populations.

The adoption of the system for the analysis of population structure, composition and distribution on the Eastern Shore was based upon expediency. No data source was available from any state or local planning office that equalled the system in terms of numbers of available indicators or in terms of disaggregation for areas smaller than counties.

The MHDPS provides demographic information abstracted from second and fourth count tapes of the 1970 Census of

Population and Housing. These data are available for each community mental health catchment area in the country and for each census tract, county and minor civil division in the nation. Data included in the system purport to represent: socioeconomic status (economic status, social status, educational status), ethnic composition, household composition and family structure, type and condition of housing and community instability. It is important to emphasize that although products of the system had been made available to the Virginia Department of Mental Health and Mental Retardation, these were never released to local communities, nor were they available to us upon request to that agency. It was necessary to secure the products of the system directly from NIMH.

The system and its products are self consciously (although not substantively) derived from the theory and methods of social area analysis which asserts that "much residence related behavior can be understood and accounted for in terms of three types of society-wide population characteristics or dimensions: social rank, life style or urbanization, and ethnicity" (Redick and Goldsmith, 1971:3)

A total of 130 indicators from the decennial census were assigned or classified in the system according to their perceived relevance to these population characteristics or dimensions. Redlick and Goldsmith argue that the three standard social area dimensions are insufficient to

account for variation affecting "such varied phenomena as infant mortality, poverty, ethnic residential segregation, alcoholism, suicide, personal disorganization, delinquency, retardation and mental illness, to mention just a few." Consequently, census variables are assigned to one of the three dimensions based upon reported relationships between census type data and mental health outcome. The wide variation in reported relationships makes the derivative system suspect (Appendix A) but the products of the system filled a need to disaggregate data to the smallest possible unit for analysis. In addition to providing small area aggregate performance across these 130 variables, the system provides computerized printouts of age-sex-race population pyramids for each county and sub-county areas. Norms for rural and urban areas throughout the United States are also available for comparison purposes.

The smallest areal unit for which system variables are available (in rural counties) is the magisterial district. Accomack County encompasses five such districts (Atlantic, Lee, Metompkin, Pungoteague, and the Islands); Northampton County encompasses three (Capeville, Eastville, and Franktown). While these magisterial districts are further sub-divided into enumeration districts, data other than total population and population by race are not available for enumeration districts.

There are 43 enumeration districts in Accomack County ranging in population from 3 to 1,494; in

Northampton County there are 13 enumeration districts ranging in population from 93 to 1,122. The lack of other social, economic and housing data for these small areas seriously hampered our attempt to differentiate and describe enumeration districts. Strong correlations between per cent black population and indicators of disadvantage -- economic, employment, housing, family, and educational status--permitted some inferences regarding relative "risk" among residents of these small areas.

The performance of the counties and magisterial districts according to 130 census variables (with norms for all other U.S. rural counties) are included in the Appendix B. It is sufficient for the present purposes broadly to describe analyses based upon these data.

Displays available in age-sex-race population pyramids confirm that the Eastern Shore of Virginia and its subdivisions share in the rural phenomenon of out-migration of employment-aged members, particularly males. This out-migration, coupled with differential rates of birth and death by sex and race result in high ratios of both aged and youth dependency. Furthermore, that segment of the laborforce which is left behind is prevented from employment generating reasonable incomes and tax revenues. Coupled with the need for increased support of the dependant population, this fact is taken to account for the inability of the counties and communities to mount adequate human service systems.

Population pyramids also reveal important intra-county and racial differences in distributions of dependent populations. Tables 4.5 (A-F) illustrate these differences for Northampton County and one magisterial district (Eastville).

Analyses were undertaken using the 130 variables (per magisterial district) available from MHDPS. First, the performance of each magisterial district was plotted against the performances of all U.S. rural counties by decile rankings across each variable available from MHDPS. That is, each magisterial district performance was identified for the 130 variables in accordance with decile groupings of the performance of all U.S. non-metropolitan counties with rural populations in excess of 50 per cent. This plotting was grouped in accordance with the major divisions employed by the system: income and housing (15 variables), employment and labor force participation (18 variables), education (10 variables), household composition and family structure (19 variables), persons not in families (11 variables), housing indicators (16 variables) and "special populations with high potential for use of health, welfare and related services" (13 variables).

The plotting of performances permitted the verification of two subjective impressions: (1) by reference to the condition of other U.S. rural counties, the Eastern Shore generally and its intracounty divisions display "poor" performances, generally ranking in the lowest

Table 4.5 A: Age-Sex Population Pyramid
for Total Population of Northampton County, Va.: 1970

Total Population			Males (N=6433)	Females (N=7608)		
Number	Per cent	Age			Per cent	Number
41	0.33	85+		F	0.65	94
75	0.52	80-4	M	FF	0.17	126
149	1.03	75-9	MM	FFFFF	1.70	246
268	1.86	70-4	MMMM	FFFFFF	2.17	313
333	2.31	65-9	MMMMM	FFFFFFF	2.85	412
387	2.67	60-4	MMMMMM	FFFFFFFF	3.16	457
443	3.07	55-9	MMMMMMM	FFFFFFFFF	3.01	435
422	2.92	50-4	MMMMMM	FFFFFFFF	3.01	435
399	2.76	45-9	MMMMMM	FFFFFFFF	3.22	465
416	2.88	40-4	MMMMMM	FFFFFFFF	3.21	463
346	2.40	35-9	MMMMM	FFFFFFF	2.90	419
263	1.62	30-4	MMMM	FFFFF	2.24	324
259	1.79	25-9	MMMM	FFFFFF	2.43	351
329	2.28	20-4	MMMM	FFFFFF	2.54	367
690	4.78	15-9	MMMMMMMMMM	FFFFFFFFFFFF	4.72	681
820	5.68	10-4	MMMMMMMMMMMM	FFFFFFFFFFFFFF	5.89	850
651	4.51	5-9	MMMMMMMMM	FFFFFFFFFFF	4.64	670
535	3.70	0-7	MMMMMMMM	FFFFFFFFF	3.47	501

Table 4.5 B: Age-Sex Population Pyramid
for Total Population of Eastville Magisterial District, Northampton County Va.: 1970

Total Population			Males (N=1559)	Females (N-1621)		
Number	Per cent	Age			Per cent	Number
5	0.16	85+		F	0.63	20
19	0.60	80-4	M	FF	0.91	29
38	1.19	75-9	MM	FFFFF	1.73	55
63	1.98	70-4	MMMM	FFFFFFF	2.70	86
82	2.58	65-9	MMMMM	FFFFFFF	2.70	86
89	2.80	60-4	MMMMMM	FFFFFF	2.61	83
95	2.99	55-9	MMMMMM	FFFFFFF	2.92	93
103	3.24	50-4	MMMMMM	FFFFFFF	2.80	89
100	3.14	45-9	MMMMMM	FFFFFFFF	3.27	104
104	3.27	40-4	MMMMMM	FFFFFFFFF	3.36	107
66	2.08	35-9	MMMM	FFFFFFFF	3.33	106
54	1.70	30-4	MMMM	FFFFF	1.92	61
43	1.35	25-9	MMM	FFFFF	1.86	59
62	1.95	20-4	MMMM	FFFFFFF	2.89	92
174	5.47	15-9	MMMMMMMMMM	FFFFFFFFFF	4.28	136
195	6.13	10-4	MMMMMMMMMMM	FFFFFFFFFFFFFF	5.88	187
140	4.40	5-9	MMMMMMMM	FFFFFFFFFFF	4.56	145
127	3.99	0-4	MMMMMMM	FFFFFF	2.61	83

Table 4.5 C: Age-Sex Pyramid of White Population of Northampton County, Va.: 1970

White Population (N=6835)						
			Males (N=3219)	Females (N=3616)		
Number	Per cent	Age			Per cent	Number
28	0.41	85+	M	FF	0.88	60
46	0.67	80-4	MM	FFF	1.32	90
86	1.26	75-9	MMM	FFFFFFF	2.36	161
152	2.22	70-4	MMMMM	FFFFFFFF	2.91	199
193	2.82	65-9	MMMMMMM	FFFFFFFFFF	3.58	245
227	3.32	60-4	MMMMMMMM	FFFFFFFFFFFF	4.13	282
241	3.53	55-9	MMMMMMMMM	FFFFFFFFFF	3.56	243
208	3.04	50-4	MMMMMMMM	FFFFFFFFFFF	3.92	268
198	2.87	45-9	MMMMMMM	FFFFFFFFFF	3.41	233
200	2.93	40-4	MMMMMMM	FFFFFFFFF	3.22	220
172	2.52	35-9	MMMMMM	FFFFFFF	2.60	178
144	2.11	30-4	MMMMM	FFFFFF	2.09	143
159	2.33	25-9	MMMMM	FFFFFFF	2.49	170
196	2.87	20-4	MMMMMM	FFFFFFF	2.65	181
256	3.75	15-9	MMMMMMMMM	FFFFFFFFF	3.57	244
290	4.24	10-4	MMMMMMMMMM	FFFFFFFFFFFF	4.37	299
213	3.12	5-9	MMMMMMM	FFFFFFFFF	3.36	231
212	3.10	0-4	MMMMMMM	FFFFFFF	2.47	169

Table 4.5 D: Age-Sex Population Pyramid of White Population of Eastville Magisterial District, Northampton County, Va.: 1970

White Population (N=1157)						
			Males (N=570)	Females (N=587)		
Number	Per cent	Age			Per cent	Number
4	0.35	85+	M	FF	0.86	10
9	0.78	80-4	MM	FFF	1.30	15
16	1.38	75-9	MMM	FFFFFFF	2.33	27
29	2.51	70-4	MMMMM	FFFFFFFFFF	3.98	46
46	3.98	65-9	MMMMMMMM	FFFFFFFFFF	3.72	43
44	3.80	60-4	MMMMMMMM	FFFFFFFFFFF	4.32	50
43	3.72	55-9	MMMMMMMM	FFFFFFFF	3.11	36
28	2.42	50-4	MMMMM	FFFFFFFFF	3.46	40
33	2.85	45-9	MMMMMM	FFFFFFFFF	3.46	40
41	3.54	40-4	MMMMMMM	FFFFFFFF	3.11	36
26	2.25	35-9	MMMM	FFFFFFFF	3.11	36
23	1.99	30-4	MMMM	FFFF	1.56	18
23	1.99	25-9	MMMM	FFFFF	1.99	23
35	3.03	20-4	MMMMMM	FFFFFFFF	3.20	37
53	4.58	15-9	MMMMMMMMM	FFFFFFFFF	3.63	42
54	4.67	10-4	MMMMMMMMM	FFFFFFFFF	3.63	42
21	1.82	5-9	MMMM	FFFFFFF	2.65	33
42	3.63	0-4	MMMMMMM	FFF	1.12	13

Table 4.5 E: Age-Sex Population Pyramid of Black Population of Northampton County, Va.: 1970

Black Population (N=7555)						
Number	Per cent	Age	Males (N=3591)	Females (N=3964)	Per cent	Number
20	0.26	85+		F	0.42	32
29	0.38	80-4	M	F	0.46	36
63	0.83	75-9	MM	FFF	1.09	82
115	1.52	70-4	MMM	FFFF	1.51	114
138	1.83	65-9	MMMM	FFFFFF	2.18	165
160	2.12	60-4	MMMMM	FFFFFF	2.32	175
202	2.67	55-9	MMMMMMM	FFFFFFF	2.49	186
214	2.83	50-4	MMMMMMM	FFFFFF	2.20	166
202	2.67	45-9	MMMMMMM	FFFFFFFFF	3.06	231
213	2.82	40-4	MMMMMMM	FFFFFFFFF	3.20	242
173	2.29	35-9	MMMMM	FFFFFFFFF	3.18	240
117	1.55	30-4	MMM	FFFFFFF	2.37	179
95	1.26	25-9	MM	FFFFFFF	2.36	178
131	1.73	20-4	MMMM	FFFFFFF	2.44	184
434	5.74	15-9	MMMMMMMMMMMMM	FFFFFFFFFFFFFFFFF	5.77	436
529	7.00	10-4	MMMMMMMMMMMMMMMM	FFFFFFFFFFFFFFFFFFFF	7.29	551
434	5.74	5-9	MMMMMMMMMMMMM	FFFFFFFFFFFFFFFFF	5.81	439
322	4.26	0-4	MMMMMMMMM	FFFFFFFFFFF	4.32	326

Table 4.5 F: Age-Sex Population Pyramid of Black Population of Eastville Magisterial District, Northampton County, Va.: 1970

Black Population (N=2016)						
Number	Per cent	Age	Males (N=985)	Females (N=1031)	Per cent	Number
1	0.05	85+		F	0.50	10
10	0.50	80-4	M	FF	0.69	14
22	1.09	75-9	MM	FFFF	1.39	28
34	1.69	70-4	MMMM	FFFFF	1.98	40
36	1.79	65-9	MMMM	FFFFFF	2.13	43
45	2.23	60-4	MMMMM	FFFF	1.64	33
52	2.58	55-9	MMMMMM	FFFFFFFF	2.83	57
75	3.72	50-4	MMMMMMMM	FFFFFFF	2.43	49
67	3.32	45-9	MMMMMMM	FFFFFFFFF	3.17	64
63	3.13	40-4	MMMMMMM	FFFFFFFFFF	3.52	71
40	1.98	35-9	MMMM	FFFFFFFFFF	3.47	70
31	1.54	30-4	MMM	FFFFFF	2.08	42
18	0.89	25-9	MM	FFFFF	1.79	36
25	1.24	20-4	MM	FFFFFFFF	2.73	55
121	6.00	15-9	MMMMMMMMMMMMM	FFFFFFFFFFFF	4.66	94
141	6.99	10-4	MMMMMMMMMMMMMMM	FFFFFFFFFFFFFFFFFFFF	7.19	145
119	5.90	5-9	MMMMMMMMMMM	FFFFFFFFFFFFF	5.56	112
85	4.22	0-4	MMMMMMMM	FFFFFFFFF	3.37	68

three deciles; (2) more importantly for our purposes intra-county distinctions were made visible.

This analysis led to the elaboration of intracounty differences in a manner which would permit ranking of magisterial districts in accordance with relative intra-area disadvantage. To facilitate this ranking, performances of each magisterial district across all variables were standardized. Census indicators were again grouped by major category and a mean score for each magisterial district was computed from standardized scores for each indicator. Finally, a summary table, reproduced as Table 4.6, compared rankings of magisterial districts in terms of standardized mean scores across major categories of census indicators. The techniques of McHarg (1969) were then employed to represent visually the relative disadvantage of each magisterial district. This technique employs acetate map overlays shaded to represent performances per area by major categories of social indicators. As acetate overlays are added for additional categories of indicators, the "build-up" of shaded densities indicate clearly areas at greatest cumulative disadvantage.

The technique of averaging unweighted standardized performance scores is subject to criticism, particularly when these performances are used as predictors of mental health "risk". That is, from empirical evidence, it is apparent that some social indicators are more or less predictive of risk for mental disorder. The evidence in

Table 4.6: Comparative Rankings of Magisterial Districts
(Expressed in Mean "Z" Scores)

Aggregated Indicators	Accomack County--Magisterial District--Northampton County							
	Atlantic	Lee	Metompkin	Pungoteague	Islands	Capeville	Eastville	Franktown
Income	.932	.257	-.029	-.615	.198	-.358	-.600	.216
Employment	-.185	.495	.332	-.135	.179	-.326	.117	-.025
Household Composition & Family Structure:								
General	.715	.344	-.406	-.410	1.220	-.893	-.353	-.268
White	.737	.020	-.835	-.015	.977	-.986	-.393	.525
Black	.204	.296	.225	-.215	-1.237	-.143	.184	.204
Education	.062	.594	-.385	.614	-.090	.112	-.215	-.376
Housing	-.392	-.452	-.473	-.628	.186	.492	.562	.140
Special Populations Children at Risk	.150	.118	.160	-.364	1,342	-.726	-.496	-.169
Special Populations Aged at Risk	1,202	-.479	-.455	-.637	.047	.382	-.333	.327

Appendix A, however, prevents any intelligent weighting of scores since wide ranges are reported in the literature for the association of mental disorder with sociodemographic characteristics. While reasonably convinced of the direction of influence (that is, performance contributes to or protects from "risk"), assignment of relative weights to each variable was considered imprudent.

Estimating Service Need

It is important to recollect the purpose of these exercises: to assess the need for mental health services. The social indicators approach to needs assessment is based primarily on inferences of need drawn from descriptive statistics. The underlying assumption is that it is possible to make useful estimates of the social well-being and needs of those in a community by analyzing population characteristics found to be strongly correlated with rates under treatment.

Rosen (1975) states that to estimate mental health service needs, it is common practice to assume that there exists some level of mental disorder in the population (e.g., 2 per cent, 5 per cent, 10 per cent). The distribution of this level, however, is unequal. Since the demographic data for the Eastern Shore demonstrates a catchment area which can be internally differentiated according to these indicators, it appeared inappropriate to assign a uniform level of need to the entire area. A

ranking of sub-county areas according to relative disadvantage as a factor of need was considered appropriate. Table 4.7 presents the rank ordering of relative disadvantage of the magisterial districts of the Eastern Shore and factors a conservative estimate of "need" by this rank ordering.

At the time of the studies, principals were aware of deficiencies within the model, as evidenced by the following:

> The district deprivation/risk rankings are of considerable significance to this report and their importance should be stressed. We are acutely aware that a variety of mechanisms might be employed to rank the predicted risk of social areas. The previous method is simplistic. It does not take into account the social values of particular communities. The degree to which social planners may choose to serve a population or subpopulation is, finally, a matter of community values. We have attempted to be objective in our ranking of the needs of particular magisterial districts. We have avoided responding to specific needs: black needs vs. white needs; or the needs of children as opposed to the needs of the aged; or the 'raw numbers' of persons at risk within specific geographic areas. In the aggregate, however, it appears to us that magisterial districts can be ranked according to relative social disadvantage and we view mental distress as but one of many sequelae of social disadvantage. (Kernodle and Morrison, 1975:135).

As a final step in this preliminary set of analyses, current use of public mental health services was compared with projections of use at a 2 per cent rate, factored by our "risk prediction score." Immediately apparent was the fact that the Islands District (the most affluent and

Table 4.7: Rank Order of "Relative Disadvantage" Indices of Eastern Shore Magisterial Districts (N=8)

Composite Indicator	Magisterial District							
	Atlantic	Lee	Metompkin	Pungoteague	Islands	Capeville	Eastville	Franktown
Income	1	2	5	8	4	6	7	3
Employment	7	1	2	6	3	8	4	5
Household Composition and Family Structure	2	3	6	7	1	8	5	4
Education	4	2	8	1	5	3	6	7
Children "At Risk"	3	4	2	6	1	8	7	5
Aged "At Risk"	1	7	6	8	4	2	5	3
	3.00	3.17	4.83	6.00	3.00	5.83	5.67	4.50
Standardized "Risk Factor" (Z Score)	.6435	.6833	1.0792	1.3565	.6435	1.2773	1.0000	1.0000

the least black) was that district in which services were used at highest rates. This finding led to presentation of Table 4.8 presenting the "adjusted utilization rate" and per cent black population within the magisterial district. The association between black population and use of services is virtually perfect in an inverse direction. Only with respect to the midrange of use--Franktown, Atlantic and Capeville--is there some confusion in the relationship. This confusion may reflect the location of the clinic and its satellites; however, high rates of use of services in the Islands, Lee and Metompkin appear to have no relevance to the location of the clinic. We attributed this "anomaly" to the relative affluence of certain districts and the availability of transportation to those who perceive themselves to be in need of services. Conversely, the three districts with lowest use rates (Capeville, Pungoteague, Eastville) are among those with highest percentages of black population and, by virtue of economic disadvantage, poorest access to private transportation. Ironically, that district with the lowest use of mental health services as a factor of predicted need had the highest proportion of black population and lies immediately adjacent to the Eastern Shore Mental Hygiene Clinic.

The Structure, Staffing and Use of Public Mental Health Services

A major part of the research effort was directed to

Table 4.8 A: Use of Outpatient Services by Magisterial District with Projection of Use at 20:1000, Factored by "Risk Score"

Magisterial District	Outpatient Use		"Risk Factor"	Projected Use at 20:1000	
	Number	Rate:1000		Projected Number	Per cent Projection Now Served
Accomack County					
Islands	39	12.0	.6435	42	92.9
Atlantic	67	10.4	.6435	83	80.7
Metompkin	102	18.3	1.0792	120	85.5
Lee	96	11.8	.6833	111	86.5
Pungoteague	108	19.3	1.3565	152	71.1
Northampton County					
Franktown	89	1.67	1.0000	107	83.2
Eastville	31	.98	1.2773	80	38.8
Capeville	115	1.94	1.3169	157	73.3

Table 4.8 B: Per cent Projected Need Now Served and Black Population of Magisterial District

Magisterial District	Per cent Projected Need Now Served	Per cent Black Population
Islands	92.9	1.3
Lee	86.5	36.6
Metompkin	85.5	38.3
Franktown (a)	83.2	49.5
Atlantic (b)	80.7	44.0
Capeville (c)	73.3	49.0
Pungoteague	71.1	50.8
Eastville	38.8	66.2

Notes: (a) The Eastern Shore Mental Hygiene Clinic (ESMHC) is located in the Franktown district.

(b) A satellite of ESMHC is located in the Atlantic district.

(c) A satellite of ESMHC is located in the Capeville district.

the study of the use of public mental health, mental retardation and substance abuse services by residents of the Eastern Shore.

Inpatient services are provided by the Eastern Shore Community Mental Hygiene Clinic for clients with a primary diagnosis of mental illness not requiring hospitalization. The Eastern Shore Vocational Training Center provides training and day-care services for mental retardates not requiring institutionalization. Outpatient alcoholism counseling is provided by a counselor employed by the Mental Hygiene Clinic. A local general hospital provides limited emergency hospitalization although no psychiatric beds or accredited services were available at the time of our study. Inpatient hospitalization for psychiatrically ill patients is provided by the Eastern Shore Hospital located 120 miles from the mid-point of the Eastern Shore. Mentally retarded persons requiring institutionalization are served at the Southeastern Virginia Training Center in Chesapeake and by the Southside Virginia Training Center in Petersburg.

The governance and operation of local outpatient mental health, mental retardation and substance abuse services is the responsibility of the Eastern Shore Community Mental Health and Mental Retardation Services Board. This citizen board is mandated by law and operates under guidelines established by the Virginia Department of Mental Health and Mental Retardation. It establishes policy and/or

is advisory to agencies serving mental health, mental retardation and substance abuse services needs of residences of the two counties of the Eastern Shore.

The board consists of fifteen citizen members whose appointment must be approved by the board of supervisors of the county of their residence. Sixteen ex-officio members, largely staff members of health, mental health, mental retardation and alcoholism services agencies, are also represented on the board. The board is staffed by a single executive and his secretary, neither of whom are mental health professionals. Although mandated in 1970, the board was not established or staffed until 1973. The executive is a retired Navy Captain from one of the oldest and most prestigious and influential agricultural families of the Shore.

Research included the examination of patient records for all institutionalized patients from the Eastern Shore as of July, 1975 at the Eastern State Hospital, Southeastern Virginia Training Center and Southside Virginia Training Center. Similarly, records of all clients served by the Eastern Shore Community Hygiene Clinic, The Eastern Shore Vocational Center and Eastern Shore Alcoholism Treatment Service were analyzed. Research instrumentation included the preparation and pretesting of a standardized recording form in a format providing data on core sociological variables (age, race, sex, marital status, occupation, etc.), diagnosis, duration of hospitalization or

treatment, prognosis, therapeutic programs and services provided and additional items of interest.

At the time of these analyses, 633 outpatients were under treatment at the Eastern Shore Mental Hygiene Clinic. We were able to examine the records of 586--the disparity due to those records in use by staff or temporarily out of file when data were collected. A total of 105 mentally ill and/or retarded patients from the Eastern Shore were hospitalized at the Eastern State Hospital and the records of each of these patients were studied. The records of 59 institutionalized retardates at the Southside Virginia Training Center and four institutionalized retardates at the Southeastern Virginia Training Center were reviewed. Out-patient records for 16 clients served by the Eastern Shore Vocational Training Center and for 52 outpatients receiving counseling for alcoholism were also analyzed.

Abstracts of study findings and methods related to service use which follow are limited to mental health inpatient and outpatient services by Eastern Shore residents at Eastern State Hospital (ESH) and the Eastern Shore Mental Hygiene Clinic (ESMHC), respectively. A number of retardates and alcoholics are also served by these facilities, reflecting both the general inability to isolate distinct diagnostic categories and the need to provide services to as many distressed citizens as possible using limited available treatment sources. Individuals served only for retardation (at Eastern Shore Vocational Training

Center, Southeast Virginia Training Center, Southside Virginia Training Center) or alcoholism (by the Eastern Shore Alcoholism Counselor) are excluded from these analyses.

At the time of our analysis, the 633 outpatients receiving treatment at ESMHC were served by a staff directed by a part-time, semi-retired psychiatrist, aged 80, who visited from Norfolk for one day of patient and staff consultation each week. A small number of patients were seen directly by the psychiatrist; his services consisted largely of reviewing staff recommendations for changes in dosage levels or medication prescribed by him. The full-time clinic staff consisted of one M.A. clinical psychologist, an M.A. counselor, a business manager/receptionist, and a typist.

The clinic was located in a converted, double-wide mobile home unit in Nassawadox (Northampton County) adjacent to the Northampton-Accomack Memorial Hospital and the offices of the executive of the Eastern Shore Mental Health and Mental Retardation Services Board. Satellite clinic services were offered once each month at Cape Charles, near the southern tip of the peninsula, and in Accomac, the county seat of Accomack County. A satellite service commenced operation in Saxis (Accomack County) one day every two months during the study. No rationale was available for the location of satellite clinics other than the concentration of currently served clients in those towns.

The second purpose of the study included evaluating

the appropriateness of treatment provided. Research assistants consistently commented upon the lack of information contained within patients' records. Much of the research effort involved deciphering record entries that were cryptic, incomplete or allowed little opportunity to trace the treatment process. Some clients, for example, who had been treated for a number of years lacked original diagnoses or other indications of symptom formation. Notations regarding their clinic visits were limited to "client seems O.K." or "client seems better/worse today," with no baseline information.

The great majority (87 per cent) of outpatients were receiving one or more psychotropic drugs. Clients lacking the ability to purchase these pharmaceuticals privately and not having transportation were provided one month supplies mailed to them by the State Department of Mental Health and Mental Retardation. Since home visits were rarely undertaken by the clinic staff, many patients had received medications without personal contact for more than one year.

Although 40 per cent of outpatients served were black and a small number were Spanish-speaking, all members of the clinic staff were white and none was bilingual. The two full-time clinical staff members were under age 35. The general environment of the clinic was crowded but friendly and staff members were energetic, cheerful and hardworking. Outpatients visiting the clinic were

frequently accompanied by friends or relatives. All were transported in private transportation. Research assistants repeatedly recorded their impression that the waiting room was filled with white, well-dressed clients, many of whom were teenagers. Women were disproportionately represented in clients observed on-site at the clinic. Many clients were not seen directly by treatment staff, but simply were present to pick up monthly medication supplies and report general status to non-professional workers. Research workers recorded the time spent by treatment staff with each patient on one clinic day. The time ranged from five to twenty-five minutes in private consultation with a median time between 12-13 minutes.

Staffing and treatment provided to inpatients at the Eastern Shore Hospital in Williamsburg are administered by the State Department of Mental Health and Mental Retardation. The 105 Eastern Shore patients institutionalized there at the time of the study were dispersed throughout the hospital (children's ward, adolescent ward, geriatric ward, chronic ward, etc.).

Treatment services in state mental hospitals, at the time of the research, were supervised largely by foreign medical graduates, many without accredited post-professional training or experience in psychiatry. For this and other reasons, the Eastern State Hospital failed to be accredited by the Joint Commission on Accreditation of Hospitals during the time of the research.

About one-half (51.4 per cent) of ESH patients had been institutionalized for five or fewer years with the balance being nearly equally divided between those who had been admitted in the period 1960-1969 (25.7 per cent) and those whose admission had been prior to 1960 (22.9 per cent). Of the 105 inpatients, nearly equal numbers were recommended for discharge (contingent upon availability of community care) or for continued institutional treatment. That is, had appropriate support mechanisms and treatment services been available on the Eastern Shore, 51 institutionalized patients (49 per cent) could appropriately have been discharged to community care.

Beyond these impressions and gross findings, analyses taken at the time of the study were focused in two areas: (1) an examination of the relationship between rates of the population under treatment (as in-patients or out-patients) by magisterial district and the population characteristics of the districts revealed through MHDPS; (2) attempts to profile users of in-patient and out-patient services according to primary diagnosis and core sociological variables (age, race, sex, marital status, occupation, religious affiliation, etc.).

Rates of Use and User Profiles

The first and most striking finding was the low overall rate of use of public services for those diagnosed as mentally ill. Overall, the combined rate of use of

inpatient and outpatient services was 17:1000, with a range according to magisterial district from 9.8:1000 in Eastville to 18.3:1000 in Metompkin. Imputation of "reasonable" rates of mental disorder is a precarious exercise, however, mental health service use rates reported in the literature seldom fall below 50:1000 even in the most socially cohesive rural areas. A study of Hutterite colonies in the Midwestern United States is generally considered as reporting the lowest rates of service use in rural areas. In that study (Eaton and Weil, 1955), a rate of 23:1000 was reported.

Rates of service use by magisterial district on the Eastern Shore differed by a factor of two from lowest to highest. A first analysis, therefore, was to determine the association between these rates and performance by magesterial districts across 23 census indicators considered by authors of the MHDSP to be most predictive of "risk" for mental illness. It is emphasized that rates under treatment per magisterial district form the dependent variable in this analysis without reference to the personal or social characteristics of individuals under treatment, consequently, little interpretation of the correlations is appropriate beyond notation that strong associations were few and presented no inference of pattern. The findings are presented in Table 4.9. Subsequently, correlations of inpatients and outpatients with all MDHPS variables were analyzed with no reportable findings except

Table 4.9: Pearson Product Moment Correlation Coefficients:
Utilization Rates with Selected Eastern Shore Demographic Variables
from the Mental Health Demographic Profile System

Social Indicator (a)	ESH Outpatients	ESMHC Inpatients	Social Indicator	ESH Inpatients	ESMHC Outpatients
General Population			Ethnic Composition		
Total Population	.4819	.7184	Per cent Black Households	.3289	.3300
Male Population	.4296	.6672	Other Non-White	.4076	.1671
Female Population	.5239	.7538	Foreign Stock	-.2764	-.0388
Group Quarters	.4268	.5712	Household and Family		
White Population	.1624	.3789	Percent Husband/Wife Households	-.4523	-.4476
Black Population	.6081	.7498	Median Age Household Head	-.0134	.1337
Economic Status			Youth Dependency Ratio	.4864	.5057
Median Family Income	-.3382	-.3535	Aged Dependency Ratio	-.1236	.0995
Per cent Families in Poverty	.1457	.1886	Type of Housing		
Social Status-Employment			Per cent Single Dwelling Units	-.0684	-.2291
Per cent Males Low Status	.2641	.2955	Per cent High Rise Housing	(b)	(b)
Per cent Males High Status	-.3792	-.2488	Condition of Housing		
Educational Status			Per cent Overcrowded	.4523	.4302
Median School Years Completed	.2979	.4353	Per cent Standard	-.4452	-.3478
			Community Instability		
			Per cent Recent	-.0678	-.2617

Sources: 1970 NIMH-MHDPS data per magisterial district of Eastern Shore and physical counts of inpatients and outpatients per magisterial district, July, 1975.

Notes: (a) For complete variable description, see Appendix B
(b) Not reported; too few cases.
(c) Rates are not Magisterial Districts (N=8). Small N precludes multivariate analysis.

that use of services bore little systematic relationship with variables in the system--in itself an interesting preliminary result. The small number of magisterial districts (N=8) precluded responsible use of multivariant analyses.

Finding that rates under treatment were not strongly associated with ecological characteristics, the task remained to provide profiles of aggregate characteristics of users of institutional and outpatient services. This was accomplished through analysis of coded information contained in patient records. Since research objectives included reference to severity of diagnosis, earlier analyses required tabulation of core sociological factors with diagnostic categories. Table 4.10 in which data relating ages of patients/clients and diagnoses represents the format in which earlier tabulations were presented. These analyses were performed separately and together for clients/patients at ESMHC and ESH according to age, race, sex, occupation, residency, etc. In addition, analyses were undertaken of clients/patients according to agency or individuals referring or committing the individual to treatment. For the present purposes, summary information in the form of rates of treatment in the two facilities according to a limited number of social variables is considered sufficient. These social variables include residence, age, sex, marital status, race, education, and occupation.

Residence

The two counties of the Eastern Shore are

Table 4.10: Age and Diagnoses of Eastern Shore Mental Health Clinic Outpatients: 1975

Age	Retarded	Organic Brain Syndrome	Schizophrenia	Affective Disorder	Psychotic	Neurotic	Social Adjustment	Personality Disorder	Alcoholism	Behavior problems of Child / Adolescent	Diagnosis Deferred	Other	Total
Under 18	10	1	1	3	-	2	19	1	-	42	27	12	118
	(8.5)	(.8)	(.8)	(2.5)	-	(1.7)	(16.1)	(.8)	-	(35.6)	(22.9)	(10.2)	(20.1)
18-25	7	2	12	14	-	6	13	5	-	2	17	2	80
	(8.8)	(2.5)	(15.0)	(17.5)	-	(7.5)	(16.3)	(6.3)	-	(2.5)	(21.3)	(2.5)	(13.7)
26-35	5	4	21	25	-	12	8	4	2	-	11	2	94
	(5.3)	(4.3)	(22.3)	(26.6)	-	(12.8)	(8.5)	(4.3)	(2.1)	-	(11.7)	(2.1)	(16.0)
36-45	-	3	17	13	-	15	3	3	6	-	3	2	65
	-	(4.6)	(26.2)	(20.0)	-	(23.1)	(4.6)	(4.6)	(9.2)	-	(4.6)	(3.1)	(11.1)
46-65	2	15	21	65	2	31	1	6	14	-	12	9	178
	(1.1)	(8.4)	(11.8)	(36.5)	(1.1)	(17.4)	(.6)	(3.4)	(7.9)	-	(6.7)	(5.1)	(30.4)
Over 65	1	10	6	19	1	3	-	-	3	-	1	7	51
	(2.0)	(19.6)	(11.8)	(37.3)	(2.0)	(5.9)	-	-	(5.9)	-	(2.0)	(13.7)	(8.7)
Total	25	35	78	139	3	69	44	19	25	44	71	34	586
	(4.3)	(6.0)	(13.3)	(23.7)	(.5)	(11.8)	(7.5)	(3.2)	(4.3)	(7.5)	(12.1)	(5.8)	(100.0)

differentiated not only in terms of population distribution (two-thirds of the population resides in Accomack County and one-third in Northampton County), but in terms of racial composition, income, education, occupation and other characteristics. The southern county (Northampton) is less densely populated with fewer towns and villages and a greater proportion of the land area devoted to agriculture. Blacks account for 40.6 per cent of the total population of the Eastern Shore; however, 52 per cent of the population of Northampton County is black as opposed to 37 per cent of the population of Accomack County.

As Table 4.11 indicates, differences in patterns of use of institutional and outpatient facilities are also associated with county of residence. As outpatients, Accomack residents account for 63 per cent of ESMHC clients, a proportion approximating the distribution of the population. Institutionalized patients from Accomack County comprise 59 per cent of residents from the Eastern Shore hospitalized at ESH. In terms of gross rates of population under treatment, Northampton County has higher rates for both institutional (2.84:1000) and outpatient care (14.75:1000). A combination of factors including relative disadvantage, "risk" and proximity of the clinic and other public agencies within the county providing referral services may account for differing rates of use.

Differences were also found in our analyses of

Table 4.11: County of Residence of Eastern Shore Population (1970) and Inpatients and Outpatients (1975)

County of Residence	1970 Eastern Shore Population (a)			ESH Inpatients (b)			ESMHC Outpatients (b)		
	Number	Per cent of Population	All Patients Rate: 1000	Number	Per cent Inpatients	Rate:1000	Number	Per cent Outpatients	Rate:1000
Accomack	29004	66.8	12.69	62	59.0	2.03	368	63.3	12.69
Northampton	14442	33.2	17.73	43	41.0	2.84	213	36.7	14.75
Total	43446	100.0	15.79	105	100.0	2.42	581	100.0	13.37

Sources: (a) NIMH-MHDPS data from 1970 Census of Population and Housing.
(b) Physical counts of inpatient (ESH) inpatients and (ESMHC) outpatients, July, 1975.

diagnosis according to county of residence. Of ESMHC clients, rates of diagnosed retardation, organic brain syndrome and schizophrenia were higher for residents of Northampton than for Accomack County. These diagnoses represent irreversible or relatively intractable conditions. Similarly, Northampton County residents were less likely to be recommended for discharge from institutional care at Eastern State Hospital due both to severity of diagnosis and lack of family or community support systems for care following hospitalization.

Attempts to locate the residence of patients and clients in areas smaller than county of residence and to relate numbers of cases under treatment to general population characteristics became a difficult task. Addresses of institutionalized clients consist of the town and zip code of the post office location. Population data are available only for incorporated towns and do not include the extensive surrounding rural areas served by the town post office. Client record files at ESMHC, however, did permit the location of treated cases by magisterial districts for which population data were available from MHDPS. Rates of use of outpatient treatment services vary from 10.06:1000 in Eastville to 17.83:1000 in Pungoteague. As previously indicated, these service use rates exhibit little relationship to indicators of relative disadvantage of the populations within magisterial districts.

Age

In terms of age, users of outpatient treatment services ranged from infants under one year to one centenarian. The youngest institutionalized patient from the Eastern Shore was 20 years old and the eldest 77. Table 4.12 displays age groupings of inpatients and outpatients and of the general population of the Eastern Shore. The median age for outpatients was 37 years and for inpatients 59 years. Data for all outpatients served by federally funded community mental health centers indicate a median age of 28.9 years for rural clients. The older median age for institutionalized patients reflects the neurobiological effects of aging and the increased prevalence of organic brain syndromes requiring institutional care.

Children and adolescents tend to be seen as outpatients, although their rates of service are low in contrast to the proportion of population they represent. Adults of working age (20-64) comprise two-thirds (66.3 per cent) of the outpatient caseload at the ESMHC compared to one-half (49.2 per cent) of the population. Older residents comprise 15 per cent of the population compared to approximately 10 per cent of the outpatient caseload. For institutionalized patients, linear rate increases occur from 2.8:1000 in the youngest age group (20-24) to 6.3:1000 for residents aged 65 and over.

The table presented previously as an exemplar (Table 4.10)relates age of outpatient client and diagnosis.

Table 4.12: Age Distribution of Eastern Shore Population (1970) and Inpatients and Outpatients, July, 1975

Age Grouping	1970 Eastern Shore Population (a)			ESH Inpatients (b)			ESMHC Outpatients (b)		
	Number	Per cent Population	All Patient Rate: 1000	Number	Per cent Population	Rate:1000	Number	Per cent Population	Rate:1000
Under 15	11621	26.7	6.02	0	-	-	70	11.9	6.02
15-19	3802	8.8	16.83	0	-	-	64	10.9	16.83
20-24	2164	5.0	32.35	6	5.7	2.77	64	10.9	29.57
25-44	8723	20.1	20.86	22	21.0	2.52	160	27.3	18.34
45-64	10607	24.4	19.13	36	34.3	3.40	167	28.5	15.74
65 and Over	6523	15.0	15.64	41	39.0	6.29	61	10.4	9.35
Total	43442	100.0	15.90	105	100.0	2.41	586	100.0	13.49

Sources: (a) NIMH-MHDPS estimated data from 1970 Census of Population and Housing

(b) Physical counts of inpatient (ESH) and outpatient (ESMHC) records, July, 1975.

Clear patterns demonstrate that with the exception of mental retardation, younger clients are seen as outpatients largely for "behavior" problems. Nearly one in five clients under treatment at ESMHC is under 18 and the preponderant number of these represent referrals from the public school system. More severe diagnoses (schizophrenia, affective disorders) prevail among adults and the organic consequences of aging are clearly apparent in the diagnoses of older outpatients.

Institutionalized patients of all ages, by contrast, are modally diagnosed as schizophrenic (44.8 per cent) with the second most frequent diagnosis being organic brain syndrome (34.3 per cent). Rates of schizophrenia vary inversely with age of hospitalized patients, contrasted with increasingly strong positive associations of age and organic brain syndrome beyond middle age.

Study recommendations highlighted the need to destigmatize treatment services, particularly for young outpatients. The diagnosis of many school-aged referrals was "non-psychiatric". Their referral to a public mental health agency and labeling as "mentally ill" for minor behavior problems was seen as unnecessarily stigmatizing and harsh. Conversely, for older outpatients, we recommended decentralization of services with home visitation for the majority of clients who were seen primarily for medication review. In general, service provision for outpatients in the form of visits to a centralized clinic

was not seen as appropriate to the age distribution and expectations for psychiatric difficulties associated with age.

Sex

Distributions of inpatients and outpatients according to sex generally confirm expectations regarding differential diagnosis by sex (Table 4.13). Rates of outpatient treatment were 11.05:1000 for males and 15.82:1000 for females at ESMHC. Rates of institutionalization, however, were virtually identical (2.48:1000 for males and 2.49:1000 for females). Males and females represented 47.1 and 51.9 per cent of the total Eastern Shore population, respectively. The sex ratio per magisterial district, however, varies from 88.2 males per 100 females in Franktown to 92.6:100 in the Atlantic magisterial district.

Among outpatients, males were more likely to be diagnosed as retarded (5.7 per cent of clinic cases for males vs. 3.3 per cent female), as organically impaired (8.4 per cent vs. 4.5 per cent) or schizophrenic (15.4 vs. 12.0 per cent). Females were over-represented in terms of affective disorders, the neuroses, social maladjustment and personality disorders. Young males were much more likely to be diagnosed as behavioral problems of childhood or adolescence than females (12.3 per cent vs. 4.5 per cent). About 10 per cent of males seen at ESMHC were

Table 4.13: Sex Distribution of Eastern Shore Population (1970) and Inpatients and Outpatients (1975)

Sex	1970 Eastern Shore Population (a)			ESH Inpatients (b)			ESMHC Outpatients (b)		
	Number	Per cent Population	All Patients Rate: 1000	Number	Per cent Inpatients	Rate: 1000	Number	Per cent Outpatients	Rate: 1000
Male	20454	47.1	13.54	50	47.6	2.48	227	38.7	11.05
Female	22564	51.9	18.34	55	52.4	2.49	359	61.3	15.82
Total	43446	100.0	15.90	105	100.0	2.42	586	100.0	13.49

Sources: (a) NIMH-MHDPS data from 1970 Census of Population and Housing.
(b) Physical counts of inpatient (ESH) and outpatient (ESMHC) records, July, 1975.

diagnosed as alcoholic, contrasted with less than one per cent of females with this diagnosis.

Among institutionalized patients, males were more likely to carry diagnoses of retardation, organic brain syndrome or schizophrenia than females, had been hospitalized for longer periods of time and were less likely to be recommended for release to the community.

While differences would be expected in use of outpatient treatment services by males and females, the fact that ESMHC clients were more than 1.5 times as likely to be females was seen as related to hours of service availability. Clinic hours were 9:00 a.m. to 5:00 p.m., on Monday through Friday, coinciding with normal working hours for both males and females. Our recommendations lay in the direction of scheduling service hours for "non-traditional" times in the evening and on weekends.

Marital Status

A social variable alleged to have high predictive value in assessing risk for mental disorder is marital status. Whether marriage "protects" individuals from vulnerability or simply reflects the ability to win and keep a mate is unclear. National studies of rates under treatment, however, consistently report the highest rates for the divorced followed by the widowed. Rates for the divorced are larger by a factor of 2.5 than rates for those widowed. For marrieds, male rates are lower than

female rates. This difference is reversed for individuals never married, a status associated with higher rates of treatment for males than for females.

The records of ESMHC and ESH confirm the non-random distribution of treated cases by marital status (Table 4.14) although estimation of rates under treatment in each status is a precarious exercise, due to the manner by which census data record marital status.

Single (never married) clients account for about 40 per cent of the ESMHC outpatient caseload. When individuals below age 15 are removed, 29.1 per cent are accounted for in this category. Married clients comprise 42.6 per cent of the caseload older than 15; the widowed, divorced and separated account for 25 per cent of clients presumed to be marriageable by virtue of age. Differences between inpatients and outpatients are apparent. All Eastern State Hospital patients were over age 20, and only 16 per cent of these were married (as contrasted to 42.6 per cent of clinic outpatients). The widowed, separated and divorced accounted for 37 per cent of hospitalized patients vs. 25 per cent of clinic outpatients.

Computation of rates for each marital status is difficult. Some comparability is provided by extrapolation of census data. For example, 18,210 Eastern Shore individuals shared the status of heads of husband/wife households in 1970. This number constituted 41.9 per cent of the population, paralleling the 42.6 per cent of

Table 4.14 A: Marital Status of Eastern Shore Inpatients and Outpatients: July, 1975

Marital Status	ESH Inpatients (a) Number	Per cent Inpatients	ESMHC Outpatients (a) Number	Per cent Outpatients
Single, Never married	47	44.8	150 (b)	29.1
Married	17	16.2	220	42.6
Widowed	21	20.0	44	8.5
Divorced	9	8.6	24	4.7
Separated	9	8.6	61	11.8
Unknown	2	1.9	7	1.4
Total	105	100.0	516 (b)	100.0

Sources: (a) Physical counts of (ESH) inpatients and (ESMHC) outpatients, July, 1975.

(b) Excludes patients under 15 years of age (N=70).

Table 4.14 B: Population Characteristics 1970 Census of Population and Housing (NIMH-MHDPS)

Indicator	Accomack County	Northampton County
Per cent White Households Husband/Wife	68.8	67.2
Per cent Black Households Husband/Wife	55.4	51.9
Per cent Males Never Married	9.9	11.7
Per cent Females Never Married	6.7	8.1
Per cent Males Separated/Divorced	3.9	5.5
Per cent Females Separated/ Divorced	4.6	6.8
Per cent Females Widowed	18.9	18.0

outpatients in married status treated at ESMHC. Males and females over the age of 14 who were never married totaled 2,219 in 1970, comprising 5.1 per cent of the total population. Their over-representation in both outpatient and inpatient treatment populations attests to some vulnerability. Divorced and separated males and females totaled 1,506 in 1970, comprising 3.5 per cent of the total population but a substantially higher proportion of patients and clients. Widowed females comprised 18 and 19 per cent of the female populations over age 14 in the two counties in 1970. The census provides no data for males who survive their spouses. The 20 per cent of institutionalized clients at Eastern State Hospital who are widowed is presumed to approximate widowed status in the general population. Outpatients (male and female) who were widowed and in treatment at ESMHC constituted only 8.5 per cent of the clinic treatment population over age 15.

Family Structure and Household Composition

Discussion of marital status calls attention to the broader issue of household composition and family structure in the studied area. Not only is the Eastern Shore economically depressed, undereducated in terms of rural norms, horizontally and vertically stratified, stressed by high levels of seasonal unemployment and chronic underemployment, characterized by poor or substandard housing

and high dependency ratios for both young and aged population, but the area deviates substantially in the "undesireable" direction from national rural norms related to household composition and family structure.

While the median household size differs only slightly from that of all U.S. rural counties (2.4 on the Eastern Shore vs. 2.6 for all rural counties), families comprised of a single individual account for 20.4 per cent of Accomack County families and 21.5 per cent of Northampton County families, as opposed to 16.7 per cent of national rural families.

Nationally, 85 per cent of all children in rural areas live with both parents. On the Eastern Shore, only 69 per cent of Accomac children and 63 per cent of Northampton children live in such families. The sex ratio is depressed below the 96.5 rural norm to 91.5 in Accomack and 89.0 in Northampton.

Nationally, 74 per cent of all rural white households are headed by a husband and wife, but only 68.8 per cent of Accomack County and 67.2 per cent of Northampton County households are so constituted. For black households, the percentages (55.9 for Accomack and 51.9 for Northampton) more closely approximate the national rural black norm of 56.2 per cent.

Eastern Shore rates of divorce and separation are higher than national norms and the per cent of widowed females substantially exceeds the 13.8 per cent median

for all rural counties. Further, about one-quarter of all families on the Eastern Shore (24.9 per cent in Accomack and 27.5 per cent in Northampton County) are female headed, compared to 18.3 per cent of all rural counties. Female headed households with children under 18 comprise 12.9 per cent and 16.4 per cent of such households in Accomack and Northampton Counties respectively, contrasted with 7.5 per cent reported as the national median for rural counties in 1970. For black families, about one-quarter of all families were female headed with children (24.5 per cent for each county). Coupled with the fact that more than one-half of all mothers on the Eastern Shore are employed (51.5 per cent for Accomack and 65.4 per cent for Northampton) and 44 per cent of these mothers in Accomack and 52 per cent in Northampton County have pre-school children, the emerging picture is one of weakened family structure and of households without adequate resources for the socialization of children. The stereotypic notion of rich resources available through extended family and kinship structure is refuted both by objective data and our observations over the period of field investigation. Alternative support mechanisms such as pre-school day care for children or companion services for the elderly are nonexistent. A single private day care center exists on the Eastern Shore and serves only white pre-school children at relatively expensive rates. Companion and home care services are available only from the private

sector

Race

The racial distribution of inpatients and outpatients approximates the population distribution on the Eastern Shore. Table 4.15 reveals that about 42 per cent of the population on the Eastern Shore in 1970 was black and that this proportion was paralleled both at ESMHC (40.6) and ESH (41.0 per cent). Minorities other than blacks accounted for .3 per cent of the total population in 1970 but for nearly one per cent of outpatients and 4.7 per cent of institutionalized patients. Expressed as rates under treatment, blacks are served as outpatients at slightly lower rates (12.94:1000) than whites (13.76:1000) at ESMHC. For institutionalized patients this differential is reversed with black rates at 2.34:1000 vs. white rates of 2.29:1000.

Microanalyses of the data, however, reveal that a substantially higher rate of black "aftercare" clients exists at ESMHC. Patients discharged from ESH are automatically referred to ESMHC for aftercare services, and follow-up care is mandatory. Consequently, proportionately fewer blacks among the outpatient clinic population are considered truly voluntary than are whites. Further, once institutionalized, blacks tend to experience longer periods of hospitalization than whites. There are two apparent reasons for this differential: (1) "severe"

Table 4.15: Distribution by Race of Eastern Shore Population (1970) and Inpatients and Outpatients (1975)

Race	1970 Eastern Shore Population (a)			ESH Inpatients (b)			ESMHC Outpatients (b)		
	Number	Per cent population	All Patients Rate: 1000	Number	Per cent Inpatients	Rate: 1000	Number	Per cent Outpatients	Rate: 1000
White	24936	57.4	16.04	57	54.3	2.29	343	58.5	13.76
Black	18394	42.3	15.27	43	41.0	2.34	238	40.6	12.94
Other	116	.3	86.21	5	4.7	4.31	5	.9	4.31
Total	43446	100.0	15.90	105	100.0	2.41	586	100.0	13.49

Sources: (a) NIMH-MHDPS data from 1970 Census of Population and Housing

(b) Physical counts of (ESH) inpatient and (ESMHC) outpatient records, July, 1975.

diagnoses in the form of mental retardation, organic brain syndrome and schizophrenia are more common for blacks at Eastern State Hospital than for whites; and (2) black patients are less frequently recommended for discharge to the community, primarily because of lack of financial or other support mechanisms within the community to provide continuing support.

Differences in severity of diagnosis also exist for outpatients served by the ESMHC. Of the 238 black outpatients, 41.2 per cent are diagnosed as retarded (8 per cent), schizophrenic (23.5 per cent) or organic brain syndrome cases (9.7 per cent) as opposed to 11.6 per cent of 343 white outpatients bearing these severe diagnoses. Virtually all (93 per cent) black outpatients with these difficult diagnoses are patients referred for aftercare services following institutionalization. When the aftercare population is removed from outpatients, the characteristics of black outpatients include educational, occupational and employment statuses and diagnoses that are similar to those of white outpatients. These similarities do not obtain for the general population suggesting that self-selecting or referred black outpatients are more educated and better employed than either the black aftercare population or the general black population of the Eastern Shore.

Education and Occupation

Of the social variables associated with risk for mental disorder, socioeconomic status is the composite variable most consistently reported in the literature to bear a strong (inverse) relationship with rates of mental disorder. The composite variable is most often constituted from occupation, income and education scales. Unfortunately, neither MHDPS nor records for inpatients or outpatients from the Eastern Shore provide sufficient information from which to constitute the composite variable. Aggregate data related to income, employment and education reported in MHDPS cannot be disaggregated in any meaningful way to provide a composite indicator for individuals which can then be re-aggregated. Clinic and hospital records provide no information on income and employment data are of limited usefulness since, in the instance of hospitalized patients, employment status is recorded for the last employment prior to institutionalization. Many institutional patients have been hospitalized for a number of years and their employability is probably limited. From that information available, however, analysis of patient/client status and occupation and education is possible.

Table 4.16 reports educational attainment of Eastern Shore Mental Health patients and clients. Predictably, institutionalized patients are less well educated

Table 4.16: Education Levels of Eastern Shore Inpatients and Outpatients, July, 1975

Formal Education Completed	1970 Population Estimated Per cent (a)	ESH Inpatients (b) Number	ESH Inpatients (b) Per cent Inpatients (N=105)	ESMHC Outpatients (b) Number	ESMHC Outpatients (b) Per cent Outpatients (N=583)
No Formal Education	(c)	8	7.6	22	3.9
Grade School					
Completed	53.7	(c)	(c)	70	11.9
Not Completed	46.3	(c)	(c)	149	25.5
Total	100.0	56	53.3	219	37.4
High School					
Completed	32.6	(c)	(c)	77	13.2
Not Completed	67.4	(c)	(c)	145	24.8
Total	100.0	30	28.6	222	37.9
Technical or College					
Completed	4.6	(c)	(c)	10	1.7
Not Completed	95.4	(c)	(c)	37	6.3
Total	100.0	6	5.7	47	8.0
Unascertained	(c)	5	4.8	73	12.6
Totals		105	100.0	3	100.0

Sources: (a) Extrapolation of NIMH-MHDPS data, 1970 Census, See Appendix B for detail
(b) Physical counts of (ESH) inpatients and (ESMHC) outpatients, July, 1975
(c) Data not available from records or other sources.

in the aggregate than outpatients. Twice the proportion of hospitalized patients have no education than clinic outpatients. Of institutionalized patients, 60.9 per cent had grade school education or no formal education. By contrast, the proportion of clinic clients with grade school or no education was 41.3 per cent. The proportion of clinic patients with high school and higher education and technical training is also greater than the proportion of institutionalized. The levels of education of outpatients is biased by inclusion of the 20 per cent of clients who are in student status and whose educational attainment was recorded at intake.

Comparable data are not available from MHDPS, but it is known that the median school years completed for residents of Accomack County in 1970 was 9.5 and for Northampton was 9.2 compared to a national median of rural counties of 10.6.

There is a substantial difference between whites and black median school years completed, with the white population in the two counties recording 10.7 and 8.8 years completed in 1970 (compared to 11.1 as the national rural median), while blacks had completed 7.0 years in both counties (contrasted with 8.2 as the national rural median for blacks). The proportion of total population with 8 or fewer years of education was 46.3 and 48.9 per cent for Accomack and Northampton, respectively in 1970.

This proportion was much greater for blacks than for whites. About three-quarters of the black population have fewer than eight years of education (75.1 per cent for Northampton and 72.8 per cent for Accomack), compared to about one-third of whites (34.9 per cent in Accomack and 27.0 per cent in Northampton). Nearly three times as many whites as blacks have completed high school according to MHDPS data, although this differential is diminshing, as evidenced by the percentage of young persons aged 18-24 recorded as completing high school in 1970 (See Appendix B). Less than 4.6 per cent of all Accomack County residents and 5.4 per cent of Northampton County residents had completed a college education.

Data by which to compare occupational status of clients and patients with the general population are also difficult to acquire. Table 4.17 provides the numbers and proportions of cases treated at the clinic and the hospital by occupation. While an estimate of the occupation and employment status of all residents was prepared in 1973 by the Tayloe-Murphy Institute for the Office of State Planning, these data are considered of little value since they were compiled from a sample of the population residing in Chincoteague, an area not considered representative of the general population of the Eastern Shore. Chincoteague is an island resort community with a year-round population largely comprised of commercial fishermen and a summer population of vacationers. The reasons

Table 4.17: Occupations of Eastern Shore Inpatients and Outpatients: July, 1975

Occupation	ESH Inpatients (a)		ESMHC Outpatients (a)	
	Number	Per cent Inpatients	Number	Per cent Outpatients
Business/Professional	2	1.9	8	1.4
Other White Collar	4	3.8	17	2.9
Non-Farm Labor	27	25.7	85	14.6
Farm-Labor				
Migrant	1	1.0	10	1.7
Resident	12	11.4	15	2.6
Total	13	12.4	25	4.3
Domestic/Custodial	13	12.4	3	.5
Retired/Semi-Retired	0	0	15	2.6
Unemployed				
No Income	(b)	(b)	187	32.2
With Income	(b)	(b)	59	10.2
Total	33	31.4	246	43.3
Housewife	11	10.5	69	11.9
Student	0	0	112	19.3
Other	2	1.9	1	.2
Total	105	100.0	581	100.0

Sources: (a) Physical counts of (ESH) inpatients and (ESMHC) outpatients, July, 1975
(b) Patient records not disaggregated.

Notes: Occupation data for the employed population provided in Table 4.4. No comparable data that include occupations of both employed, unemployed and retired persons available for comparison purposes.

Percentages may not total 100.00 due to rounding.

for the selection of this area as a sample by the Institute are not known.

MHDPS data related to employment and occupational status are dated and do not reflect high levels of seasonal unemployment on the Eastern Shore. Of the total laborforce, 6.3 per cent of civilians were unemployed in Accomack County at the time of the 1970 Census and 12.4 per cent were in that status in Northampton. Blacks experience unemployment and underemployment at higher rates than whites. In Accomack County, 8.8 per cent of the black population was unemployed at the time of the Census, compared to 4.7 per cent of whites in that county. The difference is even more marked for Northampton County where 4.7 per cent of whites were unemployed, but 19.7 per cent of blacks were in that status. Underemployment and the marginal economic position such status provides is endemic on the Shore. Among blacks, underemployed males constituted 21.6 per cent of all black males of employment age in 1970 in Accomack and 24.0 per cent in Northampton. In addition, women participate in the laborforce at higher rates on the Eastern Shore than is usual for U.S. rural counties. Forty and 47.9 per cent of all women in Accomack and Northampton respectively were in the laborforce in 1970. Of black women, the proportion was 53.8 and 57.7 for these counties.

Of employed males, about one-third of the white population were in low status occupations in 1970 (32.6

per cent in Accomack and 36 per cent in Northampton). For blacks, more than three-quarters of the male civilian labor-force who were employed were in low status occupations (78.9 per cent in Accomack and 82.3 per cent in Northampton). About one-fourth of all white males were in high status occupations in 1970, contrasted with 3.5 per cent and 2.6 per cent of black males in these occupations in Accomack and Northampton Counties respectively. Women were disproportionately represented in low status occupations in 1970 with the ratio of black to white women in these low statuses recorded at about 2:1.

The unemployed, marginally employed and seasonally employed farmworkers were over-represented in the three categories of highest severity (retardation, organic brain syndrome and schizophrenia). It is not known whether this fact represents occupational "vulnerability" or is an artifact of severe symptoms preventing employment in all but at least skilled occupations. Of housewives, by contrast, about 45 per cent were diagnosed as affective disorders and 17.4 per cent were diagnosed as neurotic, diagnoses considered relatively "mild".

Income levels are recorded neither for clinic clients nor institutional patients. While a sliding schedule of fees exists for institutionalized patients, few efforts are made to collect fees for hospital services except for those possessing third party insurance. At the time of

our investigation, the clinic was mounting an aggressive campaign to collect fees for service from clients. This effort might be predicted to result in even fewer low income clients than the disproportionately small numbers constituting the caseload in 1975.

Summary Profile

In summary, the profile of clinic outpatients and institutionalized patients that emerged supported other findings. Given the relative disadvantages experienced by various sub-populations, clinic clients were disproportionately white, educationally advantaged, female and employed than would be expected from a risk prediction model. Institutionalized clients, on the other hand, conform more closely to assumptions of risk. The likelihood of commitment to institutional care is greater for the educationally, economically and employment disadvantaged and for blacks. The most disadvantaged social statuses also are predictive of probability for severe and/or irreversible diagnoses.

The analyses reported here and in previous reports are relatively unsophisticated. Problems of rate validity and the ecological fallacy inhibit the usefulness of higher order analysis. The analytical snarls discussed in Appendix A influenced the decision to eschew statistical manipulations beyond those reported here.

The most significant finding remains that rates of

mental health service use are substantially lower than an ecological model would predict in terms of service needs. Efforts to reconstellate mental health service delivery to address unmet need were consistently spurned by those responsible for the operation of the system. The community leadership was simply disinterested in extending preventive or therapeutic services beyond the level then provided, even though state and federal sources stood ready to disburse the funding for matching services more closely with projected need. The wide range in reported bivariate relationships between social variables and mental disorder limited the cogency of arguments we were able to provide related to predicted "need".

An additional conclusion reached by research principals is notable. Consultants to the field staff included clinical psychologists, mental health planners, social work educators and sociologists. Review of project data and on-site visits to inpatient and outpatient services led to the consensus that these services had little to recommend them as effective therapy. In the end, the reluctance of the local leadership to reconstellate services was matched by our collective judgment not to recommend the extant services to any but the most desparate of the large number of distressed persons we encountered.

Field Studies and Survey Research

Field interviews and survey research were employed

in an attempt to gain quantitative data related to mental health service needs as perceived by local leaders and service providers, local residents and itinerant farmworkers. Two limitations inhibited the usefulness of this work: (1) funding sources did not permit reliable sampling; (2) responses were not considered valid or reliable for reasons discussed below.

Three separate efforts incorporated use of questionnaires. First, structured personal interviews of farmworkers were conducted in a sample of migrant labor camps. A second effort employed personal interviews of local residents in a sample community. Finally, mailed questionnaires were directed to the universe of known professionals and public agency personnel whose activities were relevant to mental health.

Interviews of Migrant Farmworkers

During the initial summer months of the project, the research staff penetrated a selection of 21 (of 120) migrant labor camps and interviewed 206 itinerant farmworkers to assess perceptions of incidence/prevalence and disposition of cases of mental illness, mental retardation and substance abuse or addiction within this population. The questionnaires used were carefully tailored to adapt to the language and cultural views of subpopulations of farmworkers (single black males, Spanish speaking

workers, etc.), insofar as we were able correctly to understand these. Even so, we found that responses from migrant workers were of limited value, in large part because many respondents were inebriated and/or clearly psychologically impaired.

In the 21 camps studied, environmental conditions of life were deplorable beyone compare (including conditions observed by principals in primitive and developing societies). Clinical assessment of the personal characteristics and behavior of the inhabitants would have labeled virtually every respondent as "disabled" mentally, physically, or as a result of addiction; we were unable to use respondents' perceptions and definitions of the situation as valid. The very debilities were observed, coupled with respondents' fear of reprisal and need to sustain a marginal existence created a "definition of the situation" totally unlike our own. Failure to secure quantitative data from the perceptions of the population in no way, however, altered our own definitions. The population was deviant, and personal deviance was exploited for economic gain to the labor contractors and growers who manipulated workers and held them in virtual peonage, commonly using deviance as the mechanism by which workers were held in human bondage.

Many camps were peopled exclusively by "skid row" alcoholics who were shanghaied into the labor force from

cities. Their work was remunerated with cheap wine and liquor sold at unsurious rates by crew leaders from the meager wages paid for labor. Workers were often in debt to the crew leader when, each week, charges for their illegally sold alcohol were withheld from wages. Their addiction and its manipulation assured that they would continue to work for daily, carefully doled, expensively purchased stupor.

Other camps contained extraordinary numbers of deinstitutionalized mental patients from the cities to the north and south. These unfortunates were recruited from city ghettos where they had been "dumped" from state hospitals and institutions in the "humanitarian" movement to empty mental hospitals in favor of community care. They were frequently without the psychotropic drugs prescribed for their aftercare and without these chemical straightjackets occasionally behaved in violent attacks on self and others. More often they docilely accepted their new "reality". When disabled from labor by psychotic breaks or dysfunctional behavior, crew leaders would intercede with public health nurses on behalf of workers to secure prescription drugs which would enable them to labor. Less tractable cases were expelled from the camps, physically punished or abandoned when the work crew moved on.

For some recruited or shanghaied deviants, farmwork

was not possible. When farmwork proved too strenuous, alternate system-maintenance roles were assigned: provision of sexual services to other workers, assistance in preparation and service of food sold by the crew leader or polishing the crew leader's Eldorado, a standard symbol of status and power.

In small numbers, some laborers came forth for relief and we were able with our legitimated presence to bring these to the attention of the community mental health system. Because of the lack of residential treatment resources and the refusal of the hospital to admit such patients (since they could rightfully claim that no psychiatric services were available) this treatment consisted of hasty evaluation, prescription of psychoactive drugs or simply committment to the state mental hospital. Mental health workers refused to enter labor camps and dealt with referred outpatients in a manner which suggested both fear of these clients and annoyance at having to receive and provide service to the dirty, disheveled and severely disturbed clients brought to them. For extreme cases in which protective custody was indicated, staff resorted to the most visible local institution of social control--the county jail.

The blatancy of this system of social control of mental incompetents and addicts as instrumental members of the secondary laborforce deeply penetrated our conscience

and provided germinal ideas as to the "real" nature of deviance and social control. These manifest uses of deviancy for economic gain by the dominant society became a key to the more subtle expression of the same phenomenon latently concealed in the rhetoric of the community mental health movement, at least on the Shore and, perhaps, elsewhere.

Community Interviews

An additional field research attempt was made at the end of the first summer before the departure of the summer research assistant staff. Door-to-door interviewing was conducted in the town of Atlantic (Accomack County), selected as a "typical" Shore community. Sixty-two residents were interviewed and while the sample permits no generalization of quantitative findings related to perceptions of prevalence of mental disorder within the community, the open-ended discussions with these respondents were instructive to our understanding of the social definitions of mental disorder. Generally, these confirm the presence of fatalism and religiosity, ascription of the phenomena to supernatural causation, belief in the power of faith to heal, and a social order in which at least two strata of the poor exist and are differentially accorded sanction: the respectable or deserving poor and the undeserving poor.

The three phenomena (mental illness, mental retardation and alcoholism and other chemical dependency)

about which we raised questions were accorded differing levels of acceptance or stigmatization. The alcoholic appeared to be viewed as a "sinner" whose behavior should be rewarded with "treatment", usually viewed as involuntary commitment. The mentally retarded whose existence in the community was recognized were seen as objects of pity, sympathy and help.

Respondents varied in their recognition of mental illness within the community. Many knew of an affluent family in the community of which several members were apparently under treatment "across the Bay." The behaviors of other members of the community were clearly recognized as deviant, but no "disease model" was presented as a metaphor to account for the phenomenon. Aberrant behavior found its usual explanation in "possession by the devil" or "caused by the changes in the moon" or simply wickedness. There was little identification of treatment as a helping resource. Deviant behavior was apparently to be ignored until it surpassed an unstated tolerance level, then institutions (jails, prisons, state hospitals) form the appropriate social control resource. Return to the community after expulsion to these institutions is not expected.

Only among "outsiders" did we find community responses congruent with our own definition of the situation: a new minister wished to use his influence to convince his parishioners of the "curability" of mental disorders; the

visiting daughter of one respondent disagreed sharply with her mother's assessment of the community incidence and prevalence. In her view, the town was full of "crazy people, drunks and drug addicts" for whom community services of a non-punitive nature should be provided, as they were in Wilmington where her daughter now lived. Her mother dismissed such notions as foolish: how people behave is of no concern so long as they work and leave others alone; Christ will care for his wandering sheep; the flock is impotent to save those who stray too far.

Survey of Professionals and Agency Staff

A survey of professionals and agency staff also yielded unusable quantitative data but reinforced a nascent but growing understanding of local social definitions. A mailed questionnaire was directed to the community of "professionals" on the Eastern Shore requesting information regarding the formal and informal encounters with the mentally disordered, respondents' knowledge and evaluation of treatment resources, and candid impressions regarding the extent of untreated mental disorders. A total of 456 questionnaires were mailed to the known universes of physicians (23), registered nurses (53), licensed practical nurses (84), the clergy (118), social workers (32), members of community human service citizen boards (62) and administrators and staff of human service delivery agencies (46), attorneys (28), and dentists (10).

The questionnaire was directed to both employed professionals and unemployed targets where lists of such professionals were maintained (as in the case of licensed practical nurses, many of whom were no longer practicing or employed).

Despite two mail follow-ups to non-respondents and phone calls to locatable targets, only 102 (22 per cent) usable returns were received. Of these, 93 (91 per cent) were from publicly or quasi-publicly employed professionals. Their responses were uniform: the Eastern Shore has many untreated residual deviants but resources do not exist to provide appropriate services. Evaluations of the treatment resources, however, were nearly always positive. A few "new" people deviated from the standard response and were critical of local resources for treatment. For example, despite the large number of clergy known to exist on the Eastern Shore only ten of 118 replied. All these were "new" to the Shore; their responses were coupled with apologies for not yet knowing or understanding the local social system.

For the preponderant number of "public agents" who formed the response sample, answers were carefully couched in official language. "My training and experience do not permit me to respond to these questions" was a response encountered far too frequently to occur as a random function. Questionnaires mailed individually to members of citizen boards were answered with official letters from

board chairpersons stating the official function of the board and avoiding questions posed in the instrument.

In the course of addressing questions to the audience of citizen board members, a significant finding was unearthed: a list of 352 members and officers of 22 boards and citizen associations (welfare, corrections, health, mental health, boards of supervisors, housing agencies, mental health associations, associations for retarded citizens, nursing homes, hospitals, etc.) was culled to eliminate duplication. Sixty-two persons represented the unduplicated universe of citizen members of human services boards and associations. This fact of interlocking directorates has relevance to the argument later presented.

To complement questionnaire surveys, the author also conducted formal personal interviews of agency functionaries until the limited usefulness of this work became apparent. The formality and similarity of responses received was beyond random probability. Few respondents knew of or encountered "mental health problems" among the clients served by their agencies. Applicants for these services (health, welfare, housing) came for assistance and were awarded this assistance with careful attention to eligibility criteria. Hours of access to services were strictly enforced and "traditional", i.e., daytime, week day hours. Applications were taken, eligibility

determined and services provided in centralized agencies, typically located in the two county seats. Transportation assistance was meager (consisting of subsidized taxi rides) and allocated with niggardly regard for cost. Only migrants received decentralized "outreach" services or widespread transportation services. These elements are mandated by federal guidelines governing service provision.

Agency functionaries interviewed described their own plight in supplying support in any measure consonant with need. Frequent reference was made to policies inhibiting services; these were perceived to be the product of federal "red tape" and state "bureaucratic bungling." Respondents' superordinates, the professionals and political appointees to executive positions, attributed the cause for meager services to these same sources, but also invoked as explanation the scarcity of tax revenues at the local level to support upgrading and extension of services. They identified the conservative elected officials (members of the board of supervisors) as wholly resistant to measures to increase tax revenues and provide local matching funds which would bring exponential funding from federal sources. In point of fact, few human service delivery agencies known to us presented budgets for approval to these elected boards which would require increased allocation from the locally generated tax base. Consequently, the point was moot.

During the research period, there were two exceptions

in which supervisors approved requests for increased local funds. The Accomack County Health Department presented a request to secure minimal matching funds to permit the construction of a new public health clinic to replace a clearly inadequate one owned by the county. The request was approved when it became possible to rent the old clinic to the welfare department which had been housed in a new county "courthouse" where welfare applicants had become an embarrasment and annoyance to the more "respectable" agencies housed in this edifice. Their vacated space was, in turn, occupied on a rental basis by the local Office on Aging and the District Planning Commission--agencies not encumbered by long queus of individual service applicants. Thus, two income-producing rental opportunities provided "payback" for the minimal formula for local matching funds required for construction. The array of health services provided remained as before.

In a second instance, funds were requested to renovate an unused retail outlet to become the "sheltered workshop" for the mentally retarded. This expenditure was accompanied by a plan for the inauguration of a new "cottage industry" using retardates as workers. The sale of the products of this industry were then to be used to decrease the cost to local sources for the operation of the Eastern Shore Vocational Training Center. These were sound financial investments which would maximize income to the local treasuries without generation of new costs

for increasing public utility flow. In neither instance was expansion of services employed as an argument or rationale for requested funds.

In short, research principals were beginning to learn important principles guiding the social system. The poor are differentiated as worthy or unworthy depending upon willingness or ability to participate in a local economy dependent upon their devalued labor. Human services are regarded as appropriate or useful only insofar as these support such participation. Services based solely on "personal" need are seen as "meddling" and are resisted by a taciturn small group of local leaders whose influence permeates the full array of publicly funded human services.

These understandings do not emerge directly from social fact data; they are acquired only through immersion in community life. Sensitivity to real lessons to be learned comes not primarily from data, useful as these may be for cues. The required sensitivity is human intelligence operating in human interaction, the structure of which is not immediately apparent.

SOCIAL DEFINITION: UNDERSTANDING "COMMUNITY" AS A MEDIATING PROCESS

In this section, attention is directed to processes of the Eastern Shore social structure. The section is brief because the primary research template, as an

expression of the social fact paradigm guiding major aspects of the field research provided little guidance. It is believed nonetheless that within the "social definition of the situation" lies the key to understanding of the "anomalies" discovered through the examination of secondary data and survey research. These studies would not, in fact, have required physical presence, for secondary data were available in the form of MHDPS, public records and other measures, and survey research can be conducted by mail.

The definition of the situation, however, did require presence, persistence and a final rejection of "normative" definitions and expectations brought in the form of intellectual and moral baggage.

Participant Observation

Little can be said regarding the formal methods employed in the sustained attempts by the author, who remained in residence once research assistants, consultants, and the "summer people" had gone. I immersed in local community life, but my identity was known as was my viewpoint and bias. I lived modestly in a "respectable" community and came to know its norms and how these differed from those of other, less respectable communities. I was not invited into the social life of the elite, but I was welcome in places of official business. I maintained a work site at the local community college

and might, had I chosen, formed collegial relations with the faculty. I resisted this seduction because faculty members were also, in the main, outsiders with little to offer, except the comfort of viewpoints congruent with my own but divergent from the views I was present to study.

I also maintained an office in the small residence I had rented where I worked during the day with two CETA clerk typists, black women graduated from the "secretarial science" curriculum of the local college. One was a young, married mother of a pre-school child who sometimes played in the leavings of scholarly work. His putative father had long since out-migrated to the cities of the north, as had many of the relatives and peers of the CETA staff. His maternal grandmother, mother of my assistant, was a domestic and I engaged her for household assistance. The three generations were frequently present at the same time and their interactions were "observed".

This multi-generational family had no male breadwinner since the head of household was disabled. The grandmother and young mother provided the total income for the household. They were remarkably well connected with service delivery programs, lived in public housing, received transfer income, and participated in employment and training services. I learned that relatives of the family who had out-migrated to northern cities had stimulated their application for a variety of support services to which they were entitled. When these relatives visited

they brought information on social programs with which they were acquainted and I frequently served as an advisor, counseling the women on how to apply for these supportive services.

The second CETA clerk was single, unencumbered by children, and engaged to be married to a "good boy" from the community. Both CETA employees were functionally illiterate but learned quickly with modern equipment (and gallons of correction fluid) to correct errors detected in their typing, and later to self-correct with interesting results. Our bonds became affective as well as instrumental.

My modest residence was the former home of a deceased millwright, rented to me by his middle-aged daughter who lived across the street with her disabled husband who had been an entrepreneurial waterman until a stroke incapacitated him. She had worked for a number of years in the high school cafeteria, had two sons in "prestigious" colleges and seemed possessed with boundless energy and goodwill in the face of adversity. The neighborhood was inhabited by white craftsmen, operatives, functionaries and operators of small businesses in the town. The homes were small and immaculately kept and a sense of quiet orderliness prevailed.

My cottage abutted the end of the town and not 100 yards away, concealed in brambles, was an abandoned chicken coop, weathered and rotting into the landscape.

Until the year prior to my arrival it had been inhabited by an elderly black couple who raised a few chickens, sold a few eggs, fished in the local waters and were found dead, together, of starvation during a particularly harsh winter. They had been avoided, but tolerated by their local neighbors. Children told me about them in hushed, fearful terms and adults confirmed the stories told by the children. Their eccentric life style was one which would not have been tolerated in an urban setting where they would have been considered "institutional" material.

On many days, my work consisted of travel into the small villages, communities and enclaves throughout the peninsula observing as unobtrusively as possible the interactions before me. Particularly, I visited those towns and villages with "disadvantaged" statistical profiles. In several of these, the entire populations seemed to me to be mentally disordered, either "bizarre" in behavior or appearance or "functionally retarded." I took visiting professionals to these towns to confirm my "diagnosis". Our definitions were congruent. Checks of clinic records, however, revealed no incidence of treated mental disorder in these communities.

In one small fishing village, the location of a monthly "satellite" clinic, sharing the statistical profiles of other communities I sought to observe, more than one-half the citizenry was under outpatient care at the clinic. Later I was to learn that a single, "acting-out"

adolescent male from this community had been referred for outpatient treatment by his high school counselor and provided by ESMHC staff with a welcome and generous supply of psychotropic drugs ("downers"). He had recruited friends and relatives to treatment in numbers sufficient to justify bringing the clinic staff to the community, reversing the general pattern of service delivery.

Many of the residents of this idyllic village seemed stuporous beyond the general atmosphere of Eastern Shore communities. On clinic days, the town people dutifully turned out to receive a one month supply of tranquillizers and to bring gifts of oysters, crabs and fresh fish. A noon day feast was made from these gifts in which therapists and patients shared. I was to learn that the behavior of these clients constituted an elaborate game in which symptoms were rehearsed in advance of the clinic visit and prescribed medications were shared and bartered in the interim between these visits. The villagers were all white and many were adolescents and young adults who were fresh and attractive in appearance and mannerism.

In the role of observer-as-participant I attended scores of public meetings of community boards of human services agencies. These were most frequently held during evening hours at the community college and were open to the public and announced in the weekly newspaper. Never, however, was a "private" citizen encountered at these meetings whose presence was not a part of a functional

role as member of the group or staff of the agencies controlled by the group. This was small wonder for the meetings were largely administrative with staff presenting financial reports and receiving little comment from their public overseers. At best, fully half the board members present dozed, knitted or impatiently scanned materials presented for their consideration.

At the beginning and end of each month, as many as five such evening meetings were scheduled, one each evening of the weekday. I grew to know well by sight the small number of directors who served on multiple boards. Their surnames formed a litany of respectable Eastern Shore agricultural families and I soon was able to discern the same names among the employed agents of human service delivery programs.

A system approximating primogeniture prevails on the Shore and a crafty nepotism is in full effect which carefully avoids breaking the letter if not the spirit of the law. Leading families, that is families controlling land and jobs, are represented on all boards, usually in the person of wives of growers or businessmen and women who operate commodity or service outlets controlled by these same families. Because federal mandates require consumer participation, "housewife" is frequently encountered in the occupations listed for board members. These are the wives of growers, and in some instances represent a title chosen by the member or agency in lieu of one more

descriptive held by this same member: owner of the most prominent real estate firm on the Shore, delegate to the Republican National Convention, wife and agribusiness manager of the wealthiest resident family on the Shore. These agents move in bored silence from meeting to meeting, recruiting from their own when positions become vacant, and demonstrate little familiarity with or substantive concern for the content of their official role.

Little concern is evident for little concern is required. The chief administrators of the programs governed by these boards bear the same surnames, are members of the same or linked families, reflect the same penurious conservatism. They are the second and subsequent sons or daughters of the elite. To the first born or the most aggressive goes governance of the family enterprise. Other sibs become military officers or "public servants", or both upon retirement from the military. In turn, their sons and daughters and the less fortunate cousins, nephews and nieces become the paid functionaries (social workers, nurses, bureaucrats) in agencies parallel to those administered by their slightly more successful and prominent family elders and governed by the heads of family-states or their surrogates. It is a system ingeniously designed to preserve the social order and protect it against alien ideologies. It is formal, legalistic and careful.

Impressions formed by observing the apparent quality

of behavior at these official forums led me to insert frequent challenges. My position was that there were countless untreated cases of mental illness, mental retardation and substance abuse for whom treatment could be productive. The data (MDHPS), I asserted, speak for themselves. Further, provision of supportive services could prevent many new cases of mental disorder and dysfunctional behavior, increase productivity, enhance the quality of life and lead to a more harmonious social order.

To these challenges, leaders responded with soft-spoken clarity. My "evidence" was met with paternalistic but polite rebuttal: the Shore is different, unique, idiosyncratic. That harmonious social order which exists is not understood by the outsider. There are many poor, but their meager needs are provided. Behaviors which are intolerable to outsiders are tolerated by the leadership because they alone understand these people and their "genetic" disendowment.

Leaders were self-congratulatory in their ability to meet ignorance, unsocialized behavior, lack of skills, disability and derangement with "honorable" work of the only sort matching the competency of those whom they benevolently protect. The poor, they asserted, wish no more. They are happy; ask them. Outsiders who wish to impose "programs" for the betterment of the poor will destroy the only respectable part of their lives: the

work ethic. The leadership does not desire the presence of these demeaning programs. Outsiders simply do not understand. The facts do not speak for themselves: only the local elite can, and do, define the meanings of these facts.

Key Informants

Sources of knowledge sometimes arise serendipitously. When the project commenced, a young couple and their two children docked their handsome, large, but unpretentious sailboat in the harbor of the town in which I lived. They were situationally penniless after a year at sea in an alternative life style experiment. They were well-educated and of impeccable southern ancestry. They wished to stay on for a year or two and earn income for their next journey. They quickly penetrated the local establishment; many members of the local social order are fixated on boats and sailing craft. The father, son of the Episcopal Bishop of a southern state, was recommended to me as a temporary research assistant by the executive of the community mental health system who had agreed to employ him as the Shore's first alcoholism counselor when funding became available at the end of the summer. The mother was a skilled editor and daughter of the owner-publisher of a South Carolina newspaper. I hired both. They shared my definition of the situation and our friendship was close, but became increasingly strained as they

bridged disparate worlds and operated in local social networks.

In field research in migrant labor camps, they became angry with the exploitation of addiction. Both vowed that when transferred to employment in the "system" they would attempt to provide treatment resources for this derelict population. The female read all of the clinic cases as research assistant, encoded all data, supervised report preparation, and acted as chief in my frequent absences. At the end of the project, she became administrative assistant to the mental health executive and continued quietly to influence the decisions of this office.

Throughout the project, these informants fed information to me, unusable in reports of the time for their short-term futures were dependent upon acceptance by the community. They also participated in a social network of young school teachers, social workers and civil servants closer to their age and interests than I and other senior project staff. These young "insiders" also shared to a greater or lesser degree the social definitions held by our corps of "liberal outsiders." They did not share our optimism for social change. Disrespectful of the tactics of the leadership (often senior members of their own families) they were nonetheless convinced of the centrality, endurance and perseverance of the elite.

My own social network was extended by the hiring of

two young adults, twin brothers, who were available from the town's supply of "respectable" secondary laborers. These college-aged brothers began by tending the lawn and flower beds of my rented residence, an essential function in the town of manicured lawns and hedges. They were "referred" to me by neighbors who recognized their harmless deviance and mistook project staff to be psychologists or counselors who might be helpful to them. They were grandchildren of the owners of the most successful morturary establishment on the Shore. Their deviance was tolerated, viewed as transitory and causally attributed to the divorce of their parents in their early childhood, the banishment of their mother from the community (she had moved to an urban center in an adjoining state) and their residential movement back and forth from Shore to city where they were contaminated by alien influences.

The brothers were small-time dealers in marijuana, both "home-grown" and imported. Their erratic and largely ignored schooling had included terms in the prestigious local private academy and in public high schools. Their friends and clients included young people of all social classes, many of whom were sons and daughters of local elites attending colleges off-shore and returning during holidays to re-establish ties of friendship. Others were black and white children of poor families attending the local community college or scratching out a marginal existence from casual labor.

Their extended family crossed many social circles. The funeral establishment operated by their paternal grandparents attracted clients from all social strata and employed fascinating systems for the social separation of corpses and mourners, fee collection, camouflaging successful suicides, etc. An uncle was County Administrator, useful to our purposes and theirs on several occasions. Their father, now re-married to an "imported" social worker, operated small businesses (retail clothing, historic house restoration) catering to affluent locals and "summer people."

As trust built between "hired hands" and employer, the cottage became an unofficial youth center of the town with the twins recruiting their friends to meet the strange outsider who was studying their domain. The social lubricant for these group sessions was cold beer. No effort was made to conceal these legal social interchanges from neighbors and townsfolk, and if there was objection, it was never openly voiced.

From these exchanges, much was learned regarding the "deviant youth sub-culture", the acceptable boundaries of tolerance for deviance, the sanctions met when boundaries and norms were violated according to social position and race of the violator, and the norms governing "games" played by young adults and their elders. Through these exchanges, for example, I became aware of the game played by clients of the clinic referred for

"behavioral problems of adolescence."

The majority of these guests held or espoused "liberal" views prevalent in youth. Most were at the age of transition into adult roles and responsibilities and in process of internalizing behavioral norms for these new roles. They also constituted the first generation of "television babies" whose weltanschauung included referents beyond the isolated peninsula.

From young black friends, we learned of the docility of their elders reinforced by "oreo" preachers and other leaders of the black community, of the harsh social sanctions imposed upon those who challenged the "system", and of the vertical dimensions within the horizontal (racial) dimension of social stratification. They shared their hopes for out-migration; remaining on the Shore was a symbol of abandonment of aspiration. From young white friends we learned of the duplicity of their elders, of the invisible backstage preparation of conflicts that preceded and accompanied the smooth dramaturgy of visible, formal, social interaction. On occasion, these backstage performances were associated with the formal meetings I was privileged to attend in my role as observed. The insights were incalculably valuable, although no scientific canons would justify their selection as a representative sample of the population.

To augment our understanding of the mechanisms by which the Shore's system of social stratification

was perpetuated, it was determined that a "natural experiment" should be staged.

SOCIAL AND ORGANIZATIONAL BEHAVIOR AND SOCIAL CHANGE: THE LAKESIDE EXPERIMENT

From the migrant study phase of the investigation, an embarrassing number of "horror stories" had been illuminated to public visibility using the willing cooperation of off-shore mass communications media. Our compatriots in these exposures included the redoubtable influence of the Virginia Council of Churches, long "respectably" active in providing services to children of migrant laborers. The local members of this voluntary association of Protestant congregations included ministers of high status (Episcopal, Presbyterian) congregations whose cooperation in an emerging plan was assured by the endorsement of their state association and the promise of visibility for their social concern.

We developed with these allies a plan for the operation of a subsidized temporary shelter for the social misfits, deinstitutionalized mental patients, down-and-out alcoholics, and physically incapacitated migrant workers who were abandoned by their crew leaders. Their plight made visible, it became increasingly costly to the community to assure humane and legal disposition of this human debris. With extralocal resources identified by project principals, it was possible to negotiate the rental and

renovation of an isolated, unused forty-bed motel to provide temporary shelter. The services of the facility and staffing were designed to assure early transfer of these wards back to their home states, to institutions or elsewhere off-shore. The entire project would be overseen by a policy board of local human service agency chiefs and representatives of the religious community and operated as a non-profit enterprise.

Endorsed by the Virginia Council of Churches, board recruitment and the incorporation of the Lakeside Interagency Care Facility, Inc., were relatively easy tasks. Emphasized in our proposal were the aspects of local control, extra-local funding, temporary services and early transfer of clients to permanent locations off-shore. Client referrals would be facilitated by the representation of the public health agency, the community mental health system, corrections agencies, migrant services projects, welfare agencies, the local clergy, etc., who would simultaneously provide community legitimation and acceptance. It was a clear exercise in co-optation of these agents whom we knew to be under mandates including care for this population.

Lakeside Home (so-called because it was adjacent to a "lake" later discovered to be a repository of the offal of the poultry charnel house operated by Purdue, Inc. which also owned a motel property) previously had been used to house alien workers imported to supplement the local unskilled laborforce. This activity increasingly

had become diseconomical as rates of local unemployment rose and workers became available from the local supply. Lakeside Home opened to a full house of residential clients in the second summer of the research project.

Our former research assistant, now alcoholism counselor for the local mental health system was the first chairman of the Lakeside board, a position in which he experienced considerable role conflict. Board members included the public health officer and director of the migrant health project for the two counties, the chief of the mental health system, representatives from each of the two counties' welfare agencies, the executive of a newly funded federal Rural Health Initiatives Project, sheriffs of the two counties, the local probation officer, a representative of the Department of Vocational Rehabilitation, the social worker from the community hospital, a local Catholic parish priest, two distinguished pastors of local Protestant congregations, the clinic's mental health counselor, and the director of a large nursing home. These locals provided referrals and legitimacy in the community. Outside members were, initially, the executive of the Virginia Council of Churches, the director of social action programs of the Catholic Diocese, two project principals (including the author) and the Virginia director of the Department of Labor's Farmworker CETA Program (from whose treasuries came the fee-for-service income providing operating funds). As farmworker programs and projects

proliferated, representatives from new programs including an ACLU Farmworker Legal Project, a farmworker housing advocacy program and other special projects and advocacy groups were added.

A staff of CETA employees was assembled and trained to provide round-the-clock paraprofessional services and case management. None were professionally certified, thus diagnostic services or specialized treatment were not available on-site. The facility served rather as a stabilization center providing shelter, food and referrals to community services and transportation to support agencies located in the areas of permanent residency of the clients. As the facility became acceptable to locals in its handling of itinerant workers, increasing referrals of residents from the "undeserving" poor local populations were admitted as clients.

From July 1, 1976 through November, 1978 when the facility was forced to cease operation due to lack of funds, nearly 2,000 clients were served, about 65 per cent of whom were itinerant workers. A balance of 700 local residents were provided services by referral from local agencies. Admission was based solely upon need and the ability of the staff to provide at least marginal care and security to the client. A total of nearly 20,000 bed-days were accumulated by clients who ranged from infancy (protective services in child abuse and neglect cases) to the very old and infirm. Conditions which created need for

shelter included frank psychoses and other severe mental disorders, temporary destitution, physical disability, physical abuse or neglect, abandonment, senility, after-care following surgical or other hospitalization, loss of shelter (fire, flooding, lack of heat, eviction) and a host of other problems plaguing the poor.

The facility was licensed as a "board and care facility" permitting a range of client problems and avoiding expensive regulations governing more sophisticated classes of residential treatment service. "Hard" diagnosis of clients was not possible, but staff estimates revealed that fully 10 per cent of clients were autistically impaired, another 20 per cent were diagnosable at varying levels of mental and emotional impairment suitable for psychiatric admission had such care been available, and the majority of the balance could have benefitted from appropriate outpatient psychiatric intervention. These estimates apply to migrant workers and locals alike.

Lakeside clients, by virtue of their indigency, were generally eligible for an array of social, health, mental health and income maintenance programs. A part of the service strategy of the facility was advocacy for clients in securing these entitlements. At first, clients were simply transported to service agencies to make application. Staff soon learned however, that a more aggressive advocacy was critical to securing even the clearest of

entitlements. Those attempting to secure services based upon a "local" definition of their situation (as in the case of mental health services) were even less likely to be defined as legitimate in their claim.

Female clients, referred for food stamp application, were frequently told by food stamp officials that so long as they could market sexual services, they were unwelcome as applicants. Male applicants were denied access to application procedures so long as food stamp workers were aware of a single unfilled work order for secondary laborers. Since there always existed some excess of work orders over willing or able potential workers, this was the norm. Clients referred to the community hospital for emergency treatment were denied services unless a staff member was present to insure that emergency room administrators were aware of their mandates under the Hill-Burton Construction Act which had financed the building of the modern community facility.

Mental health clinic staff, embarrassed by the numbers of clearly disturbed clients referred to them and preferring to keep Lakeside clients from disturbing the friendly local cliques of waiting room clients, soon began to serve Lakeside clients on-premise, frequently providing prescribed medications authorized by a psychiatrist who never saw the client.

Advocacy organizations represented on the Lakeside

Board of Directors cooperated in the successful application for funding of a farmworker legal advocacy project under the aegis of the American Civil Liberties Union. Other board members, including research principals, had access to sympathetic mass media resources and became increasingly involved in national forums directed toward the problems of migrant and resident farmworkers. These legal and public opinion resources brought about more careful attention to the laws and guidelines governing eligibility for services, but staff and sympathetic board members were acutely aware that the "real" definition of the situation remained essentially unchanged.

As legal and media attention was directed to Lakeside, human services agencies recognized its utility in providing temporary shelter and quick removal from the area of incapacitated farmworkers and residents for whom no level of service previously existed.

A delicate symbiotic relationship between locals and advocacy members emerged in which the unwritten criteria for operation became understood: in those cases in which clients were clearly disabled from any level of productivity, the facility was free to function and local agencies cooperated in providing mandated services with the objective of removing these disabled persons from the area into nursing homes, board and care facilities, mental institutions, etc. located elsewhere. Partially disabled clients able to function in the secondary laborforce were

to be attached quickly to this avenue for independent, if marginal, existence. In cases in which the level of disability could be subjected to "differential diagnosis," it was to the advantage of client and facility alike to make the sheltered stay and services brief.

A trial attempt was made to augment access to Lakeside Services with outreach workers who would enter labor camps and communities rather than relying on referrals from local and farmworker agencies. The plan was quickly abandoned when pressure, including threats of violence to outreach staff, outweighed the advantage of imposing our "definitions of the situation" which differed markedly from definitions held by growers, crew leaders and community leaders. In short, Lakeside was tolerated only insofar as it did not disturb control of the manner by which definitions of ability to serve in the secondary laborforce were made.

The continued existence of Lakeside depended upon active, persistent pursuit of scarce funding not in competition with local categorical services. These discretionary monies became more difficult to secure, in part, because locals could also influence the allocation of these resources, and because the time and energy of project principals were increasingly diverted to macrostructural policy and debate. A kind of entropy began to establish in which the motivation of staff diminished because of lack of funding and reliability or constancy of

support from board members whose ideologies were consonant with their own. Finally, it became increasingly apparent to all parties that the experiment, far from "de-institutionalizing" the definition of the situation held by locals, aided and abetted the function of ensuring control of secondary laborforce by removing from the scene those unable to participate and "band-aiding" and returning to local "ownership" those from whom additional services could be extracted.

Lakeside closed in late 1978. A small gift from the local mental health service provided funds to pay accounts with local merchants and attorneys. It was the only grant of any consequence ever received from resources controlled by locals. It provided the decent if ignominious coup de grace which symbolized the neutralization and rejection of alien assault on an organic culture.

The twin brothers have attempted to relocate and function off-shore, but they return for nurturance, acceptance and repair when repulsed from other social systems. Our research assistants who attempted to "go local" left after two years and it seems less probable that the book in which we all planned to collaborate will materialize. Other project principals continue to use the rich material to illustrate our teachings, to document our efforts to bring change in social policy at local, state and federal levels and to provide an internal "checkpoint" or mental laboratory in which academic notions, theories and

findings can be reality tested.

The living communities we studied have closed over any minor wounds created by our intrusions. Far more intensive assaults have been repulsed. An industry that sought to locate a major, unionized heavy equipment manufacturing operation there after winning the support of the general population has determined to locate elsewhere after repeated injunctions against their invasion brought by a small, powerful elite (including the chief executive of the local mental health system in a different, private, role) eroded any cost-benefit they might have realized in altering access to (and the allegiances of) the local secondary laborforce.

There is, however, a new MacDonalds now on the main highway. On a recent visit, we encountered our CETA typists. One was an employee, the other a customer. They seemed genuinely pleased to see us, but somewhat concerned that they not be observed being more than politely attentive to the presence of these notorious outsiders.

Summary: The Need for Triangulation in Applied Research

The major conclusions of these field studies appear in Chapter I. The conclusions acknowledge and confirm the existence of a large population of impoverished, poorly housed, undereducated, unemployed or underemployed, geographically dispersed and socially isolated persons and families of "weakened" structure in urgent need of services

directed toward the amelioration of these conditions but avoiding labels of mental disorder except in cases of clear functional impairment for which a restorative or therapeutic technology exists. We concluded that the chief barrier to appropriate, effective and acceptable services was the citizen board that the political structure had put into place to regulate the flow of this public utility. This board, in our opinion, reflects the values and motives of a political, economic and social elite dependent upon the devalued contributions of a large, docile secondary laborforce. The ideology of this elite contends that the extension of any ameliorative service (income maintenance, housing assistance, employment and training services, food stamps, social services, health services, mental health services, etc.) destroys the work ethic and has the net effect of decreasing the availability of this laborforce.

This argument is difficult to refute for few rational beings would prefer the arduous work available at the prevailing wage to the full array of income and in-kind services to which many are objectively entitled. Consequently, the prospects for decentralizing and increasing access to these services were not considered great so long as the structure of community organizations and staffing patterns remained as encountered.

The final conclusion of the earlier reports urged the reorganization of structures mediating between need and service: selecting members of human services citizen boards who reflect the demographic, cultural and economic

conditions of the population and who are sympathetic to the need to improve the quality of life for all the citizenry, and ensuring that staff of agencies supervised by these boards are selected on the basis of expertise in the field of employment and sensitivity to the unmet needs of the population and subpopulations.

Project principals were not optimistic that these conclusions would affect future mental health service programming in the area. In fact, the only major changes in these programs following the study were the employment of a full-time psychiatrist and the leasing of expanded centralized clinic space in a new, privately financed medical complex built adjacent to the community hospital.

Whether or not one agrees with these conclusions, it seems clear that the conclusions could not have been reached without the complementary use of several sociological perspectives and research methodologies. That is, without triangulation of perspective and method, conclusions of the studies would have been radically different than those presented. It is necessary to elaborate only briefly what the conclusions from any single perspective, without triangulation, might have been.

From the social factist perspective, demographic analyses and inferences from social epidemiological research--the sole template available from federal or state sources to assess "need"--would have argued that a large

(but unspecifiable) segment of the population was "in need of mental health services" or "at risk for mental illness". In general, this segment would have represented those with least power: minorities, the very poor, children and the aged, the unemployed and underemployed, and those without primary group support and protection (members of "deficient" families, etc.). The unwillingness of principals to make such an argument rested upon two sources of evidence: (1) correlations supporting the argument are spurious; (2) the therapeutic value of mental health services without substantial commitment to address the root causes of vulnerability--that is, powerlessness--is questionable. Principals argued, rather, that these segments of the population were at risk for the application of the label mental disorder and that, insofar as therapies are frequently iatrogenic (Illich, 1976), these populations should be "protected" from being labeled. Ironically, these population segments are protected from the risk for labeling by the very power structure normally applying such labels. On the Shore, the need for unskilled workers outweighs the need to address issues related to the quality of life or internal emotional or psychological states of these workers.

By contrast, epidemiological studies of the treated population might have led to support of notions regarding the "idyllic" nature of rural life. Rates under treatment

were extremely low and could have documented such an argument had our understandings been limited to examination of secondary data. In the past similar arguments have been employed to explain differences between rural and urban rates under treatment.

Our analyses, however, explored differences in the specific labels applied to various segments of the population (by race, sex, marital status, employment status, occupation, etc.) and discovered that these labels lead to a range of "services" considered appropriate from the provision of euphoric medication in festive community settings to punitive expulsion and institutionalization. Low rates under treatment did not lead to conclusions regarding the attractiveness or harmonious quality of rural life, however, because we were able personally to observe the harsh conditions of poverty, discrimination and prejudice which prevailed. Rather, we concluded that the application of labels of mental disorder, the type of label applied and the treatment prescribed seemed to conform to a system of reward and punishment linked to "worth" of the individual (or the population segment represented by the individual) as perceived by the practitioner and his/her superordinates. The fact that those predicted to be most "at risk" from models in use were also most likely to be treated in punitive fashion could not escape our attention.

Survey research was largely unstable, in part

because funding did not provide for adequate sampling, pretesting and sophisticated analyses, but also because patterns of response--particularly those received from community leaders (professionals, agency supervisors and staff)--were uniformly "formal" and most questions were simply unanswered as being outside the official domain of the respondent. An important data point resulting from survey research was the fact of interlocking directorates of community organizations. This discovery led to more careful observation of the structure of community organizations and identification not only of individuals serving on multiple boards but of the "webs of affiliation" of other board members and the need to explore beyond the "occupational title" (housewife, consumer) of board members to discover relationships of the incumbents to the small number of families who constitute the economic, social and political power structure. The funded research design prevented documentation of these networks and their influence beyond impressionistic data. These data, however, systematically support the observation that the sphere of influence of the elite extends not only over ownership of the land and employment, but over governance and operation (including staffing) of ameliorative programming.

The point bears brief elaboration. Analysis of secondary data related to community organizations and the leadership of these organizations would not have automatically revealed the penetration of the elite into these

organizations. Occupational titles do not readily reveal the cultural and ideological attachments of incumbents. In fact, simple analysis of the occupational titles, surnames, etc. of boards and staffs of human service organizations would reveal a socially "responsible" set of leaders who voluntarily contribute their expertise to community services targeted to the disadvantaged. Not only do these individuals and families contribute untold hours to community service, but adult offspring are apparently encouraged to enter the helping professions and to serve as underpaid functionaries in public service agencies. It would be all too facile to remark on the "altruistic" manifest function of community service and ignore the latent and potentially more important function of social control this "community service" provides.

A final example is to be found in the "social experiment" of Lakeside Home. The erection of a "community services board" to govern this activity was an easy task. Superordinates in human services agencies were only too willing to identify with this effort to provide services for a derelict population of itinerants and locals and to refer large numbers of distressed individuals and families. The outsider observing this experiment might identify the source of failure of the experiment to the redirection of extralocal funding that supported the endeavor. Only an "insider's" view would identify the fact that referrals were made only in cases in which the individual in distress

was no longer useful in the secondary laborforce, that no local funding was provided, and that the local leadership was unwilling to support proposals for additional extra-local funds to expand and maintain the service. Far from "co-opting" community leadership, the facility served the manifest function of providing humane "services" to the distressed, but also served the important latent function of ridding the community of human debris without cost. The experiment failed, finally, as much as a result of the unwillingness of "advocates" on the board to foster this latent function as from withdrawal of support by funding sources and by leaders of the local community agencies.

It is important to recognize that the author came to the project with a viewpoint biased by the purposes of the funded research which embraced certain implicit assumptions. Among these assumptions was the notion that mental health services constituted a benefit to be extended to all those sharing certain "risks". The field research began by examination of the "aberrant" case of the itinerant farmworker. Through careful observation of the structure and processes of this labor system, it became apparent that mental health services are more appropriately to be viewed as a part of a system of social control extended at the pleasure of the powerful for purposes which enhance and extend their influence and control over this population. This nascent understanding was to be amplified through the use of trusted key informants. It is not

known whether these informants were representative. Their insights, however, influenced principals to look beyond "needs assessment" to study the dynamics and power relationships among and between those who respond (or do not respond) to the needs of "populations at risk".

Unfortunately, little guidance or support for this shift of perspective is available from the theoretical or research literature of the applied field of the sociology of mental disorder or the emerging field of the sociology of community mental health. Labeling theory, as will be demonstrated in the final chapter, continues to focus upon behaviors of individuals which bring recognition and the application of labels by members of the dominant social order but provides little explicit guidance for analyzing the essentially rational system by which this dominant social order makes decisions related to the recognition and labeling of residual deviance. The mass of empirical social epidemiological evidence that has accumulated over the past half-century attests to social processes underlying <u>differences</u> in rates of labeling across communities, yet these same studies are most often used to argue that some <u>normative</u> rate of disorder exists among populations and sub-populations possessing some social characteristic or set of characteristics.

From a policy perspective this lack of comprehensive sociological guidance seems especially unfortunate. The

federal effort to expand the availability of mental health services was coupled with the decentralization of these services and the placement of control of these services in the hands of community leaders. If one accepts the premise that these services represent a benefit which should be extended "equitably", it becomes critical to identify the determinants of variation across communities that affect rates of service. These determinants are not to be found solely in population data, for as Blau (1969:49-51) intimates, population structure and other demographic data may more appropriately be viewed as consequences of social organization. The federal effort and the earlier perspective of this author focused on social conditions (as revealed through census data) treated as independent variables to account for patterns of behavior and attitudes of individuals. In the field studies reported here, it became apparent that this treatment could not account for the social processes observed. The structure of leadership in the communities we observed were not only disinterested in altering social conditions thought to result in disordered behavior, they were interested in preserving these social conditions. To explain and interpret that which was observed it became necessary to view the characteristics of social structure and the social characteristics of the population as dependent variables to be explained by reference to antecedent factors--the dependence of the status quo upon large numbers of secondary laborers

whose availability would be substantially diminished (in the perception of the community leadership) by the extension of mental health or other "human services". Viewed as mechanisms of social control, mental health services provide a part of the armamentarium by which a dominant social order maintains control of the behaviors of subordinates. The field studies reported here indicate that this form of social control may be employed along a continuum ranging from reward to punishment. More importantly, the purposes of social control may be served by withholding these and other services or providing them in such fashion that they are inaccessible, inappropriate or unacceptable to elements of the population one chooses not to serve.

A reorientation of perspective appears essential to accommodate these findings and impressions and represents no minor departure. The most promising of sociological theories pertinent to the field--labeling theory--requires reformulation to place appropriate emphasis on social conditions and social structures as dependent variables and to reorient methodological procedures to ensure these procedures are consonant with the reformulation.

In the following chapter this reformulation is attempted.

CHAPTER V

SUMMARY, IMPLICATIONS AND A REFORMULATION

Each of the preceding chapters is summarized at its close in a manner attempting to build incrementally and with complementarity. The summaries support the argument that a more comprehensive sociology of community mental health will require a fundamental reformulation of the image of the subject matter and a triangulation of research methods in support of theoretical approaches that reflect more accurately the totality of social processes under consideration. This chapter integrates materials from these summaries in an attempt at such a reformulation.

The reformulation examines the propositional statements of selected sociologists and social psychologists prominent in the field and identifies conceptual problems believed to be significant in light of field studies reported in this work. The chapter closes with comments related to policy research in the applied field.

Summary Statement on Sociology and The Community Mental Health Movement: The Need for Reformulation

Sociological contributions to the understanding of mental disorder as a form of residual deviance and of the

systems of social control exercised by the dominant social order over this residual deviance have provided important but incomplete guidance to the social movement toward decentralization and extension of mental health services as a public utility.

Important American theoretical constructs and empirical studies which appear to have influenced public policy related to the recognition, recruitment to treatment, treatment and disposition of behaviors to which the label of mental disorder are successfully applied lie in human social ecology and social stratification. Implicit in both models is the unequal distribution of power.

In the ecological construct, human populations are seen as spatially distributed in accordance with underlying dimensions reflecting relative ability to compete successfully and dominate in the acquisition of scarce desireable resources (land or physical space). Among the attributes of those members unable to compete successfully is vulnerability to the label "mentally disordered". The results of this vulnerability include rates of labeled mental disorder which are correlated with other outcomes of unsuccessful competition: poverty, poor housing, low educational attainment, marginal occupational status and other forms of labeled deviance (crime, delinquency, etc.).

In the stratification construct attention is diverted from the spatial distribution of vulnerability to distribution in accordance with membership in social strata which,

in the aggregate, have differing behavioral norms and levels of power and are subject differentially to the successful application of the label of mental disorder.

These constructs and empirical studies were undertaken prior to the ideological social movement subsumed under the rubric "community mental health" when a medical model of mental disorder formed the sole metaphoric construct by which the phenomenon (mental illness) could be understood and treated. Sociologists and others tended to treat outcome measures (rates of mental disorder) as definitional rather than sensitizing concepts. While the accumulated evidence argued against the medical model as a chief explanatory construct, studies originally undertaken to emphasize the social aspects and processes of labeling residual deviance as mental disorder tended to be used to reify the medical model. That is, studies demonstrating the social correlates of defined or labeled mental disorder--generally indicators of relative powerlessness--were taken to demonstrate "real" incidence or prevalence of the disorders rather than as manifestations of a social dynamic between labelers and those labeled. This confusion is fostered by evidence that that which is labeled mental disorder includes behaviors of both genetic (biological) and environmental (social) origin. There is little dispute that a substantial portion of labeled mental disorder is social in origin; however, epidemiological (social factist) studies have concentrated on the

personal or collective attributes of individuals or social groups and classes so labeled (or "at risk" for such labeling) to the virtual exclusion of the attributes, purposes and motivations of those legitimated to socially define the phenomenon.

With the promulgation of the community mental health movement, it seems especially appropriate that sociology redirect attention to the social processes involved. Community mental health seeks simultaneously to extend and make more accessible a variety of services through identification of entire populations and sub-populations as "at risk" or "in need" of these services and has placed control over these processes in the hands of community leaders appointed through political processes. The movement is essentially ideological with proponents and detractors ranging from those who see it as a mechanism for redressing social inequities to those who view it as a sinister means for defining these inequities as personal pathologies and "blaming the victim" for the personal anger or malaise created by one's own exploitation.

Regardless of ideological commitment, however, a more complete sociology of community mental health would argue minimally for exploration of the attributes of both labelers and those labeled. With the replacement of the physician/psychiatrist as <u>individuals</u> legitimated to label mental disorder by community <u>organizations</u>, the domain becomes all the more sociologically attractive. The

involvement of the discipline in an emerging sociology of community mental health, however, may require reorientation of perspective and reformulation of theoretical propositions.

Examination of the propositional constructs of three contemporary authors provides a departure point for such a reorientation and reformulation. These constructs were selected because they both emphasize social factors in the process and provide statements which, when operationalized, may be tested empirically--a characteristic that has not been a hallmark of work in the field. The sets of statements were selected also to illustrate the present concentration on attributes of those who come to be labeled and the potential for a reordering of materials to provide a more comprehensive framework for the explanation of the phenomenon.

Scheff (1968:8-22) provides a set of propositional statements (Table 5.1) which wed aspects of labeling theory (social definitionist paradigm) with social learning models (social behaviorist paradigm). He proposes the important locating framework of "residual deviance", a term adequately broad to subsume labeled disorders of both biological and social origin. His statements are not self-consciously concerned with the differential rates of labeling (social factist paradigm) although it is clear that he is aware of these differences. The focus is instead on the relatively low rates at which residual deviance is

Table 5.1: Scheff's Research Framework on the Role of the Mentally Ill and The Dynamics of Mental Disorder (1963) with Commentary

Propositional Statement	Comments/Reformulation
1. Residual deviance arises from fundamentally diverse sources (organic, genetic, biolotical, environmental, social).	1. The recognition and treatment of residual deviance, whatever its origin, is best understood through analysis of the social system in which recognition and treatment take place.
2. Relative to the rate of treated mental illness, the rate of unrecorded residual deviance is extremely high.	2. The rates of treatment, as well as the inferred rates of non-treatment, may be viewed as sensitizing indicators of social processes operating in communities.
3. Most residual deviance is "denied" and is transitory.	3. "Denial" of residual deviance is a process under community or other dominant group control and constitutes a social process following behavior rules that can be determined (measured).
4. Stereotyped imagery of mental disorder is learned in early childhood.	4. Stereotypy governs not only the learning of general images of mental disorder, but the behavioral content of kinds of mental disorder considered appropriate to social groups and social classes. Appropriate sterotypic reactions to these behaviors are also learned in early socialization.
5. The sterotypes of insanity are continually reaffirmed, inadvertently, in social interaction.	5. The affirmation of sterotypes--including class-appropriate disordered behavior and social reaction to these behaviors--occurs continuously and is patterned, that is subject to sociological analysis and understanding.
6. Labeled deviants may be rewarded for playing stereotyped deviant role.	6. Rewards proffered to labeled deviants may be understood by analyzing the functional or secondary gains accruing to legitimated agent(s) of social control conferring labels and reward allocations and to the community legitimating these agents.
7. Labeled deviants are punished when they attempt the return to conventional roles.	7. Punishments proffered to labeled deviants can also be understood as in (6) above.
8. In the crisis occurring when a primary deviant is publicly labeled, the deviant is highly suggestible, and may accept the proffered role of the insane as the only alternative.	8. The proffered role of insanity (and other "sick roles") are made available differentially by the social system in accordance with the social status of the deviant actor; the pattern of these differences may be analyzed from the perspective of social system gain.

Table 5.1: Scheff's Research Framework on the Role of the Mentally Ill and The Dynamics of Mental Disorder (1963) with Commentary - Continued

Propositional Statement	Comments/Reformulation
9. Among residual deviants, labeling is the single most important cause of careers of residual deviance.	9. Rates of labeling as "causes of deviant careers" can be analyzed and understood as sensitizing indicators of community social processes and will differ in patterned ways. These rates may covary with other utility flows (welfare, etc.) and will vary from community to community

Source: Scheff, Thomas J. "The role of the mentally ill and the dynamics of mental disorder: A research framework." Pp. 8-22 in Stephan P. Spitzer and Norman K. Denzin (eds.), The Mental Patient: Studies in the Sociology of Deviance. New York: McGraw-Hill (1968).

labeled mental illness and the processes by which individual actors learn mentally ill roles, are nurtured within these roles and are punished when attempting to return to conventional roles.

From the present perspective, the propositions unwittingly reify notions of "illness" and "insanity" and ignore any reference to the attributes of labelers. While abundant empirical evidence exists in support of his propositions (and more has accumulated since their original statement), other evidence including observations reported here insists that learning processes and stereotypy play important roles in differentiating role behaviors appropriate to social groups and social classes that subsequently come to be labeled as different types of mental disorder "requiring" differing treatment and social responses. That is, it is believed that the stereotyped imagery of mental disorder varies in behavioral content resulting in learned behaviors that are "appropriate" to the individual as a member of a social group (women, adolescents, blacks) or social class (the poor, the middle class, the affluent). Social reaction to these behaviors also varies and treatment regimens are seen as "appropriate" in a continuum from reward to harsh penalty depending upon the behaviors learned as part of the social identity of the deviant actor. A reformulation of Scheff's statements would attempt to account for the purposes served by the proferring of differing stereotyped deviant behaviors according to social

group and social class as learning models.

Mechanic (1969:68-69) provides an alternate list of factors related to recognition of mental disorder. It is significant to note in Table 5.2 that these same ten factors are those he identifies as relevant to the recognition of any illness or disorder (tuberculosis, a broken bone) and that the language consciously affirms the presence of "illness" displayed through the appearance of "signs or symptoms". Further, his propositions are mainly cast in the frame of reference of the "sick" or deviant actor although deference is paid to "the tolerance threshold of those who are exposed to and evaluate the deviant signs or symptoms" and to "information available to, the knowledge of, and the cultural assumptions and understandings of the evaluators".

Mechanic's works have substantially influenced public policy related to mental disorder and--from the present perspective--it is unfortunate that his models are simply translations of extant work in medical sociology. This is not so much a matter of irrelevance as of incomplete formulation and inadequate emphasis on social reaction to behavior. From the work reported here, for example, the "extent to which the person perceives symptoms as serious" in the recognition process is overshadowed by the extent to which others perceive behaviors to be serious or dangerous to their purposes. Similarly, "the extent to which symptoms disrupt family, work and other social

Table 5.2: Mechanic's Factors Related to Responses to Symptoms of Mental Illness, Illness Behavior, and Help-Seeking Process (1969), with Commentary

Factors Related to Definition of Mental Illness	Comments/Reformulation
1. Visibility, recognizability, or perceptual salience of deviant signs and symptoms.	1. . .measured from the standpoint of the social audience.
2. Extent to which the person perceives symptoms as serious (person's estimate of danger).	2. . .and this "definition of the situation" is consonant with social stereotypes and social valuation of "person".
3. The extent to which symptoms disrupt family, work, and other social activities.	3. . .as interpreted by social "others": the family, the employer and the dominant community.
4. The frequency of the appearance of deviant signs or symptoms, or their persistence.	4. . .and the functional "cost" of these signs or symptoms to the dominant social order.
5. The tolerance threshold of those who are exposed to and evaluate the deviance signs or symptoms.	5. . .and the social and economic motives that "produce" differential tolerance thresholds among evaluators.
6. The information available to, the knowledge of, and the cultural assumptions and understandings of the evaluator.	6. . .which result from social stereotypy inculcated via socialization processes in those legitimated as evaluators.
7. The degree to which autistic psychological processes (i.e., perceptual processes that distort reality) are present.	7. . .and these processes are dysfunctional to the role played by the deviant actor determined by the dominant social order.
8. The possibility that competing interpretations can be assigned to the symptoms once they are recognized.	8. . .and the relative gains/losses to evaluators and community of these competing interpretations.
9. The presence of needs that conflict with the recognition of illness or the assumption of the sick role.	9. . .these conflicting needs may be generally understood by reference to community social and economic structures.
10. The availability of treatment resources--proximity, financial and psychological costs, including stigmatization, social distance, etc.	10. . .which are under the control of the dominant social order and may be understood, in themselves, as sensitizing indicators of social processes.

Source: Mechanic, David. Mental Health and Social Policy. Englewood Cliffs, NJ: Prentice-Hall (1969:68-69).

activities" is relative to other's evaluations of the nature of the work, the "worth" or the family and the nature of social interaction expected of "person". Even the "degree to which autistic psychological processes. . .are present" is important primarily insofar as reality distorting processes are salient to the audience. It is simply unimportant whether a migrant farmworker believes himself to be Napoleon or Jesus Christ so long as the crop is harvested.

Mechanic's factors become highly relevant and explanatory when the perspective is shifted from the deviant actor to the social audience. Despite a plethora of sociological works touching on the social audience in processes of labeling mental disorder, the concentration in the extant literature remains with actor rather than audience. It is believed that Mechanic's statements are much more explanatory of the findings of our research when the perspective is shifted as in the supplemental statements that accompany his listing in Table 5.2

An empirically documented set of propositions related to the generation and recognition of labeled mental disorder is presented by the Dohrenwends (Table 5.3). While the authors account for the social factist relationships between social attributes and defined disorder, their work pays scant attention to labeling theory (social definition) and its power to account for the differences they observe. While the term mental illness is eschewed in their work, it is replaced by psychological disorder,

Table 5.3: The Dohrenwends' Propositions Related to Social Class, Secondary Gain and Mental Disorder (Psychological Symptoms) with Commentary

Propositional Statement	Comments/Reformulation
1. The results of community studies of psychological disorder indicate that there is an inverse relationship between social class and psychological symptoms.	1. Strengths of relationships between social class and defined disorder vary across communities and may be understood through analysis of community social and economic structure and processes.
2. Social environmental pressures in normal civil life, even in the lowest social class, produce symptoms that persist only as long as the situational pressure continues or in the presence of secondary gain; symptoms that persist regardless of the social situation and in the absence of secondary gain are probably genetic in origin.	2. Situational pressures and secondary gains are controlled by forces outside the sphere of the deviant actors; therefore, these factors should be referenced to agents and institutions controlling the flows of pressure and gain. Symptom persistence may indicate genetic origin, but the burden of proof lies with the geneticist and not in definition by exclusion of the phenomenon from social processes.
3. Therefore, psychological symptoms in community populations are of two main types: (A) mainly generated by social situations and (1) transient in the absence of secondary gain or (2) persistent when supported by secondary gain; or (B) mainly generated by personality defect, which is probably genetic in origin and persistent even in the absence of secondary gain.	3. It is possible to analyze social processes that result in generation of social stress and secondary gain, but the analysis should focus on benefits that accrue to the dominant social system from such arrangements and utility flows.
4. Despite unreliable measures, higher rates of psychological disorder are consistently found in the lowest social class because all the main types and subtypes described above are likely to be inversely related to social class: (A) the transient, situationally-induced symptoms, because stress situations are harsher in lower- than in higher-class environments; (B) the situationally-induced symptoms that persist with the support of secondary gain, both because the stress situations are harsher and because secondary gain is more probable in the lower class; and (C) the persistent, defect-generated symptoms, because social selection processes are operating.	4. The division of labor (resulting in harsher experiences for lower-class members) and the allocation of secondary gains are controlled outside the sphere of influence of lower-class members. The social differentiation and social integration axes of the social order may be understood as dependent variables of larger community social and economic structure.
5. The relative proportions of these types of symptoms in lower-class groups are unknown. Therefore, the relative importance of genetic and social environmental factors in the etiology of psychological symptoms also remains unknown.	5. Again the burden of proof for genetic origin ought rest with those proposing biological/medical models. The preponderant evidence suggest that all labeled mental disorder ought be considered social in origin unless proved to be biological (genetic, biochemical).

Source: Dohrenwend, Bruce P. and Barbara Snell Dohrenwend. Social Status and Psychological Disorder: A Causal Inquiry. New York: John Wiley & Sons (1969:174-5).

an entity they appear willing to reify. The propositions are important in the acknowledgement of the powerful incentives of secondary gain to be experienced through acquisition of the sick role, but fail to account for the patterns and systems by which the more powerful offer or retract these secondary gains. The influence of social behaviorism in the work is apparent, but the focus remains inappropriate from the present perspective.

For example, Eastern Shore field studies systematically support the impression that secondary gain is extended in these communities primarily to those who are not members of the lowest social stratum. Secondary gains in the form of euphoric medication, professional "concern", predominantly pleasant interaction and partial release from work expectation appeared to be allocated to the "worthy" poor and the middle-class, particularly to younger, white, "attractive" clients. Thus the "probability of secondary gain" (Proposition 4[B]) for the lower class must be tempered by an understanding of the system that reserves these secondary gains for a more favored clientele. Such "secondary gain" as observed to accompany the "appropriate treatment" of diagnoses of the most intractable sorts--categories in which the lowest stratum was overrepresented--could scarcely be considered gain to the labeled actor although others in the community may experience secondary gain from the expulsion of the actor. To be sure, the "symptom formation" exhibited by members of different strata differed

in a manner that may be explained by the reformulation of Scheff's social learning propositions. "Mild" symptoms among members of the lowest stratum, however, were unnoticed and unrewarded by secondary gain whereas other favored persons and groups appeared to be "recruited" to outpatient counseling for these same symptoms. Only when gross disturbances (chiefly acts of violence against a more powerful "other") among members of the lowest stratum were apparent (recognized) was "secondary gain" in the form of treatment (institutionalization) swiftly allocated.

Summarily, the three sets of propositions reviewed contribute importantly to the understanding of social processes involved in the labeling and treatment of mental disorder, but these contributions are sharpened when the perspective is shifted from the behaviors of deviants to the systems of recognition of deviance erected and maintained by the "community" or audience of powerful others. An important distinction lies between the authors' perspectives which focus on the behaviors of individuals and the manner by which these behaviors are learned and recognized as deviant by the actors or by others and the present reformulation which views mental health services as a public utility flow. The contributions of Scheff, Mechanic and the Dohrenwends appropriately focus on the content of deviant behavior, as have numerous works before and since their publications. These and similar contributions formed the body of the extant literature

and were eagerly incorporated into policy governing community mental health programming with the unfortunate effect that the image is left of "mental illness" (regardless of its biological or social origin) residing in the individual--notwithstanding evidence that labeling of non-organic (and some organic) forms may be better understood by examining dynamics outside the control of the labeled actor. The authors' propositions are further imbued with implicit notions of "rationality" on the part of the labeled deviant--learning "insane" roles, "striving" for secondary gain, "presenting" signs and symptoms "perceived" by the actor to be more-or-less serious or dangerous or salient. That very system which endows the mentally disordered with irrational behavior and "treats" the disordered for irrationality ought not simultaneously confer rational motives to the treated.

The reformulated statements are based on the review of literature, the field studies and the epistemiological considerations contained in this work in an attempt to avoid at least some of these confusions. Viewed as a flow of public utility, the provision of mental health services becomes a rational system to be understood by reference to the accepted principles and behavior rules governing the social control of noxious behaviors <u>from the perspective of those erecting and maintaining such systems</u>. The behavior defined as noxious in such a system is of much less interest or importance than the

functional purposes to the social order served in the act of defining. Differential diagnoses reflect the instrumental purposes to be served by such differences rather than differences in "symptom formation" or the similarities in behavior among and between actors from social groups and social classes who become labeled.

Before proceeding to consolidate the propositions of a reformulated statement, it is appropriate to acknowledge the significant influence of three additional perspectives which have contributed to the reformulation. These are Gans' (1972:257-89) statements regarding the positive functions of poverty and inequality, Downs' (1957) deductive model providing an economic theory of democracy, and an emerging methodology for the analysis of community organizational networks. While none of these formulations guided the field research, they have provided post hoc explanations of the community organizational system observed in rural Virginia and of the resistance of these organizations to change.

Gans' listing of the positive functions served by poverty and inequality from the perspective of the dominant social order is reproduced in Table 5.4. The listing is frequently taken to be irony or sarcasm, but it is believed that the functions served in Gans' listing explain both the social system observed and resistance to change encountered on the Eastern Shore. The community mental health movement is self-consciously targeted toward

Table 5.4: Gans' Positive Functions of Poverty and Inequality

Positive Function (As Judged by the Values of the Dominant Group)
1. The existence of poverty ensures that "dirty" work is done.
2. The poor subsidize, directly and indirectly, many activities that benefit affluent people and institutions.
3. Poverty creates jobs for a number of occupations and professions that serve the poor, or shield the rest of society from them.
4. The poor buy goods and services that others do not want and thus prolong the economic usefullness of inferior goods and services.
5. The poor can be identified and punished as alleged or real deviants in order to uphold the legitimacy of dominant norms.
6. The "deserving" poor (disabled or victims of "bad luck") provide the rest of the population with emotional satisfaction; they evoke compassion, pity and charity.
7. The poor offer the affluent vicarious participation in illicit or deviant behavior (uninhibited sexuality, alcoholic or narcotic behavior).
8. Poverty helps to guarantee the status of those who are not poor.
9. The poor assist in the upward mobility of the nonpoor.
10. The poor add to the social viability of noneconomic groups (altruistic, philanthropic, civic and religious organizations).

Table 5.4: Gans' Positive Functions of Poverty and Inequality - Continued

Positive Function (As Judged by the Values of the Dominant Group)
11. The poor perform cultural functions; surplus capital from their labor funds "high" culture.
12. The "low" culture created for or by the poor is often adopted by the affluent.
13. The poor serve as symbolic constituencies and opponents for several political groups.
14. The poor, being powerless, can be made to absorb the economic and political costs of change and growth in American society.
15. The poor play an important role in the political process; because they vote and participate less, the political system is often free to ignore them. This adds to stability of the process for others and results in "centrist" politics.

Source: Gans, Herbert J. "The positive functions of poverty." American Journal of Sociology, 78:275-89. See also: Gans, Herbert J. More Equality, New York: Random House Vintage Books (1974).

the poor and powerless. As the poor and the clientele of community mental health services increasingly become the same population, any amelioration is seen as intrusive or potentially altering access to the poor in the service of Gans' positive functions. While it would be possible to elaborate the importance of these functions it appears redundant to do so. The reader is simply encouraged to consider the findings reported in Chapter IV from Gans' perspective. Expanding the focus from "the poor" to "the poor and those labeled mentally disordered" assists in cementing the imagery. With this substitution Gans' conclusions are remarkably congruent with findings reported here:

> My analysis suggests that the alternatives for poverty are themselves dysfunctional for the affluent population, and it ultimately comes to a conclusion not very different from that of radical sociologists. To wit: that social phenomena which are functional for affluent groups and dysfunctional for poor ones persist; that if the elimination of such phenomena through functional alternatives generates dysfunctions for the affluent, these phenomena will continue to persist; and that phenomena like poverty can be eliminated only when they either become sufficiently dysfunctional for the affluent. . .or when the poor can obtain enough power to change the system of social stratification. (Gans, 1974:120, emphasis in original).

The second major influence on the reformulation presented here emanates from the need to alter the perception of mental health services as a benefit to be distributed equitably to all who want or need it to the more appropriate

classification of community mental health programming as a public utility flow regulated through essentially political processes. Public monies in the community mental health movement infuse a system having as its objective the extension of mental health services; however, this infusion is placed under the control of "community services boards" whose service is at the pleasure of elected officials at the community level, with concurrence by elected and appointed federal and state officials. Public funding represents a scarce resource controlled ultimately by elected officials. While the system of community mental health programming seeks to serve the "irrational" or mentally disordered (who will not in the present formulation be viewed as simultaneously rational in their pursuit of economic or other secondary gain), the system itself may be viewed as purely rational in the microeconomic sense. The powerful deductive model provided by Downs in An Economic Theory of Democracy (1957) is useful for the formulation of statements subject to empirical validation. Downs' central tenet is that elected officials have one goal and one goal only: reelection. Public utility flow is regulated by these officials toward the purpose of winning votes and for no other purpose. Extension or expansion of community mental health services, therefore, is viable only if such expansion or extension wins votes from the electorate. Thus, those seeking to influence elected officials to provide ameliorative services (increase

utility flow) must convince these officials that they represent more votes among the electorate than those seeking to stabilize or decrease the flow of public utility.

The final influence on the reformulation also emanates from the need to alter the focus from the behaviors of actors who come to be labeled mentally disordered or are defined "at risk" to the behavior of dominant sectors of the social order. As observed, the field studies concluded that the single most important obstacle to the extension and expansion of community health services on the Eastern Shore was the community mental health services board of citizens representing "community leadership". The interlocking and interpenetrating nature of directorates of community organizations on the Eastern Shore was documented in Chapter IV; however, the methods employed in the studies did not provide a mechanism for measuring more subtle "webs of affiliation". These became apparent not from analysis of occupational titles and surnames but from careful observation of the latent structure of relationships of directors and staff members with the small group of families who constitute the political, social and economic elite. One reason that the studies continued no further in the analysis of community power structures lay in precisely the set of confusions encountered in applied studies of mental disorder: the theoretical and methodological paradigms that divide the applied field of sociology of mental disorder also divide the field of sociology

of community (Field, 1970; Bernard, 1973; Liebert and Imershein, 1977). The documentation and impressionistic data accumulated in the field studies indicated a need for a template or methodology that would identify and measure not only the direct influences of the elite on the governance of community organizations, but indirect influences and "deep structures" for the transmission and perserveration of the cultural values and ideological orientations of this elite.

The erection of new models that bridge traditional paradigms and provide methodologies for measurement of these indirect influences in the transmission of values and beliefs appears to hold promise. Lincoln (1977:19-50), for example, discusses the potential for synthesis of two classic sociological domains: human ecology and community decision-making. Laumann and Pappi's (1976) extensive studies of "Altneustadt" insert the important contributions of network analysis to understanding social differentiation and integration in community and tracking the influence of elites in community decision making and other collective action. Galaskiewicz (1979:1346-64) traces influence networks in community organizations affecting three domains (money, information and moral support) and maps the interpenetration of these networks in community organizations in a midwestern community. The models and methods employed in the emerging subfield of network analysis of community, community organizations, and community decision-making are

considerably beyond the scope of the present work but appear particularly relevant in their potential for identifying both formal and latent structures that influence decision-making in communities. Network analysis may also have important uses, as yet unexplored, in identifying critical differences between residual deviants who are labeled and those not labeled in terms of their suspension in a support network. These differences may become more cogent measures of "risk" or "need" than the present census variables that have as their common thread of "vulnerability" some aspect of powerlessness. That is, one's position in a social network and the size, shape and nature of that network may mediate predictions of vulnerability or "risk" based solely on one's membership in a social group or social class as measured by census indicators.

The Reformulation: A set of Propositional Statements

With these critiques of contemporary conceptual models and the incorporation of certain *post hoc* contributions (Downs, Gans, Galaskiewicz and others), it is possible to consolidate a set of definitional and propositional statements more explanatory of field study findings than previously available theoretical perspectives and methodological tools. They are set forth with humility but with the important observation that when fully operationalized they may be rejected or fail to be rejected within prestated levels of confidence.

1. Community mental health programming represents a flow of public utility.

2. Insofar as this public utility flow is controlled by elected officials, regulation of the flow will be directed toward one and only one purpose: the reelection of incumbents or other members of his/her political party.

3. The degree to which community mental health services boards are controlled by elected officials is measurable through network analysis.

4. The degree to which community mental health services boards are influenced by other constituencies and ideologies (mental health services industry, "nonpolitical" elites, minority groups and their advocates. "altruistic" organizations and values, etc.) is measurable through network analysis.

5. Community mental health services boards and the elected superordinates to whom board members are accountable respond to requests for expansion or contraction of the flow of public utility under their control based on a rational microeconomic principle: the achievement of maximum votes with minimum cost.

6. Population data and predictions of need for mental health services based on these data will influence extension or expansion of this flow of public utility only insofar as members of "populations at risk" are known or potential voters and their voting behaviors support or can be predicted to support such expansion.

7. To the degree that those who control wealth, land and access to jobs (social differentiation) also control systems of social control (social integration), the dominant criterion for decision-making regarding systems of social control (including mental health systems) will be preservation of the status quo of the influence and control of this elite. It is possible to measure the degree to which control over social differentiation and social integration axes rest in the hands of the same elite.

8. The system of recognition, recruitment to treatment, treatment and disposition of residual deviants as "mentally disordered" is part of the larger system of social control over the

behaviors of subordinate members of the social order by dominant members. Output measures (rates of mental illness, by type and by social correlate) will be significantly associated with output measures of other subsystems (welfare, health, housing, corrections, employment and training).

9. Community organizations mediate between systematic measures of "need" for public utility (human services) as input measures and service provision (rates of treatment, etc.) as output measures. The effects of this mediation are substantial and may be measured by subtracting output measures from input measures.

10. Mediation effects are significantly related to the structure of community organizations. By structure, reference is made to measures of control and influence of these organizations identified in (2) and (3) above.

11. It is possible to measure and compare the structures of community organizations both within and across communities.

12. Measures of the structure of community organizations are more predictive of outcome measures (rates of utility flow) than input data in the form of needs assessments based on population data.

13. Systems of social control--including the mental health subsystem--operate on behavioral principles: desired behavior is elicited and noxious (deviant) behavior extinguished by the systematic application of rewards and punishments. The manipulation of these reinforcement contingencies ranges from "non-treatment" (ignoring the deviant behavior) through reward to punitive expulsion and institutionalization. Treatment (the configuration of the reinforcements) is determined by the exhibited behavior with full consideration of the worth of the deviant actor. Worth is determined by the ability of the deviant actor (or others acting in his behalf) to contribute to the maintenance of the status quo or the extension of the domain of influence of those in decision-making (labeling) authority. The actual or perceived voting behavior of the deviant actor or his surrogate forms a part of the evaluation of worth.

a. deviance on the part of productive members of the laborforce will be ignored until it threatens productivity.

b. deviance on the part of non-productive members, or members without productive potential, will be met with punishment with the objective of extinguishing the behavior or expulsion from the community.

c. deviance on the part of productive members that threatens or potentially threatens productivity will be met with a mix of rewards to elicit desired behavior and mild punishments to extinguish noxious behavior.

d. evaluation of the degree to which behaviors are noxious or dysfunctional (non-productive) will be based on the values of the labelers.

14. Stereotyped imagery of mental disorder, including role-appropriate behaviors (in accordance with membership in social groups or social classes) is learned early in childhood. The stereotypes of role-appropriate deviant behavior are continuously and systematically reaffirmed through social interaction. Labeled deviants are rewarded for role-appropriate stereotyped deviant behavior and punished when attempting to return to conventional roles or adopting role-inappropriate deviant behaviors.

15. The presenting complaints (signs and symptoms) of the deviant actor will be evaluated (diagnosed) with a bias toward "role-appropriate" diagnoses. This means that the same or similar signs or systems will be differentially diagnosed in accordance with the membership of the actor in social groups or social classes that are differentially valued in communities. Since treatment is associated with diagnoses, output measures (rates of outpatient treatment, rates of institutionalization) will covary with social class variables.

These statements could be considerably expanded. When linked they suggest a simple, causal path model or system in which inputs (population data presenting symptoms)

are transformed or mediated by a social structure (community organization) resulting in output measures (rates of treatment or inferred rates of non-treatment). The data supporting the propositions--interspersed throughout this thesis--are drawn from the triangulated study of a single set of rural communities, but an attempt has been made to make the model sufficiently broad to account for processes in other communities. For example, where middle-class, professional community members constitute the bulk of the voting population, it should not be surprising to find that "mild" diagnoses predominate and that treatments are relatively non-punitive or even "rewarding" for the outpatient clients who will predominate in the rates-under-treatment data. Communities with highly differentiated social structures will have this complexity more-or-less reflected in their community organizations (as appointed by elected officials) and demonstrate a range of rates of treatment and diagnoses reflecting the value in which members of diverse social groups and classes are held and the degree to which these groups and classes are represented in the community organizations.

Whatever limited contribution to understanding of the community mental health system result from the systems model and the set of propositions emanate from two fundamental reorientations, as suggested by Blalock's (1979:891-94) Presidential Address. Sociological investigations are frequently marred by flawed conceptualizations and

inappropriate or incomplete measurements. The model suggests that the fundamental image of community mental health be altered from one viewing the system as a set of desireable services to one viewing the system as a means for the social control of deviance, made available as a flow of public utility and regulated by principles governing such flows in democratic societies. Methods proposed include the measurement of mediating (community structural) variables as well as input and output bivariate relationships.

Finally, the model has been suggested by field research sharing in the paradigms that guide sociological endeavor: social fact, social definition and social behavior. Decades ago, Wirth (1947:137-43) in summarizing theories and methods for studying the city--or any social community--proclaimed it impossible totally to separate studies of size and demography from those of social structures and normative structures peculiar to these physical and demographic entities. In the model and propositions proposed to conclude this thesis, an earnest attempt has been made to sketch these relationships and suggest how they are interrelated.

Implications for Social Policy

The thesis began by noting the seductive qualities of models which view ameliorative services as benefits to be distributed on equitable bases to those in need of these services. Federal promulgation of the ideiological

assumptions and practices of community mental health programming with its central tenets of deinstitutionalization and community control is couched in a rhetoric that views communities as somehow more altruistic and benevolent than earlier centralized control. "Deinstitutionalization" in its full sociological meaning is a more complex phenomenon than simply returning patients from state hospitals to the communities from which they were expelled. Community control may be more-or-less benevolent depending on the social and economic structure and functions of communities. Communities left to control the flow of public utility at their disposal may or may not view mental health services as desirable benefits for all their members. Such benefits may decrease the social control of the dominant social order over subordinates. Alternatively, the flow of these public utilities may consolidate the influence of these dominant members if allocated wisely to voting populations. Sociologically, it is hardly surprising or anomalous that community leaders will allocate resources in such fashion as to preserve and extend their own influence and control.

Sociological involvement in policy research concerning mental health programming is quite appropriate and the policy domain is at once challenging and rich in potential. Such involvement must transcend the techniques and strategies of "market research", however, and extend beyond assistance to a bureaucratic elite seeking to

promulgate an ideology.

When stripped of its rhetoric, the community mental health movement becomes truly sociologically fascinating. We are concerned with certain social facts about how and why certain social definitions are invoked (or are not invoked) to explain and control human social behavior. We are concerned with variation in these factual relationships and we seek to understand this variation in accordance with complex patterns of human social organization. We are concerned with attempts to change entire sets of social patterns, to alter systems of social control. We are concerned with the motives for seeking such change and with the motives of resisting these attempts. We are concerned with images of reality and with the manipulation of imagery. We are concerned with the full conceptual meaning of the term "social institution".

We are, in addition, concerned with "whose side we are on", a question which cannot be answered or understood without reference to an understanding of the sociology of sociology. To bring to policy research anything less than the full conceptual power of sociology in its multiple paradigmatic expressions is to rob ourselves and the public of that freedom from oppression that comes only from fully intellectual endeavor and the understandings of the human social condition such endeavor may, if we are diligent, produce.

APPENDIX A

Overviews of Contemporary Epidemiological Studies: The Problem of Social Factism

Reviews of contemporary research into the social epidemiology of mental health display two consistent and significant findings: (1) there is a wide disparity in the nature and strength of the reported relationships between mental disorder and sociodemographic factors; and (2) the causal explanation for this disparity remains relatively obscure (Dunham, 1955; Dohrenwend and Dohrenwend, 1969; Susser, 1972; Korper, 1976; Warheit et al., 1979).

Some obvious reasons for the wide variation in outcomes of field studies attempting to relate mental disorder to sociodemographic factors include the range of methodologies, research designs, and statistical and sampling techniques used in approaching the research questions under investigation. An overview of more than 200 socio-epidemiological studies of mental disorder conducted between 1968 and 1974 (Warheit et al., 1979:148) concludes that technical problems alone make it easy to understand why findings are fragmented and results often at variance.

It is not responsible, however, to attribute inconsistent findings in epidemiological research solely or even primarily to developmental lags in the state-of-the art or in the design and use of research tools. The

technical deficiencies in reported research point to underlying flaws in conceptual frameworks that neither fully identify nor operationalize concepts to be measured. The limitations of extant research related to construct, content and face validity are repeatedly documented as studies are analyzed for their potential generalizability to larger populations and particular uses (Sussman, 1966; Dohrenwend and Dohrenwend, 1969; Gove, 1973; Susser, 1972; Bachrach, 1975).

The proliferating body of literature has been criticized most severely for the manners in which "community", socioeconomic class, and mental disorder are conceptualized (Warheit et al., 1979; Korper, 1976). Considering these flaws in basic conceptualization of the construct to be measured, potential for further error in operationalizing these concepts increases, but this error appears to be both unmeasureable and irrelevant in light of the more basic flaws related to construct validity (Blalock, 1972:13).

Korper (1976:2) in a detailed review of the literature and microanalytic study of community mental health service use in New Haven, highlights the problem that "attempts to develop quantitative indicators (of risk) have often fallen short of adequately reflecting the breadth of the elements embodied in such conceptualization (community and socioeconomic class levels)."

In a separate overview, Dohrenwend and Dohrenwend (1967)

analyzed 45 epidemiological studies that have attempted to count untreated as well as treated cases of mental disorder and find that the rates of disorder in the general population reported in these studies varies from less than one to more than 60 per cent. They find key sociodemographic factors in these varying rates, however, to be age, sex and race.

The relationship between age and mental disorder was established in all but five studies analyzed. Lowest rates were found among the youngest group reported; however, there was no consistent pattern for the older age groupings in which maximum rates were found. Studies examining prevalence of mental disorders based on sex also fail to conform to a consistent pattern. Of 30 studies analyzed, 18 report higher rates for women and 12 report higher rates for men. The differences reported are not great enough to determine a clear trend between the factor of sex and mental disorder. The Dohrenwends also found conflicting evidence in studies comparing rates of mental disorder for blacks and whites. Of eight studies analyzed, four reported higher rates for blacks and four reported higher rates for whites.

The authors found the most consistent results to be obtained when the relationship between "social class" and rates of mental disorder was examined. In 20 of 25 studies reporting findings for this relationship, highest overall rates of disorder were found among the lowest

socioeconomic groups. By contrast, however, the authors found no consistent relationship between rates of the psychoses and social class. Higher rates of psychosis were reported about equally in the lowest stratum and in some stratum other than the lowest. For the neuroses, maximum rates were reported about equally in the lowest socioeconomic stratum and in some stratum other than the lowest.

The overview highlights the continuing methodological problems underlying variation in rates of mental disorder. Problems identified include thoroughness of data collection procedures, conceptualization of "case", and definition of mental disorder (97). After careful consideration of variation in rates of disorder, methodological problems that limit reliability, and variability of both procedures and results in attempts to assess "true" prevalence, the authors stress the need to evaluate the validity of measures of mental disorder. Their analysis proceeds systematically to examine content validity, concurrent and predictive validity, and construct validity to identify methodological problems. Their arguments regarding validity are persuasive. In terms of the first criterion measure they conclude, "it is doubtful whether content validity, in the strictest sense, can be achieved in the measurement of untreated psychological disorder, since there appears to be no universe of items that experts agree on as defining the variable." (100)

With regard to criterion-ordered validity, the

authors conclude:

> Of the two types of criterion-ordered validity, concurrent and predictive (Cronbach and Meehl, 1955), there is no evidence in the field studies for the latter. Typically conducted at one point in time, the studies have thus far not tested their assessment of disorder against criteria of future psychiatric condition, admission to treatment, or social functioning (101).
>
> Criterion-oriented attempts to establish both concurrent and predictive validity, however, face a common problem. Even with more attention, for example, to larger and diagnostically more heterogeneous patient criterion groups, independent criteria of 'wellness' and problems of response style, strong reasons exist not to rely primarily on attempts to establish criterion-oriented validity. Foremost is the fact that there are at present no generally agreed upon criteria of psychological health or disorder (104).

In consideration of canons which demand higher degrees of validity within epidemiological research, Dohrenwend and Dohrenwend (109) underscore the need for development of provable construct validity:

> Analysis of the measures of psychological disorder used in the community studies of 'true prevalence' indicates that none of these investigations have provided convincing evidence of validity. After considering each of the major types of validity for which evidence could have been sought, our position is that, with no generally accepted criteria available and no universe of content agreed upon, construct validity takes on central importance.
>
> It becomes necessary, therefore, to develop a nomological net involving psychological disorder in order to validate this construct.

The most recent published review of the literature

(Warheit et al., 1979) also highlights problems of operational definition and methodological refinement. These problems are especially salient in light of the need for controlling reported relationships between mental disorder and sociodemographic variables for other contaminating variables. Examples include apparent relationships between age, sex, marital status, race and ethnicity and socioeconomic status.

Age and Mental Disorder. -- In analyzing the relationship of age to mental disorder, many studies fail to control for two facts: (1) women tend to live longer than men, and (2) the aged generally have lower incomes than younger persons in prime earning years. It is difficult to estimate the effects of these contaminating variables and others which remain uncontrolled in the reported strong relationships between age and mental disorder.

Sex and Mental Disorder. -- Bivariate analyses of sex and mental disorder report higher rates of psychiatric difficulty among women than men. Many researchers argue, however, that this relationship is a methodological artifact of the willingness of women to report emotional psychological or mental distress. When rates of neuroses and psychoses are separated, there is evidence that females are diagnosed as having higher rates of neurosis. There are no consistent differences in rates of psychosis and sex. Studies combining these two major categories of mental disorder portray a false picture of real incidence.

Aggregation of the data does not permit control to evaluate if gender is the most important factor in the determination of differing rates. Reported relationships between sex and mental disorder are further contaminated by marital status.

Marital Status and Mental Disorder. -- When relationships between sex and mental disorder are controlled for marital status, Gove (1973) concluded that higher rates for females are due to the disproportionately high rates of mental illness among married women. An additional study examined differentials in reported rates of mental disorder according to marital status controlled for race and sex and found wide variation depending upon the application of control variables. In a summary of the effect of marital status on mental illness, Warheit (157-158) reports:

> While our data supports many of the findings reported in the literature, they modify others when controls are made for age, family income, length of time married, length of time widowed, separated or divorced, race and type of symptomotology being analyzed. To state it differently, we found that while there is a demonstrated relationship between various matters, marital status and psychological disorder relationships are not consistent; they vary with other sociodemographic factors and the kind of symptomotology manifested.

Bachrach (1975), in an analytic review of studies of marital status and mental disorder notes that "each of the two concepts embraces areas of conceptual confusion and disagreement which makes it difficult, in a practical

sense, to compare investigations." Summarizing the literature, she notes that "it seems that only a small beginning has been made in the investigation of the relationship between mental disorder and marital status and that the appropriate variables to consider and control in looking at that relationship have not begun to be identified." She calls for "a clearer definition of terms and for the conduct for research within some explicitly outlined theoretical framework, especially in cases where etiological relationships are positive."

Race/Ethnicity and Mental Disorder. -- Warheit's (160) overview reports relationships between race or ethnicity and psychiatric disorder and finds a paucity of research which controls for factors related to socioeconomic class and for variations that result from the trend toward studying only those persons receiving treatment in the public sector. The review reports that when variables of age, race, sex, education, occupation and family income are included within regression equations, blacks continue to demonstrate significantly higher symptom scores than whites. They conclude, however, that "associations between race and psychiatric illnesses are not conclusively established" (168).

Epidemiological field studies that compare mental disorder among various ethnic groups are limited, and study results are influenced by methodological artifacts which limit their value for generalization. Warheit (160)

concludes that the most significant generalization from studies relating ethnicity to mental disorders, when controlled for other variables such as social class, sex and age, is that ethnic differences, in general, follow trends and results for the dominant population.

Socioeconomic Status and Mental Disorder. -- The sociodemographic factor most often associated with a high rate of mental disorder is low socioeconomic status (Dohrenwend and Dohrenwend, 1969; Warheit et al., 1979). This finding occurs throughout the literature, however, the explanation for high rates of mental disorder among the lowest socioeconomic classes is not clear.

A serious methodological flaw is that data analyzed in reported studies frequently include only persons receiving treatment in public facilities. This sampling method discounts from the base for comparison those individuals treated by private physicians in private facilities. This factor biases conclusions due to overreporting of the poor within the sample population. Attempts to correct for this serious methodological defect through cross-sectional field studies including larger groups of treated populations are few but results of these studies nonetheless demonstrate highest overall rates of mental disorder among the lowest socioeconomic classes. Careful examination of the data reveal that disproportionately high rates of schizophrenia and personality disorder contribute to overall higher rates of mental disorder among

the poor. No consistently significant differences in rates of nuerosis for various social classes are apparent (Dohrenwend and Dohrenwend, 1972:37).

Warheit concludes:

1. The non-random distribution of psychosis among the various social classes may be the result of differential diagnosis and labeling. Similar symptom formations may be differently perceived for those in different social classes.

2. The non-random distribution of psychosis may be the result of different numbers and types of life stress events experienced by those in different social classes.

3. The non-random distribution of psychosis among various social classes may be the result of different social class manifestations of psychiatric symptomotology.

4. The non-random distribution of psychosis among the various social classes may be attributed to social consequences resulting from different disorders. Schizophrenia and personality disorders appear to produce greater downward social mobilities than do manic depressive psychosis.

5. The symptoms associated with manic-depressive disorders may be less intense, frequent, severe and debilitating than those associated with schizophrenia and personality disorders, and/or their manifestations may be better tolerated by other members of society. It may also be that certain amounts of manic-depressive behavior is conducive to success in our society since increased activities often lead to greater productivity, and depression is less threatening to others than either schizophrenia or personality disorder.

6. The non-random distribution of mental disorders may be the result of biological selection; those in a low social class may be in that status because

> they are unable to compete with the more genetically endowed members of society.
>
> 7. Most neuroses do not impair social functioning to the point that downward social mobility results. (Warheit, 1979:160-2).

Still other contaminating or confounding variables influencing the rate of reported mental disorder by socio-economic class pertain to place of residence. Since research reported to illustrate the conclusions of this thesis took place in a rural setting, it is important to overview findings of other studies related to urban/rural places of residence and mental disorder.

Rural/Urban Residence and Mental Disorder. -- Dohrenwend and Dohrenwend (1969) analyzed the distribution of mental disorder according to place of residence in a rural/urban continuum reported in nine epidemiological studies. Seven studies indicate higher rates of mental disorder in urban settings. In one study rates of disorder were highest in rural areas, and in another no differences were reported. When disorders are classified according to psychotic and neurotic categories, the rates of psychosis appear higher in rural than in urban areas, with the exception of schizophrenia which appears to be randomly distributed in terms of urban/rural residence.

The Warheit overview (1979:169) concludes:

> There is little scientific evidence to demonstrate that one's place of residence is a reliable predictive mental health factor. Neuroses have usually been reported more often for urban than rural populations,

> where the psychoses have been reported for those from rural areas. Sociodemographic factors, rather than place of residence, reflect more accurately the probability that persons or groups will have high or low rates of mental problems.

A still more recent overview of mental disorder in rural America (Flax, et al., 1979:20) was published after our field investigations were completed. With regard to epidemiology, this overview of 363 research studies concludes "statements about the prevalence of mental disorder in rural areas and rural/urban mental health comparisons, like most statements in psychiatric epidemiology must be made with a good deal of caution." Rates of disorder in rural study sites range from a low of 1.7 per cent to a high of 64 per cent. The authors conclude that it is impossible to maintain that these interstudy differences are the result of true differences in the prevalence of mental disorder. It is more likely that the discrepancies are due to differences in definition of a case and of sampling.

The overview is distinguished by its discussion of overall demographic trends in rural areas, by its sensitive delineation of differences between and among rural communities, by its discussion of rural values and rural culture, and by its recognition of the system barriers to the delivery and acceptance of mental health services in rural areas. These factors, beyond shared characteristics of age, race, sex and income are believed to contribute significantly to such differences as may exist between

rural and urban distributions of treated and untreated mental disorder.

With regard to demography, rural areas differ markedly in population structure, composition and distribution from urban areas. Population structure, the distribution of the population by age and sex, is of particular importance in terms of dependency ratios and the effects of these ratios. The overall dependency ratio in the United States was 78 in 1970. Rural areas, by contrast, had a dependency ratio of 88, or nearly one dependent person for every person in the productive age group. Out-migration accounts for other significant features in the population structure, and for rural areas out-migration has been a selective process. Those who leave the area are likely to be young and better educated, thus increasing dependency ratios. Results of this process include an increase in the proportion of those left behind in need of support services and, simultaneously fewer income-producing, tax-paying adults left behind to absorb the costs of supporting the dependent population. Ratcliffe (1942) has observed "the smaller the town, the greater the likelihood that it will become still smaller."

In terms of population composition, spatial isolation (particularly of minority groups) and poverty are among notable differences between rural and urban populations. A greater proportion of both the working and non-working poor is located in rural America as is the

proportion of groups of people vulnerable to poverty (families with young children, families headed by an older person, families headed by a disabled person, and older and disabled people living along. With respect to population distribution, low population density and spatial isolation in rural areas make it difficult to distribute public services.

These demographic "deficiencies" in rural life are complicated further by differences in values and culture. Despite the fact that rural America is an exceedingly heterogeneous entity, Flax and others argue that, on the broadest possible level, rural values tend to emphasize certain themes: man's subjugation to nature; fatalism; an orientation to concrete places and things; a view of human nature as basically evil; a view of human activity as being, not doing; and of human relationships as having their basis in personal and kinship ties. This represents an emphasis on primary, as opposed to secondary relationships. (9)

Reynolds, Banks and Murphee (1976) suggest that normative features of rural areas include a rigid social structure that tends to minimize and retard the introduction of new ideas and change. Rural areas are also ones in which the church represents the focal point of social activity. Rogers and Burdge (1972:398-399) delineate five values characteristic of the rural poor, in general, which are particularly relevant for rural blacks in the south. These

are: individualism, traditionalism, familism, fatalism, and person-centered relationships. These values, they note, are also characteristic of peasants in underdeveloped areas.

Hassinger (1976) suggests that rural life is characterized by spatial isolation, poverty, an agriculture-oriented way of life, and certain types of community organization. An important correlate of rural values is the nature of rural communities and social organization. Rural communities tend to be trade-centers, small in area and population unspecialized and relatively homogeneous from community to community. The normative consequences of this structural type of social organization are many and, according to Hassinger, include selection of public officials primarily on the basis of personal characteristics and family background rather than according to substantive issue, personal competence or expertise. Incumbents in leadership positions are selected and constrained to serve as living exemplars of community norms and values.

An additional structural feature of rural society which influences rural values is "community poverty" (Ford, 1969:168). This institutional poverty retards the adequate functioning of government, school systems, and systems of health and social services. Rural Americans cling to the fundamental belief that public institutions can and should be run by ordinary citizens with a minimum of technical qualifications, often as a part-time adjunct

to their main occupation. The belief that public institutions should perform only those functions that individuals and families cannot perform for themselves is also pervasive.

The serious problems created by institutional poverty affecting rural community organization and social change have been identified by a number of authors (Levitan, 1969; National Advisory Board on Rural Poverty, 1976; Zeller and Miller, 1968). The distinct social structural problems of rural areas and the probability of differing values from the larger urban populations point to the need for specific conceptualization of community as a mediating variable in the discussion of social epidemiology and mental disorder. This is a critical point, clearly demonstrated by our field research.

Summary of Relationships of Sociodemographic and Mental Disorder. -- Social-epidemiological studies of mental disorder in general have focused on cases that come under treatment. The development of indicators of mental health need and demand usually have resulted from studies which have examined treated populations. It is important to consider the need to expand the concept of these indicators beyond the incidence/prevalence stage. It is also important to consider whether rates under treatment in the public sector represent generalizable findings or constitute a special case biased toward the poor, minorities, and the powerless.

The use of aggregate and/or global properties as

explanatory variables rather than unit level variables (such as individual daily utilization or visitation of service facilities) leads to exploration of the methodological problems. Researchers have identified limitations in the former type of analysis, especially with regard to the problem of "ecological fallacy" in which it is inferred that "a correlation between variables derived from the attributes of ecological units will also hold between variables derived from the attributes of individual units."

These problems that have been described in contemporary research and social epidemiology are fundamentally problems of measurement and conceptualization. The measurement problem begins with the inability to reach consensus on key concepts of mental health or mental illness, community and the meaning of socioeconomic and sociodemographic status. Methodologically, lack of clarity regarding these concepts is further complicated when these concepts are placed into theoretical constructs. These constructs attempt to establish predictive and/or causal relationships between unclearly operationalized concepts. In operationalizing theoretical constructs into indicators, problems repeatedly noted include the inability to establish a nosology of mental disorder, inability to control for significant variables that may be antecedent or intervening and to control for interactive effects of these variables that can be measured. These problems become

still further compounded by inadequate sampling techniques. Sampling error, however, is a property which in itself can be measured and results tempered appropriately. The fundamental problem of measurement remains.

A measure is a number assigned to an object or an event according to rules (Stevens, 1951). Although there is an attempt to simplify definition by stating that it is object or events that are measured, in actuality it is characteristics or properties of the object or event which are measured. In fact, most often "we actually measure indicants of the properties of objects" (Kerlinger, 1964). An indicant (more often referred to as an indicator) is commonly defined as an observable phenomenon that is substituted for a less observable phenomenon, or for a phenomenon that cannot be directly observed. If the researcher is attempting to isolate observable phenomenon, the measurement procedure needs to ensure that properties being measured are the most significant, and that the relationship between objects and the events are adequately controlled so as to determine the nature of that relationship rather than simply providing a statement of covariance between properties.

The ultimate question to be asked of any measurement procedure is: "Is the measurement procedure isomorphic to reality?" (Kerlinger, 1964:417). Isomorphism means a one-to-one correspondence between two mathematical aggregates. It means being identical with or closely similar

to something else in form and structure. It means a valid reflection of the object or events.

The major problems in evaluating the current research into social epidemiology are defined in the stated limitations of the researchers themselves: access to adequate data, lack of consensus on key concepts, incompatible models that reduce opportunities for replication, conflicting indicators of phenomena, and inconsistent outcomes when differing indicators/properties of the same object or event are included in the measurement. Ultimately, the critical problem for the reviewer of the research is that it is unknown to what degree the measurements and their procedures are isomorphic to reality. The establishment of construct validity through replicable studies is necessary for the determination of both validity and reliability. Finally, when validity is uncertain, we cannot predict, we can only describe, and these descriptions will change as the measurement of the characteristics of the properties or events change. The utility of <u>description</u> to meet the programmatic needs of the community mental health movement is questionable.

Measurement, as earlier defined, is the assignment of numbers to objects and events according to rules. These rules are determined by the level of measurement and involve the basic procedures of classification and enumeration. Classification involves defining the objects or events being measured in terms of certain properties. In

the studies reviewed, people were described in terms of age, race, sex, socioeconomic status (further defined as income, education and occupation), place of residence (further defined as a community of a particular size or with particular values), and their mental health or illness. These properties of people, after classification, were enumerated and the numbers placed in mathematical formulae that established relationships. Even though covariance often was established, the problem in attempting to determine whether the measurements are isomorphic remains. Address of this problem is demanded by the fact that the characteristics of the individual are changed by taking away or redefining aspects of his membership in a universe or a collectivity under study. It is not possible to determine the value of knowing a member's age without understanding the effect of <u>not</u> knowing race, or sex, or values the member holds (or values held by the community) about health and illness. The problems of "disembodied" measurement lead to notions of disembodied membership. There is, in reality, no such thing.

Bauer (1966), nearly a decade before the promulgation of the Mental Health Demographic Profile System as a collection of social indicators predictive of mental health/illness, cites the following deficiencies in systems of social indicators: (1) invalidity, (2) inaccuracy, (3) conflicting indicators, (4) lack of data, (5) incompatible models, (6) lack of value consensus. With few

exceptions, the social-epidemiological studies conducted throughout this century and used as the basis to legitimate the Mental Health Demographic Profile System embody the deficiencies noted by Bauer.

APPENDIX B

	Total Population	Males in Households	Females in Households	Population in Group Quarters	Population White	Population Black
ACCOMACK COUNTY						
Area Statistic	29004	13709	14987	308	18101	10839
Base Population	-	-	-	-	-	-
Atlantic						
Area Statistic	6464	3109	3285	70	3615	2843
Base Population	-	-	-	-	-	-
Lee						
Area Statistic	8102	3820	4179	103	5111	2966
Base Population	-	-	-	-	-	-
Metompkin						
Area Statistic	5573	2575	2896	102	3421	2134
Base Population	-	-	-	-	-	-
Pungoteague						
Area Statistic	5607	2599	2975	33	2745	2853
Base Population	-	-	-	-	-	-
The Islands						
Area Statistic	3258	1606	1652	0	3209	43
Base Population	-	-	-	-	-	-
NORTHAMPTON COUNTY						
Area Statistic	14442	6745	7577	120	6835	7555
Base Population	-	-	-	-	-	-
Capeville						
Area Statistic	5932	2705	3144	83	3020	2900
Base Population	-	-	-	-	-	-
Eastville						
Area Statistic	3180	1553	1614	13	1157	2016
Base Population	-	-	-	-	-	-
Franktown						
Area Statistic	5330	2487	2819	24	2658	2639
Base Population	-	-	-	-	-	-

	Median Income Fam. & Unrel. Ind.	Percent Families in Poverty	Males in Low Status Occupations	Males in High Status Occupations	Median School Years Completed
ACCOMACK COUNTY					
Area Statistic	$ 4444	24.7	48.0	19.4	9.5
Base Population	10223	7686	6434	6434	17337
Atlantic					
Area Statistic	$ 5022	18.1	50.0	18.0	9.5
Base Population	2141	1625	1504	1504	3594
Lee					
Area Statistic	$ 4506	25.0	48.0	23.0	9.7
Base Population	2888	2192	1780	1780	4991
Metompkin					
Area Statistic	$ 4187	27.9	49.7	13.5	9.0
Base Population	1985	1473	1226	1226	3391
Pungoteague					
Area Statistic	$ 3437	35.8	56.6	13.4	9.5
Base Population	1931	1396	1103	1103	3239
The Islands					
Area Statistic	$ 5241	14.4	30.7	31.2	9.9
Base Population	1278	1000	821	821	2122
NORTHAMPTON COUNTY					
Area Statistic	$ 3755	32.0	56.8	15.0	9.2
Base Population	5050	3563	3130	3130	8348
Capeville					
Area Statistic	$ 3718	31.5	56.6	16.9	9.6
Base Population	2118	1432	1197	1197	3423
Eastville					
Area Statistic	$ 3426	41.0	64.2	9.7	8.0
Base Population	1055	773	713	713	1839
Franktown					
Area Statistic	$ 3956	27.4	52.6	16.2	9.5
Base Population	1877	1358	1220	1220	3086
Median All Rural Counties	$ 5659	17.3	41.3	16.5	10.6

	Percent Household Black	Percent Household Other Nonwt.	Percent Household Husb/Wife	Median Age Household Head	Youth Dependency Ratio	Aged Dependency Ratio
ACCOMACK COUNTY						
Area Statistic	37.7	0.2	64.9	54.4	61.4	28.4
Base Population	28696	28696	9713	9713	15119	15119
Atlantic						
Area Statistic	44.4	0.1	67.5	51.8	68.2	23.5
Base Population	6394	6394	2035	2035	3335	3335
Lee						
Area Statistic	37.1	0.3	65.1	55.6	60.5	31.6
Base Population	7999	7999	2747	2747	4164	4164
Metompkin						
Area Statistic	38.8	0.3	61.8	55.0	59.9	29.8
Base Population	5471	5471	1885	1885	2885	2885
Pungoteague						
Area Statistic	51.1	0.2	61.6	55.3	67.9	29.0
Base Population	5574	5574	1799	1799	2832	2832
The Islands						
Area Statistic	1.3	0.2	69.6	53.8	44.0	27.2
Base Population	3258	3258	1247	1247	1903	1903
NORTHAMPTON COUNTY						
Area Statistic	52.3	0.4	60.2	54.7	68.3	28.3
Base Population	14322	14322	4680	4680	7284	7284
Capeville						
Area Statistic	49.0	0.2	58.4	54.8	68.9	29.2
Base Population	5849	5849	1913	1913	2952	2952
Eastville						
Area Statistic	63.3	0.2	60.2	55.6	68.1	30.2
Base Population	3167	3167	1014	1014	1597	1597
Franktown						
Area Statistic	49.5	0.6	62.1	54.2	67.8	26.3
Base Population	5306	5306	1753	1753	2735	2735
Median All Rural Counties	2.2	0.2	72.7	52.1	67.7	23.0

	Pct. Yr-Round Housing Single Detached	Pct. Yr-Round Housing in High Rises	Persons in Overcrowded Housing	Occupied Housing Units Standard	Percent Population Recent Movers
ACCOMACK COUNTY					
Area Statistic	90.9	0.0	22.7	64.1	16.7
Base Population	11409	11421	28696	9713	29004
Atlantic					
Area Statistic	89.3	0.0	27.3	58.8	14.6
Base Population	2326	2315	6394	2035	6464
Lee					
Area Statistic	91.3	0.0	19.7	68.1	15.6
Base Population	3211	3208	7999	2747	8102
Metompkin					
Area Statistic	90.3	0.0	21.6	56.7	18.4
Base Population	2218	2197	5471	1885	5573
Pungoteague					
Area Statistic	93.6	0.0	29.4	55.6	17.5
Base Population	2127	2172	5574	1799	5607
The Islands					
Area Statistic	89.5	0.0	11.1	87.7	19.6
Base Population	1527	1529	3258	1247	3258
NORTHAMPTON COUNTY					
Area Statistic	88.4	0.0	27.2	59.7	15.3
Base Population	5468	5383	14322	4680	14442
Capeville					
Area Statistic	81.9	0.0	26.7	63.1	14.5
Base Population	2273	2268	5849	1913	5932
Eastville					
Area Statistic	92.0	0.0	28.6	52.9	15.2
Base Population	1215	1155	3167	1014	3180
Franktown					
Area Statistic	93.5	0.0	27.0	60.0	16.3
Base Population	1980	1960	5306	1753	5330
Median All Rural Counties	88.2		19.5	84.6	20.3

	Median Income Families White	Median Income Families Black	Median Income Individuals Total	Median Income Individuals White	Median Income Individuals Black
ACCOMACK COUNTY					
Area Statistic	6736.0	4015.0	1502.0	1518.0	1459.0
Base Population	5401	2285	2537	1660	837
Atlantic					
Area Statistic	7649.0	4730.0	1648.0	1259.0	2446.0
Base Population	1065	560	516	325	191
Lee					
Area Statistic	7383.0	3827.0	1606.0	1423.0	2037.0
Base Population	1517	675	690	474	211
Metompkin					
Area Statistic	5951.0	4544.0	1241.0	1422.0	1048.0
Base Population	992	481	512	340	172
Pungoteague					
Area Statistic	5885.0	3021.0	1303.0	1636.0	933.0
Base Population	840	556	535	254	252
The Islands					
Area Statistic	6125.0	812.0	1900.0	1991.0	786.0
Base Population	987	13	278	267	11
NORTHAMPTON COUNTY					
Area Statistic	5996.0	3633.0	1735.0	2171.0	1457.0
Base Population	2027	1536	1487	692	773
Capeville					
Area Statistic	5467.0	3846.0	1799.0	2009.0	1657.0
Base Population	846	586	686	325	361
Eastville					
Area Statistic	6086.0	3059.0	1707.0	2286.0	1192.0
Base Population	350	423	282	112	170
Franktown					
Area Statistic	7250.0	3715.0	1656.0	2345.0	1200.0
Base Population	831	527	519	255	242
Median All Rural Counties	7244	4231	1690	1767	1214

	Families in Poverty White	Families in Poverty Black	Population in Poverty Total	Population in Poverty White	Population in Poverty Black	Upper Quartile Family Income
ACCOMACK COUNTY						
Area Statistic	16.6	43.9	30.5	19.7	48.3	8972.0
Base Population	5401	2285	28727	17872	10815	7686
Atlantic						
Area Statistic	10.7	32.1	23.1	15.4	32.8	9622.0
Base Population	1065	560	6395	3565	2830	1625
Lee						
Area Statistic	16.3	44.6	31.9	19.3	53.0	9814.0
Base Population	1517	675	8013	5044	2958	2192
Metompkin						
Area Statistic	25.2	33.5	30.8	26.8	37.1	8408.0
Base Population	992	481	5482	3365	2117	1473
Pungoteague						
Area Statistic	18.2	62.4	44.7	22.1	66.0	7506.0
Base Population	840	556	5579	2697	2853	1396
The Islands						
Area Statistic	13.3	100.0	17.0	15.4	100.0	9694.0
Base Population	987	13	3258	3201	57	1000
NORTHAMPTON COUNTY						
Area Statistic	17.2	51.6	41.2	22.7	57.9	7664.0
Base Population	2027	1536	14343	6814	7503	3563
Capeville						
Area Statistic	18.0	51.0	43.1	23.5	63.5	7148.0
Base Population	846	586	5855	2984	2867	1432
Eastville						
Area Statistic	21.7	57.0	46.4	23.9	59.4	6790.0
Base Population	350	423	3174	1164	2010	773
Franktown						
Area Statistic	14.4	47.8	36.1	21.2	50.8	8713.0
Base Population	831	527	5314	2666	2626	1358
Median All Rural Counties	14.9	10.7	21.0	17.7	46.9	10,369

	Median House Value Non-Black	Median House Value Black	Median Rent Non-Black	Median Rent Black
ACCOMACK COUNTY				
Area Statistic	7445.0	4920.0	39.0	17.6
Base Population	4243	1234	1039	862
Atlantic				
Area Statistic	6090.0	5027.0	55.0	18.1
Base Population	780	350	227	154
Lee				
Area Statistic	9554.0	5665.0	36.0	18.4
Base Population	1201	375	302	285
Metompkin				
Area Statistic	6720.0	4890.0	29.0	16.5
Base Population	761	178	188	258
Pungoteague				
Area Statistic	6789.0	4251.0	29.0	17.4
Base Population	643	318	135	162
The Islands				
Area Statistic	8002.0	3750.0	59.0	*
Base Population	863	12	190	
NORTHAMPTON COUNTY				
Area Statistic	9854.0	5405.0	43.0	18.3
Base Population	1332	809	596	704
Capeville				
Area Statistic	8825.0	5632.0	45.0	20.3
Base Population	508	311	308	312
Eastville				
Area Statistic	11683.0	5342.0	45.0	17.0
Base Population	167	256	90	112
Franktown				
Area Statistic	10324.0	5094.0	40.0	17.1
Base Population	658	241	198	280
Median All Rural Counties	9946	5625	52.0	27.6

* suppressed: too few cases

	Pct. Civilian Labor Force Unemployed Total	Pct. Civilian Labor Force Unemployed White	Pct. Civilian Labor Force Unemployed Black	Pct. Male Labor Force Underemployed Total	Pct. Male Labor Force Underemployed White	Pct. Male Labor Force Underemployed Black
ACCOMACK COUNTY						
Area Statistic	6.3	4.7	8.8	16.1	13.5	21.6
Base Population	11220	7037	4157	5572	3808	1751
Atlantic						
Area Statistic	6.4	4.3	9.1	14.4	10.9	20.6
Base Population	2638	1476	1162	1283	811	472
Lee						
Area Statistic	4.9	6.3	2.5	14.8	13.6	17.8
Base Population	3146	1971	1164	1530	1039	484
Metompkin						
Area Statistic	5.1	4.0	7.0	12.0	11.3	13.2
Base Population	2243	1400	843	1020	665	355
Pungoteague						
Area Statistic	11.9	6.0	17.5	26.4	20.2	33.6
Base Population	2042	1057	970	1021	575	440
The Islands						
Area Statistic	2.3	2.3	0.0	13.1	13.1	.0
Base Population	1151	1133	18	718	718	0
NORTHAMPTON COUNTY						
Area Statistic	12.4	4.7	19.7	17.4	11.3	24.0
Base Population	5924	2898	3026	2766	1455	1311
Capeville						
Area Statistic	14.7	4.5	25.2	18.8	13.6	25.3
Base Population	2308	1171	1137	1146	640	506
Eastville						
Area Statistic	14.1	0.9	21.2	15.5	5.8	21.9
Base Population	1313	459	854	608	242	366
Franktown						
Area Statistic	9.0	6.2	12.5	16.9	11.2	24.4
Base Population	2303	1268	1035	1012	573	439
Median All Rural Counties	4.2	3.7	5.5	10.7	9.8	15.8

	Pct. Total Women in Labor Force	Pct. White Women in Labor Force	Pct. Black Women in Labor Force	White Males in Low Status Occupations	White Males In High Status Occupations	Black Males In Low Status Occupations	Black Males In High Status Occupations
ACCOMACK COUNTY							
Area Statistic	40.2	33.7	53.8	32.6	27.4	78.9	3.5
Base Population	11184	7571	3595	4292	4292	2135	2135
Atlantic							
Area Statistic	46.7	35.4	65.2	32.0	27.7	79.9	1.9
Base Population	2290	1425	865	938	938	566	566
Lee							
Area Statistic	39.7	33.0	53.7	30.6	31.9	80.8	6.1
Base Population	3210	2188	1018	1165	1165	608	608
Metompkin							
Area Statistic	44.2	41.3	49.9	34.2	19.5	74.9	3.9
Base Population	2240	1498	742	760	760	466	466
Pungoteague							
Area Statistic	40.6	35.5	46.5	38.6	22.7	79.0	1.8
Base Population	2118	1162	942	612	612	491	491
The Islands							
Area Statistic	23.2	22.6	50.0	30.4	31.3	100.0	0.0
Base Population	1326	1298	28	817	817	4	4
NORTHAMPTON COUNTY							
Area Statistic	47.9	39.5	57.7	36.0	25.0	82.3	2.6
Base Population	5454	2852	2576	1726	1726	1404	1404
Capeville							
Area Statistic	45.2	37.7	54.5	37.1	27.2	83.1	2.9
Base Population	2273	1244	1025	688	688	509	509
Eastville							
Area Statistic	48.0	27.3	62.8	38.5	18.2	85.8	2.6
Base Population	1172	491	681	325	325	388	388
Franktown							
Area Statistic	50.9	46.9	57.4	33.9	26.1	78.9	2.4
Base Population	2009	1117	870	713	713	507	507
Median All Rural Counties	34.9	35.0	40.5	37.7	17.8	75.6	3.6

	Pct. Women In Low Status Occupations	White Women In Low Status Occupations	White Women In Mid Status Occupations	Black Women In Low Status Occupations	Black Women In Mid Status Occupations
ACCOMACK COUNTY					
Area Statistic	61.6	44.0	39.6	87.0	5.7
Base Population	4079	2412	2412	1658	1658
Atlantic					
Area Statistic	72.8	53.4	30.4	91.6	4.5
Base Population	964	474	474	490	490
Lee					
Area Statistic	57.1	35.3	46.0	85.0	5.3
Base Population	1213	682	682	527	527
Metompkin					
Area Statistic	58.2	44.3	41.6	83.6	7.2
Base Population	902	584	584	318	318
Pungoteague					
Area Statistic	60.8	40.1	41.6	85.8	6.8
Base Population	696	382	382	309	309
The Islands					
Area Statistic	55.6	53.4	32.4	100.0	0.0
Base Population	304	290	290	14	14
NORTHAMPTON COUNTY					
Area Statistic	59.9	32.1	40.8	87.9	4.2
Base Population	2061	1036	1036	1025	1025
Capeville					
Area Statistic	57.8	36.7	42.8	84.5	2.3
Base Population	771	430	430	341	341
Eastville					
Area Statistic	69.6	30.0	43.1	87.7	2.8
Base Population	415	130	130	285	285
Franktown					
Area Statistic	57.0	28.6	38.4	91.0	6.8
Base Population	875	476	476	399	399
Median All Rural Counties	47.3	44.2	35.5	63.3	6.2

	Median School Yrs. Completed White	Median School Yrs. Completed Black	Total Pct. 8 Yrs./Less Education	White Pct. 8 Yrs./Less Education	Black Pct. 8 Yrs./Less Education
ACCOMACK COUNTY					
Area Statistic	10.7	7.0	46.3	34.9	72.8
Base Population	12089	5212	17337	12089	5212
Atlantic					
Area Statistic	11.3	7.3	46.9	34.2	69.5
Base Population	2304	1290	3594	2304	1290
Lee					
Area Statistic	11.0	7.0	44.6	32.0	73.7
Base Population	3456	1524	4991	3456	1524
Metompkin					
Area Statistic	10.2	6.2	50.0	36.9	79.0
Base Population	2336	1055	3391	2336	1055
Pungoteague					
Area Statistic	11.2	7.1	45.7	28.7	69.8
Base Population	1896	1318	3239	1896	1318
The Islands					
Area Statistic	9.9	8.1	44.3	44.0	76.0
Base Population	2097	25	2122	2097	25
NORTHAMPTON COUNTY					
Area Statistic	11.8	7.0	48.9	27.0	75.1
Base Population	4553	3769	8348	4553	3769
Capeville					
Area Statistic	12.0	7.2	46.4	28.6	70.7
Base Population	1967	1452	3423	1967	1452
Eastville					
Area Statistic	10.9	7.1	57.2	31.3	76.5
Base Population	788	1051	1839	788	1051
Franktown					
Area Statistic	11.8	6.5	46.7	23.3	79.0
Base Population	1798	1266	3086	1798	1266
Median All Rural Counties	11.1	8.2	39.7	35.4	43.3

	White 18 + Completed High School	Black 18 + Completed High School	White 18-24 Completed High School	Black 18-24 Completed High School	Pct. Over 24 at Least 4 Years College
ACCOMACK COUNTY					
Area Statistic	40.6	14.7	54.2	33.1	4.6
Base Population	13510	6127	1421	915	17337
Atlantic					
Area Statistic	47.2	16.4	63.7	34.7	5.3
Base Population	2635	1561	331	271	3594
Lee					
Area Statistic	42.1	18.0	49.4	48.6	6.8
Base Population	3786	1740	330	216	4991
Metompkin					
Area Statistic	31.1	12.0	49.2	33.7	2.7
Base Population	2598	1242	262	187	3391
Pungoteague					
Area Statistic	44.3	12.0	61.4	22.7	3.6
Base Population	2080	1547	184	229	3239
The Islands					
Area Statistic	39.7	29.7	61.5	41.7	2.7
Base Population	2411	37	314	12	2122
NORTHAMPTON COUNTY					
Area Statistic	49.6	16.9	63.7	46.0	5.4
Base Population	5052	4317	499	548	8348
Capeville					
Area Statistic	53.8	21.6	75.4	63.7	4.2
Base Population	2227	1642	260	190	3423
Eastville					
Area Statistic	42.3	14.1	65.9	21.2	4.8
Base Population	873	1202	85	151	1839
Franktown					
Area Statistic	49.3	15.2	58.4	56.0	7.0
Base Population	1952	1473	154	207	3086
Median All Rural Counties	46.4	23.1	60.1	43.4	5.5

	Median Household Size	Median Size With Only One Person	Median Size With 6 or More Persons	Children Living With Both Parents	Sex Ratio	Fertility Ratio
ACCOMACK COUNTY						
Area Statistic	2.4	20.4	9.7	69.2	91.5	402.1
Base Population	9713	9713	9713	9281	14987	5232
Atlantic						
Area Statistic	2.6	18.1	11.3	71.2	94.6	442.7
Base Population	2035	2035	2035	2276	3285	1231
Lee						
Area Statistic	2.4	20.3	8.8	69.8	91.4	378.0
Base Population	2747	2747	2747	2519	4179	1410
Metompkin						
Area Statistic	2.4	22.1	10.5	71.0	88.9	398.4
Base Population	1885	1885	1885	1727	2896	1004
Pungoteague						
Area Statistic	2.4	21.3	12.2	59.8	87.4	406.7
Base Population	1799	1799	1799	1922	2975	1008
The Islands						
Area Statistic	2.3	20.5	4.5	79.6	97.2	373.1
Base Population	1247	1247	1247	837	1652	579
NORTHAMPTON COUNTY						
Area Statistic	2.4	21.5	12.1	63.2	89.0	397.8
Base Population	4680	4680	4680	4976	7577	2592
Capeville						
Area Statistic	2.4	22.5	11.7	64.9	86.0	371.7
Base Population	1913	1913	1913	2035	3144	1060
Eastville						
Area Statistic	2.4	19.4	13.4	56.4	96.2	373.2
Base Population	1014	1014	1014	1088	1614	560
Franktown						
Area Statistic	2.4	21.6	11.6	65.4	88.2	440.3
Base Population	1753	1753	1753	1853	2819	972
Median All Rural Counties	2.6	16.7	11.1	85.0	96.5	439.7

	Pct. White Husb/Wife Households	Pct. Black Husb/Wife Households	Median Age Household Head White	Median Age Household Head Black	White Youth Dependency Ratio	Black Youth Dependency Ratio
ACCOMACK COUNTY						
Area Statistic	68.8	55.9	55.4	52.1	45.5	92.7
Base Population	6845	2837	6845	2837	10021	5067
Atlantic						
Area Statistic	70.7	61.4	53.4	49.0	48.4	98.6
Base Population	1343	690	1343	690	2009	1321
Lee						
Area Statistic	68.9	57.0	56.4	53.8	46.0	89.6
Base Population	1912	821	1912	821	2774	1379
Metompkin						
Area Statistic	66.2	52.0	56.4	52.3	46.2	83.8
Base Population	1300	579	1300	579	1833	1043
Pungoteague						
Area Statistic	67.8	53.1	57.1	52.8	42.4	97.9
Base Population	1065	727	1065	727	1524	1303
The Islands						
Area Statistic	70.2	35.0	53.6	62.8	43.8	52.4
Base Population	1225	20	1225	20	1881	21
NORTHAMPTON COUNTY						
Area Statistic	67.2	51.9	55.9	53.4	47.3	90.9
Base Population	2594	2057	2594	2057	3744	3512
Capeville						
Area Statistic	65.1	49.1	56.0	53.5	51.1	89.9
Base Population	1110	799	1110	799	1592	1353
Eastville						
Area Statistic	66.5	55.1	56.9	54.7	41.3	86.5
Base Population	457	555	457	555	644	948
Franktown						
Area Statistic	69.8	52.5	55.4	52.2	45.9	95.4
Base Population	1027	703	1027	703	1508	1211
Median All Rural Counties	74.0	56.2	52.1	52.5	63.6	92.7

	Persons In Group Quarters	Inmates Of Institutions	Percent In Mental Hospitals	Percent In Noninstitutional Group Quarters	House Head Primary Individual	Persons In House Unrelated to Head	Pct. Males Never Married
ACCOMACK COUNTY							
Area Statistic	1.1			0.5	21.7	1.6	9.9
Base Population	29004			29004	9713	28696	7949
Atlantic							
Area Statistic	1.1			1.0	18.9	1.2	9.9
Base Population	6464			6464	2035	6394	1700
Lee							
Area Statistic	1.3			0.4	21.3	1.3	9.7
Base Population	8102			8102	2747	7999	2242
Metompkin							
Area Statistic	1.8			0.4	24.1	2.2	10.3
Base Population	5573			5573	1885	5471	1533
Pungoteague							
Area Statistic	0.6			0.3	23.1	1.8	11.6
Base Population	5607			5607	1799	5574	1464
The Islands							
Area Statistic	0.0			0.0	21.7	1.4	6.7
Base Population	3258			3258	1247	3258	1010
NORTHAMPTON COUNTY							
Area Statistic	0.8			0.5	23.8	2.4	11.7
Base Population	14442			14442	4680	14322	3808
Capeville							
Area Statistic	1.4			1.0	25.6	2.7	11.5
Base Population	5932			5932	1913	5849	1552
Eastville							
Area Statistic	0.4			0.0	20.5	2.5	14.3
Base Population	3180			3180	1014	3167	861
Franktown							
Area Statistic	0.5			0.3	23.6	2.1	10.3
Base Population	5330			5330	1753	5306	1395
Median All Rural Counties	1.2			0.2	17.9	0.9	8.3

Numbers of institutional inmates not sufficient for areal differentiation.

Numbers of mental patients not sufficient for areal differentiation.

	White Aged Dependency Ratio	Black Aged Dependency Ratio	Families W/ Own Children Under 18	Families Childbearing Only	Families Childbearing & Rearing	Families Childrearing Only	Older Couples Childrearing Completed
ACCOMACK COUNTY							
Area Statistic	32.2	20.7	44.3	8.9	10.5	24.9	46.2
Base Population	10021	5067	7604	7604	7604	7604	6301
Atlantic							
Area Statistic	28.1	16.6	48.5	10.2	12.5	25.7	40.1
Base Population	2009	1321	1651	1651	1651	1651	1374
Lee							
Area Statistic	34.6	25.3	43.2	8.0	9.2	26.0	46.8
Base Population	2774	1379	2162	2162	2162	2162	1787
Metompkin							
Area Statistic	35.7	19.5	44.9	8.3	11.9	24.6	46.4
Base Population	1833	1043	1431	1431	1431	1431	1164
Pungoteague							
Area Statistic	36.0	20.6	42.9	7.2	10.5	25.2	49.5
Base Population	1524	1303	1383	1383	1383	1383	1108
The Islands							
Area Statistic	26.8	52.4	40.9	11.6	8.1	21.3	50.0
Base Population	1881	21	977	977	977	977	868
NORTHAMPTON COUNTY							
Area Statistic	33.7	22.6	45.3	7.1	10.8	27.4	45.9
Base Population	3744	3512	3568	3568	3568	3568	2816
Capeville							
Area Statistic	35.5	22.0	47.0	6.4	11.9	28.7	44.3
Base Population	1592	1353	1423	1423	1423	1423	1117
Eastville							
Area Statistic	38.0	25.0	40.9	6.9	9.1	24.9	49.0
Base Population	644	948	806	806	806	806	610
Franktown							
Area Statistic	29.8	21.3	46.2	7.8	10.8	27.5	45.8
Base Population	1508	1211	1339	1339	1339	1339	1089
Median All Rural Counties	23.1	21.4	52.4	10.7	13.2	28.0	39.4

	Females Never Married	Pct. Males Divorced Or Sep.	Females Divorced Or Sep.	Percent Females Widowed	Percent Female Headed	Female Head With Own Children
ACCOMACK COUNTY						
Area Statistic	6.7	3.9	4.6	18.9	24.9	12.9
Base Population	9361	10240	11740	11740	9713	3371
Atlantic						
Area Statistic	5.7	4.3	4.4	16.5	22.5	11.6
Base Population	1894	2247	2435	2435	2035	800
Lee						
Area Statistic	7.0	2.8	3.9	20.2	25.8	13.2
Base Population	2719	2897	3368	3368	2747	935
Metompkin						
Area Statistic	7.5	4.3	5.0	21.3	27.2	13.7
Base Population	1858	1936	2328	2328	1885	642
Pungoteague						
Area Statistic	9.0	4.4	6.0	17.7	27.2	17.0
Base Population	1775	1879	2249	2249	1799	594
The Islands						
Area Statistic	2.3	4.4	3.9	18.3	20.0	7.5
Base Population	1115	1281	1360	1360	1247	400
NORTHAMPTON COUNTY						
Area Statistic	8.1	5.5	6.8	18.0	27.5	16.4
Base Population	4540	5003	5760	5760	4680	1617
Capeville						
Area Statistic	8.1	6.2	6.8	19.0	29.2	17.5
Base Population	1871	2075	2374	2374	1913	669
Eastville						
Area Statistic	8.9	5.7	6.8	16.7	26.9	17.3
Base Population	978	1137	1244	1244	1014	330
Franktown						
Area Statistic	7.7	4.4	6.8	17.5	26.1	14.7
Base Population	1691	1791	2142	2142	1753	615
Median All Rural Counties	5.1	3.4	3.7	13.8	18.3	7.5

	Housing Vacancy Index	Standard Housing Non-Black	Standard Housing Black	Percent Overcrowded Housing	Overcrowded Housing Non-Black	Overcrowded Housing Black
ACCOMACK COUNTY						
Area Statistic	14.4	80.5	24.4	9.7	8.4	46.4
Base Population	11344	6876	2837	9713	17921	10775
Atlantic						
Area Statistic	12.8	77.0	23.2	12.3	8.9	50.7
Base Population	2335	1345	690	2035	3575	2819
Lee						
Area Statistic	14.1	83.1	32.9	8.2	6.5	42.2
Base Population	3197	1926	821	2747	5041	2958
Metompkin						
Area Statistic	13.8	73.7	18.3	9.2	7.8	43.7
Base Population	2188	1306	579	1885	3361	2110
Pungoteague						
Area Statistic	14.9	79.5	20.4	12.8	9.2	48.8
Base Population	2113	1072	727	1799	2729	2845
The Islands						
Area Statistic	17.5	88.4	45.0	5.3	10.9	20.9
Base Population	1511	1227	20	1247	3215	43
NORTHAMPTON COUNTY						
Area Statistic	14.1	87.5	24.3	12.0	5.8	46.8
Base Population	5446	2623	2057	4680	6841	7481
Capeville						
Area Statistic	15.0	88.7	27.4	11.4	8.1	46.2
Base Population	2251	1114	799	1913	2997	2852
Eastville						
Area Statistic	16.3	86.3	25.2	13.1	5.2	42.1
Base Population	1212	459	555	1014	1161	2006
Franktown						
Area Statistic	11.6	86.8	20.1	11.9	3.6	50.9
Base Population	1983	1050	703	1753	2683	2623
Median All Rural Counties	10.2	88.5	50.0	9.3	16.2	44.8

	Highly Overcrowded Housing	Occupied Housing Rented	Occupied Housing Trailers	Housing With Over 19 Units	Single Units Detached Non-Black	Single Units Detached Black
ACCOMACK COUNTY						
Area Statistic	9.8	30.4	4.3	0.0	95.6	98.0
Base Population	28696	9713	11344	11409	6862	2851
Atlantic						
Area Statistic	12.7	29.7	5.4	0.0	93.3	98.0
Base Population	6394	2035	2335	2326	1345	690
Lee						
Area Statistic	8.0	30.7	3.4	0.0	94.9	97.4
Base Population	7999	2747	3197	3211	1912	835
Metompkin						
Area Statistic	9.2	34.9	4.6	0.0	96.9	98.1
Base Population	5471	1885	2188	2218	1306	579
Pungoteague						
Area Statistic	14.0	33.2	3.5	0.2	97.3	98.5
Base Population	5574	1799	2113	2127	1072	727
The Islands						
Area Statistic	2.5	20.4	5.3	0.0	96.2	*
Base Population	3258	1247	1511	1527	1247	
NORTHAMPTON COUNTY						
Area Statistic	13.4	42.2	3.2	0.0	89.7	94.1
Base Population	14322	4680	5446	5468	2623	2057
Capeville						
Area Statistic	12.6	44.7	3.7	0.0	82.3	90.7
Base Population	5849	1913	2251	2273	1114	799
Eastville						
Area Statistic	12.9	41.2	5.0	0.0	94.3	96.4
Base Population	3167	1014	1212	1215	459	555
Franktown						
Area Statistic	14.5	39.9	1.5	0.0	95.4	96.2
Base Population	5306	1753	1983	1980	1050	703
Median All Rural Counties	5.8	26.6	4.3	0.1	94.1	95.1

* suppressed : too few cases

	Percent Population Rural	Recent Movers White	Recent Movers Black	Pct. Living In Other Unit Than In 1965	Pct. Living Other County Than In 1965
ACCOMACK COUNTY					
Area Statistic	All areal districts are 100 percent rural.	16.1	*	33.8	9.8
Base Population		18102		26914	25882
Atlantic					
Area Statistic		16.6	12.0	32.5	8.5
Base Population		3621	2843	5919	5714
Lee					
Area Statistic		13.7	19.0	32.4	9.4
Base Population		5129	2966	7589	7167
Metompkin					
Area Statistic		15.4	23.4	35.8	8.5
Base Population		3439	2134	5173	4930
Pungoteague					
Area Statistic		16.6	18.3	33.1	9.3
Base Population		2715	2853	5203	5123
The Islands					
Area Statistic		19.6	23.3	37.5	15.7
Base Population		3198	60	3030	2948
NORTHAMPTON COUNTY					
Area Statistic		17.5	13.2	34.7	9.0
Base Population		6856	7555	13428	12940
Capeville					
Area Statistic		20.8	7.9	32.7	7.9
Base Population		3027	2900	5511	5441
Eastville					
Area Statistic		11.0	17.6	27.7	3.6
Base Population		1164	2016	2989	2731
Franktown					
Area Statistic		16.5	15.7	41.1	13.4
Base Population		2665	2639	4928	4768
Median All Rural Counties		20.5	19.6	40.3	15.5

* suppressed: too few cases

	Total Pct. Teenagers Not In School	Black Teenagers Not In School	Percent Working Mothers	Working Mothers With Preschoolers
ACCOMACK COUNTY				
Area Statistic	14.9	12.1	51.5	44.0
Base Population	2310	1140	3684	1612
Atlantic				
Area Statistic	21.2	20.5	58.8	59.2
Base Population	486	249	890	441
Lee				
Area Statistic	9.9	0.6	53.3	47.4
Base Population	728	326	1060	422
Metompkin				
Area Statistic	16.0	6.9	55.7	37.8
Base Population	424	232	686	262
Pungoteague				
Area Statistic	10.7	9.6	50.9	45.0
Base Population	476	333	648	280
The Islands				
Area Statistic	26.0	*	24.5	11.6
Base Population	196		400	207
NORTHAMPTON COUNTY				
Area Statistic	18.4	29.0	55.4	52.1
Base Population	1368	855	1787	752
Capeville				
Area Statistic	19.1	31.4	48.7	40.1
Base Population	576	379	688	302
Eastville				
Area Statistic	5.2	13.2	60.0	48.3
Base Population	306	197	405	147
Franktown				
Area Statistic	25.9	36.9	59.4	66.0
Base Population	486	279	694	303
Median All Rural Counties	9.9	13.3	40.3	30.6

*suppressed: too few cases

	Aged Living Alone	Aged In Poverty	Crowded Units Lacking Plumbing	Female Headed House With Own Children Black
ACCOMACK COUNTY				
Area Statistic	12.4	44.9	2.9	24.5
Base Population	9713	4338	9713	1161
Atlantic				
Area Statistic	8.9	34.9	4.5	20.4
Base Population	2035	783	2035	328
Lee				
Area Statistic	13.3	45.6	2.7	23.1
Base Population	2747	1339	2747	303
Metompkin				
Area Statistic	14.4	52.8	1.3	28.0
Base Population	1885	886	1885	232
Pungoteague				
Area Statistic	12.7	50.2	4.9	27.8
Base Population	1799	819	1799	295
The Islands				
Area Statistic	12.3	36.6	0.4	33.3
Base Population	1247	511	1247	3
NORTHAMPTON COUNTY				
Area Statistic	11.4	44.4	4.9	24.5
Base Population	4680	2064	4680	787
Capeville				
Area Statistic	11.6	41.0	4.2	28.1
Base Population	1913	863	1913	299
Eastville				
Area Statistic	11.9	51.6	4.9	23.0
Base Population	1014	483	1014	204
Franktown				
Area Statistic	11.0	43.[illegible]	5.5	21.8
Base Population	1753	718	1753	284
Median All Rural Counties	9.6	38.6	0.9	20.9

	Large Household Low Income	Female Head Fam. W/ Chld, In Poverty	Pct. Disabled Non-Inmates Non-Students	Pct. Disabled & Unable To Work	Related Chld. Under 18 In Poverty
ACCOMACK COUNTY					
Area Statistic	59.0	9.4	14.7	7.4	36.6
Base Population	949	3987	14892	14892	9443
Atlantic					
Area Statistic	49.1	8.7	10.7	4.6	30.5
Base Population	230	917	2929	2929	2181
Lee					
Area Statistic	64.3	9.7	15.6	8.8	39.0
Base Population	241	1099	4581	4581	2626
Metompkin					
Area Statistic	46.7	9.2	15.8	5.1	28.3
Base Population	197	770	2443	2443	1784
Pungoteague					
Area Statistic	76.7	13.0	17.7	10.1	55.9
Base Population	215	754	3121	3121	2031
The Islands					
Area Statistic	53.0	4.5	12.2	6.6	15.0
Base Population	66	447	1818	1818	821
NORTHAMPTON COUNTY					
Area Statistic	76.6	16.2	14.4	4.9	52.0
Base Population	563	1998	7083	7083	5179
Capeville					
Area Statistic	77.8	21.1	11.1	3.0	55.3
Base Population	225	814	3015	3015	2154
Eastville					
Area Statistic	77.9	17.8	13.4	5.2	59.7
Base Population	136	416	1195	1195	1070
Franktown					
Area Statistic	74.3	10.0	18.2	6.9	44.0
Base Population	202	768	2873	2873	1955
Median All Rural Counties	42.9	4.0	13.1	5.3	21.3

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