FAMILY STRUCTURE AND MENTAL HEALTH IN URBAN GUYANA

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ABSTRACT

While there is much descriptive information on the structural features of the Caribbean family, little data exists on mental health outcomes that may be associated with these structures. Using a sample of 654 adults from urban Guyana, this study explores the extent to which family structure is related to psychological distress. The analyses indicate that female-headed households report more depressive symptoms than women in simple nuclear settings. Sociodemographic and psychosocial factors are more consistently related to mental health than family structure. [Key words: mental health, Caribbean family, psychological factors, outcomes of family structure, social support, socioeconomic status.]

Much has been written about the structural features of the family in Guyana and the Caribbean, but less attention has been given to outcomes associated with these structures. The literature emphasizes the complexity of family types in the region (Simiy 1946; Smith 1956; Clarke 1957; Smith 1962, Gonzalez 1969, Wilson 1989), and the high prevalence of female-headed households, but few empirical investigations have addressed the extent to which the well-being of adults is linked to particular patterns of family organization. This is not unlike the general trend of research on the family elsewhere which tends to focus on economic outcomes for single-parent adults (Garfinik and McLanahan 1986; Duncan and Hoffman 1985; Duncan 1984). This paper examines the association between family structure and the mental health of adults in Georgetown, Guyana. Guyana is the only English speaking country in the South American continent, and for historical and cultural reasons it is regarded as part of the Commonwealth Caribbean.

Studies of family types in the Caribbean document that a broad range of family types exist throughout the region (Simiy 1946; Clarke 1957; Smith 1962). The nuclear family is the modal form of family arrangement in the Caribbean, but most of the research to date has focused on the other forms of family arrangements (Wilson 1989). Researchers have given emphasis to the high rates of illegitimacy, female headed families, and extended family arrangements. However, empirical verification of the social and psychological consequences, if any, of these alternative family types is virtually nonexistent.

A major debate in the Caribbean family literature concerns the normative status of marital versus consensual unions and other family types (Goode 1966; Blake 1962; Rodman 1963, 1966). This central question of whether marriage is the valued or preferred union status with other forms being perceived as deviant, has implications for adult mental health. On the one hand, if marital unions are normative, as Goode (1966) asserts, then existence in non-normative structural arrangements is likely to adversely impact the psychological well-being of persons in these structures. Alternatively, if individuals in the region stretch their values to accommodate different sets of norms as Rodman (1966) suggests, then particular family configurations are unlikely to be associated with mental health status.

The general literature on the social distribution of mental health problems provides an additional reason to expect differences in outcomes based on the structural arrangements of households. It is firmly established that persons in marital unions enjoy better mental health than the unmarried. Compared to the unmarried, married
persons are less likely to be diagnosed with mental illness in community epidemiologic studies (Bebington 1987; Bloom, Acheson, and White 1978; Williams, Takeuchi, and Adair 1992). Other studies reveal that the married also have higher levels of life satisfaction and lower levels of psychological distress than the unmarried (D’Arcy and Stod ideologies 1965; Gurin, Vrnc, and Feld 1960). Some researchers have suggested that family patterns that deviate from the traditional nuclear family are "psychologica" in both social and psychiatric terms (Hollingshead and Redlich 1958, p. 125). Tracing this relationship within the context of the Guamanian family is particularly relevant because census figures indicate a consistent drop in marital unions since 1960 (Population Census of the Commonwealth Caribbean, 1980-1981, Guayana, vol. 3, Tables E2, E5).

The literature also suggests that non-nuclear family arrangements can promote mental health and well-being under certain conditions. In particular, the role of extended family arrangements is some economies and cultures has been the subject of research. It has been well documented, for example, that the extended family is an important source of social and economic support in black communities (Martin and Martin 1978; Stack 1974; Hill 1972). Recently, research has shown that extended families have implications for mental health outcomes as well (Drescher 1981; Hughes and Howe 1981). The presence of others in the household, the criteria for extended arrangements in this research, can ensure not only the greater availability of social support but some research indicates that the support from persons in the household may be more health-enhancing than support from persons outside (Ross, Maslowsky, and Goldstien 1990).

At the same time, the presence of others in the household can adversely affect health by increasing demands and decreasing privacy (Hughes and Howe 1981). The number of persons in the household can also determine the amount of economic resources available to the family. Other persons can either place additional strain on limited financial resources or enhance the economic situation of the family unit by providing an additional source of income. With almost 17 percent of the families in Georgetown extended in some way (Wilson 1989), it is instructive to investigate whether the mental well-being of those in extended family arrangements differs from those in other structural arrangements.

Prior research on the Caribbean family has also given inadequate attention to identifying the social conditions characteristic of particular family types that may be predictive of variations in mental health status. Families constitute a social context but also exist in a larger social context (Ross et al. 1990). It is likely that particular family types are differentially located in the social stratification system (Williams et al. 1992). The location of a group in the social structure will determine both its exposure to pathogenic experiences and its access to health enhancing resources (Pearlin et al. 1981). A broad range of social and psychological factors have been identified as linked to mental health functioning in socioeconomic status (Pearlin et al. 1981; Williams and House 1981). These include the quality and quantity of social relationships, perceptions of one's self, and levels of stress. Research is clearly needed that would identify family status variation in social circumstances and examine the extent to which family type remains predictive of health after adjustment for these factors.

In sum, this paper examines the association between family structure and mental health using a large probability sample of an urban Caribbean population. This paper goes beyond prior research in several important ways. First, our analyses utilize a large, heterogeneous, urban population. Most earlier studies of the Caribbean family have utilized small convenience samples in rural areas that contain a predominance of persons from the lower socio-economic classes (Wilson 1989). Second, we address the understudied and unresolved issue of the extent to which individual well-being is associated with variations in family structure in the Caribbean. Specifically, we examine the association between family type and two indicators of psychological distress. We know of no study that has explicitly focused on identifying the mental health correlates of family arrangements in the Caribbean context. Finally, we explore the social context in which particular family forms are embedded and assess the extent to which these social and psychological factors may mitigate or intensify the association between family type and mental health status.

Methods

Sample

Respondents were selected from a multi-stage probability sample of households in the Greater Georgetown area. Using a probability proportionate to size procedure (Kish 1965), 15 of 42 minor areas (census tracts) were selected at the first stage. At the second stage, 97 enumeration districts, (blocks) representing approximately one-third of the total, were selected. Households were selected at the final stage. At each sample address with a conjugal pair, the male or female (spouse or partner) was randomly selected to be interviewed. In single headed households, the adult head of the household was interviewed. In other household
types, the person designated as head was inter-
novated. A husband who was not designated
ated, an adult was randomly selected using the
Kish table (Kish 1965).

The sampling frame used for the selection of respondents was the "Visititation Records" of the
Population Census of the Commonwealth Carib-
bean, Guiana, 1980-1981, which was provided by
the Chief Statistical Office in Georgetown. These
records contain complete listings of all dwelling
units (35,392) in the Greater Georgetown area at
the time of the 1980-1981 census. Where the assump-
tion that each dwelling unit contains a single family
or household was violated, the "half-open interval
procedure" (Kish 1965) was used to select addition-
al households. Forty-six interviews from thirty-six
multiple household units resided from this proce-
dure. In all cases, those were independent families
living in owner or otherwise modified properties
with single listed addresses. In all, 654 interviews
were completed for a response rate of 86 percent.
The obtained sample is 36 percent male and has a
mean age of 43.5 years. Fifty-six percent of the
respondents were black (Afro-Guyanese); 27 per-
cent were East Indian (Indo-Guyanese), and 17 per-
cent were of Mestizo, Amerindian, Chinese,
Portuguese, or other ancestry. The ethnic distribu-
tion of the sample compares favorably with that of

Interviewing and Coding

All data analyzed here derive from face-to-
face interviews conducted in respondents' home
during the Summer of 1987. Most of the 37 inter-
viewers were students or graduates of the University
of Guyana and had completed an intensive training
program conducted over a two-week period. The in-
terviews averaged 90 minutes. In preparation for
computerization, responses were coded onto
forty sheets by nine trained coders. Coder
reliability was high ranging from 0.97 to 100 percent.
The data were computerized and cleaned during
the Fall of 1987 at the University of Michigan.

Measures and Data Analysis

Family types were constructed from the
complete household listings which were a part of
the survey. Family structure is coded in our analyses
as six family types: nuclear, nuclear extended, single
headed, single headed extended, consensual, and
single (Table 1). These six types capture the major
categories used in the analysis of Caribbean family
patterns (Simpy 1946, Clarke 1957, Smith 1962, Wil-
son 1989). The nuclear family represents two
parents living with their natural born or adopted
children. The nuclear extended is the same as the nuc-

lar family except that it is extended by the

presence of relatives or other persons. The single
headed family is a single parent living with children.
The single headed extended family is a single
headed household that is extended by the presence
of others. The consensual family type consists of
blood relatives living together. The single person
family type is an individual living alone.

Formal education based on years of school-
ing is the first measure of socioeconomic status util-
ized. Education is divided into three categories
(primary, secondary, and post-secondary) that cor-
respond to the critical points of the available educa-
tional opportunities in Caribbean society
(Freddie's, Lennon, Mundy and Fredericks
1986:45-50). The primary education category con-
sists of respondents who received no formal educa-
tion up to and including those who completed ele-
mentary school (42 percent of the sample).
Secondary education includes those who have at-
tended or completed high school (42 percent). The
remaining 15 percent, with training beyond high
school, fall into the final post-secondary category.
Education is treated as a set of three dummy vari-
bles in the regression analyses. Preliminary
analyses of these data also used income as an in-
dicator of SES. Patterns of association with income
were similar to those for education, but 18 percent
of the sample lacked data on total household in-
come. Financial strain is a second and more subjec-
tive indicator of socioeconomic status used in our
analyses. This is a six item scale based on the
respondent's self reported evaluation about finan-
cial constraints on obtaining food, medical care,
clothing, leisure activities and paying monthly bills.
The alpha (reliability) of the scale is .89. The finan-
cial strain index is strongly correlated, inversely,
with total household income. Age (in years) and
race (blacks coded 1 and nonblacks the omitted
category in the regression analyses) are sociodemo-
graphic controls employed.

Mental health status is indexed by two
measures of psychological distress that utilize
symptoms of depression and somatization as
measured by the Hopkins Symptom Checklists
(Derogatis 1977). The depression scale has an alpha
(reliability) of .79 and it sums the frequency with
which the respondent blamed self for things, had
crying spells, and felt sad and blue, trapped, lonely,
no interest in things, or hopeless about the future.
The scale of somatic symptoms has a reliability of
.74 and assessed the recent frequency of experienci-
ing back pain, muscle soreness, weakness in parts
of the body, and feeling low in energy or slowed
down. The analyses explore the extent to which two
classes of psychological factors are linked to family
structure and health. The final self-esteem concept, is
assessed by six items each from the Rosenberg self-es-
teen scale (alpha = .65; Rosenberg 1965) and the
Pearlin mastery scale (alpha = .61; Pearlin and Schoenle 1978). The second, social-support, is a measure of the quantity and quality of social ties. Social relationships have been identified as central determinants of health status (House, Uomson and Landis 1988). Two summary measures were created based on respondent reports of the frequency of contact with, and expressions of interest and caring from relatives and friends, respectively, who live apart from the respondent.

Simple descriptive analyses are used to present the distribution of family structure. A Chi-square test is used to test differences in family structure across gender categories, and one-way analysis of variance procedures (ANOVA) are used to examine mean differences in the distribution of sociodemographic and psychosocial factors. Ordinary least squares regression is used to estimate the size and statistical significance of the relationships between family structure, mental health, and psychosocial factors. Three models are estimated for each gender. The first model presents the bivariate association between family structure and mental health status. The second model adds the sociodemographic variables (age, race, education, and financial stress). The third model further adjusts the association between family structure and mental health for the psychosocial variables (self-esteem, mastery, and social support).

Table 1. Distribution of Family Structure in Urban Guyana

<table>
<thead>
<tr>
<th></th>
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<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Male N</td>
<td>95</td>
<td>57</td>
<td>16</td>
<td>12</td>
<td>21</td>
<td>29</td>
</tr>
<tr>
<td>%</td>
<td>41.3</td>
<td>24.8</td>
<td>7.0</td>
<td>5.2</td>
<td>9.1</td>
<td>12.6</td>
</tr>
<tr>
<td>Female N</td>
<td>116</td>
<td>70</td>
<td>57</td>
<td>77</td>
<td>55</td>
<td>30</td>
</tr>
<tr>
<td>%</td>
<td>28.6</td>
<td>25.2</td>
<td>14.1</td>
<td>19.0</td>
<td>11.6</td>
<td>7.4</td>
</tr>
</tbody>
</table>

Chi-squared = 42.06; p < .001.

Table 2. Means and Percentages of Select Social and Demographic Variables by Family Structure (Males, N = 230)

<table>
<thead>
<tr>
<th>Variables</th>
<th>All</th>
<th>Nuclear</th>
<th>Nuc. Ext.</th>
<th>Single Head</th>
<th>S/Head Ext.</th>
<th>Consang</th>
<th>Single</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age**</td>
<td>43.0</td>
<td>40.6</td>
<td>41.9</td>
<td>51.5</td>
<td>56.0</td>
<td>40.8</td>
<td>44.3</td>
</tr>
<tr>
<td>Education (%)</td>
<td>37.6</td>
<td>38.8</td>
<td>31.6</td>
<td>58.8</td>
<td>50.0</td>
<td>28.6</td>
<td>34.5</td>
</tr>
<tr>
<td>Secondary</td>
<td>24.8</td>
<td>21.4</td>
<td>29.8</td>
<td>11.8</td>
<td>41.7</td>
<td>38.6</td>
<td>24.1</td>
</tr>
<tr>
<td>Post-Secondary</td>
<td>37.2</td>
<td>38.8</td>
<td>36.6</td>
<td>29.4</td>
<td>8.3</td>
<td>42.9</td>
<td>41.4</td>
</tr>
<tr>
<td>Economic Stress</td>
<td>7.7</td>
<td>7.3</td>
<td>8.3</td>
<td>7.7</td>
<td>8.3</td>
<td>8.4</td>
<td>7.1</td>
</tr>
<tr>
<td>Relative Support</td>
<td>24.9</td>
<td>14.9</td>
<td>15.4</td>
<td>14.8</td>
<td>13.4</td>
<td>14.8</td>
<td>14.5</td>
</tr>
<tr>
<td>Non-Relative Support</td>
<td>15.1</td>
<td>15.1</td>
<td>14.3</td>
<td>16.4</td>
<td>14.8</td>
<td>16.4</td>
<td>15.3</td>
</tr>
<tr>
<td>Mastery*</td>
<td>12.9</td>
<td>13.3</td>
<td>12.2</td>
<td>12.4</td>
<td>11.5</td>
<td>12.5</td>
<td>13.7</td>
</tr>
<tr>
<td>Self-Esteem</td>
<td>16.0</td>
<td>15.8</td>
<td>15.3</td>
<td>16.6</td>
<td>16.0</td>
<td>17.1</td>
<td>16.4</td>
</tr>
<tr>
<td>Race (% Black)</td>
<td>48.7</td>
<td>48.0</td>
<td>40.4</td>
<td>52.9</td>
<td>50.0</td>
<td>57.1</td>
<td>58.6</td>
</tr>
</tbody>
</table>

*p < .10, **p < .05, ***p < .001
Table 3. Means and Percentages of Select Social and Demographic Variables by Family Structure (Females, N = 405)

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Age***</td>
<td>43.7</td>
<td>36.9</td>
<td>41.3</td>
<td>42.4</td>
<td>48.8</td>
<td>51.8</td>
<td>52.9</td>
</tr>
<tr>
<td>Education (%) ***</td>
<td>43.3</td>
<td>39.8</td>
<td>38.9</td>
<td>41.4</td>
<td>56.4</td>
<td>35.7</td>
<td>51.5</td>
</tr>
<tr>
<td>Primary</td>
<td>28.3</td>
<td>24.4</td>
<td>41.7</td>
<td>36.2</td>
<td>21.8</td>
<td>26.8</td>
<td>18.2</td>
</tr>
<tr>
<td>Secondary</td>
<td>27.9</td>
<td>35.8</td>
<td>19.4</td>
<td>19.0</td>
<td>21.8</td>
<td>37.5</td>
<td>30.3</td>
</tr>
<tr>
<td>Economic Stress**</td>
<td>14.6</td>
<td>14.8</td>
<td>15.3</td>
<td>14.0</td>
<td>14.8</td>
<td>15.0</td>
<td>12.8</td>
</tr>
<tr>
<td>Relative Support**</td>
<td>14.3</td>
<td>14.1</td>
<td>14.4</td>
<td>14.1</td>
<td>14.6</td>
<td>14.6</td>
<td>13.2</td>
</tr>
<tr>
<td>Non-Relative Support</td>
<td>11.9</td>
<td>11.9</td>
<td>11.6</td>
<td>12.1</td>
<td>11.6</td>
<td>12.2</td>
<td>11.7</td>
</tr>
</tbody>
</table>

Results

Table 1 presents the distribution of family structure for males and females. The results clearly indicate different structural arrangements for the two subgroups. Men are more likely than women to be in one of the nuclear family types. Forty-one percent of males are in nuclear families and an additional 5.2 percent are in nuclear extended families. The comparable numbers for women are 29 percent and 7.1 percent, respectively. Especially striking is the fact that females are twice as likely as men to head a household with their children alone, and more than three times as likely to do so in an extended household arrangement. Men are more likely than women to be in single person households (13 percent versus 7 percent) but women are slightly more likely than men to be living together with blood relatives (14 percent versus 9 percent) more men lived in two parent non-extended households than women.

Table 2 presents the distribution of sociodemographic and psychosocial variables by family type for males. The means (and standard deviations) for the variables used in the multivariate analyses are provided. There is a significant difference in the distribution of age by family type, and a marginally significant difference in mastery. Male household heads of single headed and single headed extended families are about 10 to 15 years older than men in other types of family arrangement. The pattern for mastery is less pronounced, but men in nuclear and single person households tend to be highest on mastery. There is no significant variation for race, education, economic stress or social support.

Table 3 presents the results for females. There is more variation for women than men in the social and economic context in which families live. Family types vary by age, race, education, economic stress, and social support from relatives. The youngest women (average age 36.9 years) are found in the nuclear family. These women living in non-extended two parent households are about 15 years younger than women in single person households and those living with blood relatives, approximately 12 years younger than those living in single headed extended households. Some 60 percent of the obtained female sample is black. Black females are less represented in the nuclear family types, with 44 percent of the respondents in nuclear families and 51 percent in nuclear extended families being black. In contrast, black women comprise 70 percent of single headed households, 77 percent of single headed extended, and 73 percent of consensual family types.

The distribution of education and economic stress by family type in Table 3 is consistent with what some have termed the feminization of poverty (Ehrenreich and Fink 1984). Female headed and female headed extended households exhibit both low levels of education and the highest levels of economic stress. Women in consensual households have the highest level of educational attainment and the lowest level of economic stress. The highest levels of support from relatives are reported by women living in extended nuclear families and consensual households, while women who live alone have the least social support.
### Table 4. Unstandardized Regression Coefficients for the Association Between Family Structure and Mental Health

**Males (N = 227)**

<table>
<thead>
<tr>
<th>Variables</th>
<th>Depression</th>
<th>Somatic Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I</td>
<td>II</td>
</tr>
<tr>
<td>1. Family Structure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nuclear (omitted)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nuclear Extended</td>
<td>.59</td>
<td>.37</td>
</tr>
<tr>
<td>Single Headed</td>
<td>.75</td>
<td>.63</td>
</tr>
<tr>
<td>Consanguinal</td>
<td>.56</td>
<td>.41</td>
</tr>
<tr>
<td>Single Person</td>
<td>-.14</td>
<td>-.09</td>
</tr>
<tr>
<td><strong>Sociodemographic</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Age</td>
<td></td>
<td>.01</td>
</tr>
<tr>
<td>3. Race</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td></td>
<td>-.54</td>
</tr>
<tr>
<td><strong>Non-black (omitted)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary (omitted)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary</td>
<td>-.07</td>
<td>-.11</td>
</tr>
<tr>
<td>Post-Secondary</td>
<td>-.32</td>
<td>-.56</td>
</tr>
<tr>
<td>5. Economic Stress</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary (omitted)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary</td>
<td>.17**</td>
<td>.10**</td>
</tr>
<tr>
<td>6. Support (Relatives)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Support (Non-Rel)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Mastery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Self-Esteem</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Constant</strong></td>
<td>9.96***</td>
<td>7.60***</td>
</tr>
</tbody>
</table>

Table 4 shows the relationship between family structure and mental health for males. Because of relatively small numbers, both the single headed and single headed extended family types are collapsed into one category for males. Initial exploratory analyses reveal though that these categories were similarly related to the mental health outcomes. Three models are presented for each of the dependent variables. Family structure is coded as a set of five dummy variables with the nuclear family as the omitted category. The first model shows that there is a general trend for men in nuclear extended, single headed and consanguineal household to have higher levels of depressive symptoms than their counterparts in nuclear families, but none of these differences are significant. In fact, family structure is unrelated to symptoms of both depression and somatization for men.

Table 4 also indicates that the sociodemographic and psychosocial variables considered are related to depression but not to somatic symptoms. The sociodemographic variables explain 11 percent of the variance in depression, and the psychosocial variables account for an additional 12 percent. There is a marginally significant tendency for blacks to have lower levels of depressive symptoms than non-blacks but this relationship is reduced to non-significance when controlled for the psychosocial variables. As expected, economic stress is positively related to depression and both
Table 5. Unstandardized Regression Coefficients for the Association Between Family Structure and Mental Health

Females (N = 365)

<table>
<thead>
<tr>
<th>Variables</th>
<th>Depression</th>
<th></th>
<th></th>
<th>Somatic Symptoms</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I</td>
<td>II</td>
<td>III</td>
<td>I</td>
<td>II</td>
<td>III</td>
</tr>
<tr>
<td>1. Family Structure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nuclear (omitted)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nuclear Extended</td>
<td>.90</td>
<td>.08</td>
<td>.07</td>
<td>-.02</td>
<td>-.15</td>
<td>-.21</td>
</tr>
<tr>
<td>Single Headed</td>
<td>1.16**</td>
<td>1.17**</td>
<td>1.16**</td>
<td>.12</td>
<td>.02</td>
<td>.02</td>
</tr>
<tr>
<td>Single Headed Ext.</td>
<td>.71</td>
<td>.65</td>
<td>.71</td>
<td>-.23</td>
<td>-.61</td>
<td>-.58</td>
</tr>
<tr>
<td>Consanguinal</td>
<td>-.26</td>
<td>-.24</td>
<td>-.22</td>
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<td>.99</td>
<td>.61</td>
<td>.25</td>
<td>.03</td>
<td>.18</td>
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<td>2. Age</td>
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<td>3. Race</td>
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<tr>
<td>Black</td>
<td>-.83***</td>
<td>-.67***</td>
<td>-.48**</td>
<td>-.39**</td>
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<tr>
<td>Primary (omitted)</td>
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<td>-.11</td>
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<td>5. Economic Stress</td>
<td>.29***</td>
<td>.20***</td>
<td>.18***</td>
<td>.14***</td>
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<td>6. Support (Relatives)</td>
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<td>7. Support</td>
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<tr>
<td>(Non-Relatives)</td>
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<td>8. Mastery</td>
<td></td>
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<td></td>
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<tr>
<td>9. Self-Esteem</td>
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<tr>
<td>Constant</td>
<td>9.77****</td>
<td>8.21***</td>
<td>11.75***</td>
<td>90.45***</td>
<td>3.90**</td>
<td>4.75**</td>
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</table>

measures of social support and mastery are inversely associated with depression.

Table 5 presents results similar to those in Table 4 for men. Unlike the findings reported in Table 4 for men, there is a significant relationship between family structure and mental health status for women in urban Guyana. Women in single headed households have higher rates of depression than women in nuclear families. Although women in nuclear extended families, single headed extended families, and single person families tend to have higher scores on the depression variable, none of these differences are significant. Models II and III show that the relationship between family structure and depression remains unchanged when adjusted for the sociodemographic variables and the psychosocial resources. Thus, the factors considered here play no role in accounting for the higher level of depression of women in single headed households.

Similar to the results for males, family type is unrelated to somatic symptoms for women. However, unlike the findings for men, the sociodemographic and psychosocial variables are re-
late to both depression and somatic symptoms. In fact, each class of factors explains about 10 percent of the variance in each of the dependent variables. The association between race and mental health was stronger for males than for females. Compared to their non-black peers, black women have lower levels of both depression and somatic symptoms. This relationship is reduced somewhat but remains robust when adjusted for the psychosocial variables. Economic stress is positively related and mastery and self-esteem inversely related to both depression and somatic symptoms. There is the expected inverse relationship between social support and psychological distress, only for support from relatives and only for depression.

Other analyses, not shown, examined the extent to which the mental health status of adults in extended families differed from that of adults in other types of family arrangements. For these analyses, family structure was coded as a set of five dummy variables with the two extended family categories (nuclear extended and single-headed extended) as the omitted groups. There were no significant differences for either depression or somatic symptoms for both males and females. Thus, adults in extended family types have levels of psychological distress that are similar to those of persons in other household structures.

Discussion

The Caribbean family is not a homogenous entity. The nuclear family is the modal form for both men and women but the majority of households reflect family types other than the simple nuclear family. This study assessed the implications of these alternative structures for the mental well-being of adults. The central conclusion that emerges from these analyses is that family structure is related to mental health but only among women and only for depressive symptoms. Women in female-headed households report higher levels of depressive symptoms than women in nuclear families. Clearly, our analyses of cross-sectional data cannot address the causes of variations in mental health status and future prospective analyses are required to ascertain the determinants of mental health problems instead of merely the correlates of them.

This study provides little support for the notion that adults in family forms that differ from the simple nuclear family have higher levels of mental health problems than persons in the modal family type. The absence of a spouse and the mere presence of others in the household are not associated with elevated levels of psychological distress. In fact, our analyses indicate that other sociodemographic and psychosocial factors are more central to explaining variations in mental health status for both men and women in Guyana, than are the structural arrangements of households. Our findings thus lend some support to Rodman's (1966) "values in action" conceptualization of Caribbean families, which predicts that variations in family type would be unrelated to psychological well-being. Structural characteristics of the family are related to mental health but only under a fairly restricted set of conditions: single mothers living with their children.

Our findings are similar to an earlier study that assessed the relationship between family structure and the mental health of children in a poor black urban community. The study found that children in female-headed families where other adults were absent, had poorer levels of psychological well-being and social adjustment than children in other family structures (Kellam, Entinmeyer, and Turner 1977). The researchers concluded that the absence of the father was less important than the loneliness of the mother. Our results suggest that when other adults are absent the mental health of women in female headed families is also adversely affected. Thus, female heads of households in extended arrangements reported higher levels of psychological distress than women in the simple nuclear arrangement.

If the absence of social support (emotional and instrumental) from another adult in the household is a critical determinant of the higher levels of ill health in female headed households, our findings suggest that support from relatives and friends outside of the household does not compensate for this lack. The association remained unchanged when adjusted for these variables. This is consistent with the evidence that suggests that support from others within the household is more health enhancing than support from individuals outside (Ross et al. 1990). It is also instructive to note that although female headed households were particularly likely to have low scores on our indicators of socioeconomic status, controls for these variables did not alter the relationship. It may be that other unmeasured aspects of socioeconomic status contribute to the higher levels of depression in female headed households.

Another important finding of this paper is the ethnic variation in mental health status. Black women have lower levels of depression and somatization than nonblacks. A similar pattern is observed for men with depression but this relationship became nonsignificant once psychosocial factors were considered. Whether or not this is a function of variation in coping strategies or other factors is not addressed in this study. However, a
broad range of social, economic and cultural activities differ for the various ethnic groups in Guyana (Danss 1982). These differences are evident in occupational specialization, religion, recreation, trade unions, and political party identification.

Our findings highlight the need for research to catalog and quantify the specific aspects of life in various family structures and ethnic groups that are related to health status. We considered the role that sociodemographic factors as well as psychosocial resources (social support and self-concept) could play in reducing the association between family structure and mental health. Yet, the obtained picture is still incomplete. Research efforts must seek to identify the additional factors linked to family structures that contribute to the ill health of women in female headed households, as well as those that differentiate the mental health of various ethnic groups.

Acknowledgements

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