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**Social workers' knowledge of client culture and its use in mental  
health care of English-speaking Caribbean immigrants**

**Matthews, Lear, D.S.W.**

**City University of New York, 1994**

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SOCIAL WORKERS' KNOWLEDGE OF CLIENT  
CULTURE AND ITS USE IN MENTAL HEALTH  
CARE OF ENGLISH-SPEAKING CARIBBEAN IMMIGRANTS

by

LEAR MATTHEWS

A dissertation submitted to the Graduate Faculty in  
Social Welfare in partial fulfillment of the requirements  
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University of New York

1994

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This manuscript has been read and accepted for the graduate Faculty in Social Welfare in satisfaction of the dissertation requirement for the degree of Doctor of Social Welfare.

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## Abstract

SOCIAL WORKERS' KNOWLEDGE OF CLIENT CULTURE AND ITS  
USE IN MENTAL HEALTH CARE OF ENGLISH-SPEAKING  
CARIBBEAN IMMIGRANTS

by

Lear Matthews

Advisor: Professor Gary Anderson

The literature on what social workers know about the culture of their clients and how that knowledge is transformed into effective practice, is lacking. This study is undertaken to learn more about cross-cultural, worker/client relationships, specifically, psychiatric social workers' knowledge of English-speaking Caribbean culture and the ways in which that knowledge is utilized in mental health care. Social workers' responses to four categories, namely knowledge of culture, sources of cultural knowledge, use of cultural knowledge, and obstacles to the acquisition of cultural knowledge, were analyzed.

Findings indicate that (I) psychiatric social workers were generally aware of aspects of the clients' culture (ii) the extent of their cultural knowledge was influenced by cultural background, and (iii) use of cultural knowledge in practice was precluded by programmatic and professional

relationship obstacles. The implications of the findings are discussed.

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I wish to dedicate the dissertation in memory of my parents, brothers Clem and Ken, and sister Florence.

Special thanks to my son Dion, daughters Malindi and Nicola, for their tolerance and understanding, and to the very 'cultured' lady, my wife, Monica, whose encouragement made this endeavor possible.

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SOCIAL WORKERS' KNOWLEDGE OF CLIENT CULTURE AND ITS USE IN  
MENTAL HEALTH CARE OF ENGLISH-SPEAKING CARIBBEAN IMMIGRANTS

CHAPTER I

INTRODUCTION

Problem Statement

Understanding culture is important. The rapid increase in the number of culturally diverse groups in North America, over the past two decades, primarily as a result of burgeoning immigration, necessitates an increase in cultural knowledge, by mental health practitioners. An understanding of how that knowledge is utilized in intervention is also required. This position is reflected in the concerns expressed by mental health administrators, who have requested that social workers assume responsibility for providing adequate services to culturally disparate populations. (Rebirth, 1992; Rey, 1990; Marcos, 1993). However, the extent of the cultural knowledge-base of mental health professionals, working with ethnic immigrant populations and the use of that knowledge in mental health care, particularly in metropolitan areas, have not been

seriously examined (Sundberg, 1982; Comas-Diaz, 1989; Sue, 1987).

New York is ethnically heterogeneous, comprising one of the largest concentrations of new immigrant populations in the United States (Waldinger, 1989). Caribbean immigrants account for 32% or 900,000 of New York City's total foreign-born population of 2.7 million (Bogen, 1990). Their cultural background, coupled with the circumstances of migration often create problems of adjustment. These problems contribute to feelings of alienation, difficulties in interpersonal relations, disillusionment, and in some instances, acute emotional problems. Consequently, members of this population are involved with mental health facilities as clients. In fact, there has been a noticeable increase in the number of referrals. Nevertheless, little is known about the role and preparedness of mental health professionals in the delivery of service to this group.

This study will focus on clients from the English-speaking Caribbean, i.e., the countries which were part of the British West Indies. They include, Jamaica, Barbados, Guyana, Trinidad and Tobago, Grenada, St. Lucia, Antigua, Dominica, St. Kitts, Nevis, and Montserrat. Not only do the people from the above-mentioned countries share common cultural characteristics such as language, but they account for the largest number of immigrants from the non-Hispanic

Caribbean. Some of these countries, in particular Jamaica, Guyana and Barbados, are among the top eight sources of new immigrants to New York City (Bogen, 1990); (Department of City Planning, 1992). Furthermore, unlike their predecessors, these immigrants tend to assimilate less readily into the African-American community. Instead, they, in large measure, maintain their Caribbean customs (Walt, 1988; Sutton, 1987). A recent report indicated that they prefer to retain their West Indian identity, with many of them choosing not to become United States citizens (Carib. News, 1992). Their culture is perpetuated in the United States by events such as the annual West Indian Day Parade, more frequent travel to and from the Caribbean and participation in increasing numbers of cultural organizations. These activities inevitably result in continued strong ties to their homeland.

Thrasher and Anderson (1988) point to the gap which exists in clinicians' knowledge of various key dimensions of the culture of English-speaking Caribbean immigrants. They expressed a need for addressing the issue of understanding cultural values of Caribbean clients, as a prerequisite to effective treatment. Similarly, Barrow-Luard (1981) found a critical lack of comprehension, by social workers, of salient aspects of Caribbean culture, which would have an impact on therapeutic effectiveness. She noted that stereotypes about Caribbean clients and the lack of cultural

information by clinicians, frustrate efforts to intervene successfully with this group.

The purpose of this study is to explore the nature and extent of cultural knowledge of social workers, providing direct mental health services to English-speaking Caribbean immigrants and how that knowledge is applied in intervention. It is hoped that the study will help to identify the psycho-social problems this population struggles with and the knowledge and skills needed to deal with them. This information would not only be helpful in identifying the gaps in current mental health service delivery to ethnic minorities, but will elucidate the issue of cultural sensitivity and cultural relevance, in working with immigrant groups. Finally, it will contribute to the development of in-service training in a critical dimension of human services and offer a theoretical framework for policy makers and practitioners, in the attempts to provide mental health services to Caribbean immigrants.

#### Objectives

The first objective of the study is to identify what social workers know about English-speaking Caribbean culture. Secondly, to determine what knowledge of English-speaking Caribbean culture is used in intervention by social workers in a mental health setting. Finally, the researcher

will examine how social workers take what they know about a culture and formalize it, so that they can use it in practice.

#### Justification of the Study

The role of cultural knowledge and culture-specific intervention in social work has become increasingly significant with the expansion in the number of culturally diverse immigrant groups. More than 5,000,000 legal immigrants have settled in the United States during the past 15 years (Department of City Planning, 1992), many of these from developing countries. In the advent of structural transformations occurring in the health care system, mental health is imminently at risk of receiving reduced services. New regulations imposed by Managed Care Systems and proposed expansions of mental health services to immigrant populations, require increased accountability and sensitivity by providers. These changes also suggest a shift to a population-based system of care.

It is therefore important for the development of programs, which will facilitate culturally relevant, cost effective human services with expanding segments of the client population, including ethnically different immigrant groups. The English-speaking Caribbean population is one such group. However, knowledge of their culture and the

development of specific treatment procedures are essential in order to prevent harm and to adequately implement such desired programs. Realizing a deficiency in this area, the New York City Department of Mental Health has provided funding of over \$400,000 for the sponsorship of mental health programs for Caribbean immigrants. Among the issues to be addressed in these programs were staff preparedness and their understanding of the culture of the clients' country of origin (New York City Department of Mental Health, 1992).

If there is a lack of cultural knowledge among social workers or if such knowledge is used inaccurately in intervention, clients will be hurt rather than helped. Cortes (1990) aptly notes that avoidance of culturally congruent health care for diverse populations, in a multi cultural society is both unrealistic and inadequate. In an attempt to ensure that mental health providers respond adequately to cultural differences, the department of mental health, through an administrative directive, encouraged the development of culturally competent practice by its sponsored agencies, (Marcos, 1993). Cultural competence is viewed as "a set of congruent behaviors, attitudes and policies that come together in a system, agency, or among professionals and enable that system, agency or those professionals to work effectively in cross-cultural situations" (Cross, et. al, 1989).

In summary, schools of social work, as well as mental health providers, are faced with the challenge of training clinicians to meet this growing need for expertise in working with various ethnic groups. However, the role of culture in the psychiatric treatment of newly arrived immigrants has been undervalued. By identifying the knowledge-base of what is known and required for working with this population, it is hoped that mental health professionals will view the acquisition and increase of cultural knowledge as an integral prerequisite to the intervention process.

## CHAPTER II

## REVIEW OF LITERATURE

Culture and Mental Health

A basic premise of this study is that culture is a significant factor in the delivery of human services. This review will commence by focusing on theories and research concerning the importance of culture in mental health. Secondly, the knowledge required by social workers, who work with English-speaking Caribbean immigrants will be established, since this is a prerequisite in determining if they have the cultural knowledge-base. Culture, as used here, refers to the shared history, customs, practices, beliefs and values of a racial, regional or religious group of people (d'Ardenne, P. and A. Mantani, 1990). An extension of this definition, for purposes of this study, include the characteristics of immigrant experiences, such as adjustment problems, adaptation and levels of acculturation.

The role of culture as a key factor in mental health care became increasingly important with the onset of the community mental health movement (Foulks, 1980). Prior to the 1960's, cross-cultural knowledge and a multi-cultural approach were not thought to be significant enough to warrant special consideration in human services delivery.

However, with the increase of diverse immigrant groups, such as Caribbeans, Latinos, Vietnamese and more recently, Eastern Europeans, in the United States, as a result of immigration, the interest in cultural relevance has escalated. (Kinzie, 1978, Fandetti and Oldmeier, 1988, McGoldrick, et al 1982; Chau, 1991). These writers assert that the manner in which the clients interact with the mental health system, is a function of their cultural background. In addition, it was suggested that clinicians must come to grips with the realities of dealing with clients, whose cultural background was different from their own. Culture does not only play a major role in shaping how people think, feel and behave, but often provides the guidelines for evaluating emotional illness, for its management and treatment. David McGill, (1992), suggests that therapists are not expected to know everything about a particular culture, but must be responsible for knowing something about the customs of different cultural groups with whom they work.

Mental Health practitioners are expected to treat large numbers of ethnically diverse individuals, whose problems are often identified as unique and requiring special intervention approaches (Kinzie, 1978). This has led to the development of concepts such as cultural or ethnic sensitivity (Lorenzo and Adler, 1984, Devoe and Schlesinger, 1981); multiculturalism (Dillard, 1983; Sue, 1981); bi-

culturalism (de Anda, 1984; Pedersen, 1985). Ethnically competent practice (Gibbon, 1983; Cross, 1988; Due, 1977) and culture-compatible approaches (Flaskerud, 1986), emerged as the prescribed methods of treatment for these populations.

The thrust of this literature was the promotion of a multicultural perspective, concerned with the efficacy of services to the various ethnic groups in particular, Latino, Asian and African-American, focusing on their cultural values and socio-cultural realities (Chau, 1991). However, these concepts and approaches have clearly not been applied. Furthermore, studies have concluded that "ethnic minority groups" are under served and poorly served in the mental health system (President's Commission on Mental Health, 1978; Sue, 1987; Kellerman, 1986). This is due in part to the unfamiliarity with the clients' customs, which would inform intervention, by social workers and other mental health practitioners.

The effects of acculturation on psychosocial functioning and mental health, have been addressed in the literature (Matsuoka, 1990; Padilla, 1980; Broom and Selznick, 1963). Broom and Selznick (1963) note that in the course of adjusting to their new environment, immigrant groups to the United States undergo varying degrees of acculturation, i.e., a form of cultural change in which they take on the cultural forms, beliefs, values and practices of

the host society. The rate and extent of cultural adaptation and its effects on mental health, vary among groups. Comas-Diaz(1982) in her study of the role of acculturation in the psychopathology of Latinos, identified different levels of acculturation, each characterized by various degrees of adherence to one's culture of origin or adaptation to the host society.

Similarly, McNicol (1993) observed two types of "cultural transitions". The first is a physical transition, which involves economic security, employment and educational opportunity; communicating adequately in the host society; and being able to comprehend the difference in social and political systems. In the second stage, immigrants try to deal with the psychological pain of relinquishing what they are accustomed to and accepting the new society. This phase can result in stress and dysfunction. It includes the loss and mourning the loss of family, friends and culture. Occasionally, the loss is exhibited in psychosomatic illness, poor social and occupational adjustment, depression, a state of uncertainty, increased aggression, conflict in interpersonal relationships, and denial of feeling relating to depression. It was strongly suggested that clinicians assess the clients' acculturation and use that knowledge to enhance their intervention.

Matsuaka (1990) points out that immigrants' exposure to a different framework of implicit rules and expectations, "predisposes individuals to disruptive emotional states and a perceived loss of personal effectiveness" (1990 p. 341). Consequently, problems of adjustment to the new society should be given as much consideration as intrapsychic concerns. Berry and Annis (1974) in their study found a correlation between the rate of behavioral disorders and stresses of migration. The factors inducing stress include culture change, breakdown in family ties, and various forms of discrimination. Balgopal (1988) in his study of Asian immigrants (including East Indians from the Caribbean) to the United States, concluded that for effectiveness, it is important that social workers have a basic knowledge about immigrant groups and develop sensitivity to the pain and conflict experienced by this group, in the process of adaptation.

#### Cultural Knowledge in Mental Health Care of Culturally Diverse Groups

Although many writers identify the need for social workers' knowledge of the culture of clients (Banks, 1975; Sundberg, 1984; McGoldrick, 1982), there is a paucity of research on this issue. In his analysis, Dugans (1981) asserts that culture is an ever present factor in psychotherapy. The significance of a cross-cultural

knowledge-base in mental health has been elaborated in the literature. (Green, 1982; Sue and Zane, 1987). Lack of such knowledge often leads to misunderstanding and misinterpretations of cultural variation, which cause alienation and an inability to develop trust, credibility and rapport. (Sue and Sue, 1977). Furthermore, cultural knowledge is of critical importance in the formulation of diagnoses and treatment of culturally variant groups. According to Jacobs and Bowles (1988), mental health professionals need to have an understanding of the value systems, family interaction patterns, gender roles, parent-child relationships, help seeking behaviors and the impact of immigration. In addition, a comprehension of language characteristics, inflection, accent and differential use of words are essential. With a knowledge of these cultural factors, social workers will be better prepared for practice and thus avoid treatment failures with ethnically variant groups.

A similar position is put forward in the literature on cross-cultural counseling (Baker, 1989; Marsella and Pedersen, 1981; Brislin and Pedersen, 1976); Pedersen, 1983; Giordano, 1976; Green, 1982; Sue, et al, 1982; Kavanagh and Kennedy, 1992). The principal view of these writers is that a working knowledge of the clients' culture will not only preclude misunderstandings, but will also decrease ignorance, racism and cultural insensitivity. However,

sensitivity with inadequate cultural knowledge often results in fear of mismanaging situations and causes resistance. One of the practice competencies identified by Sue, et al, (1982) is that which requires specific knowledge and information about the particular client groups. The knowledge-base is needed for developing cross-cultural understanding of the generic dimensions into which all cultures fit (Baker, 1989). Pedersen (1988) outlines three sequential stages of multicultural development, namely; awareness, knowledge and skills.

The awareness stage emphasizes assumptions of differences and similarities of behavior, attitude, and values. The knowledge stage expands the amount of information about culturally learned assumptions. The skills stage adapts effective and efficient action with people of different cultures and to participants' clarified assumptions and accurate knowledge. (p. 188).

It is the knowledge stage that is emphasized in this study. Cultural awareness and cultural knowledge would facilitate informed skill in working with different ethnic groups.

Sue and Zane (1987) in their analysis suggest that in developing treatment plans, it is crucial to consider culture and ethnicity and their effect on therapeutic outcomes. Nevertheless, Green (1982) and Sue (1987) conclude that both the current degree of cultural knowledge by social workers and the approaches used to acquire that

knowledge are inadequate at best. This is evident when workers act on insufficient knowledge or over-generalize what little has been learned about ethnically diverse groups. Furthermore, use of particular theoretical framework by social workers is not sufficiently examined within the context of the clients' needs and values. A basic requirement for this, however, must be a knowledge of the ethnic group's culture and experiences (Sue, 1977). Cultural knowledge and information clarify alternatives and reduce the ambiguity in the worker's understanding about a culture (Pedersen, 1988).

In the process of making clinical assessments of ethnic groups, Fandetti and Goldmeier (1988) discuss the role of the social worker as a "culture mediator", particularly for recent immigrants into the United States. Workers need to adequately interpret the ethnic influences that motivate clients to ensure effective treatment (p. 172). Such a view is directly linked to the culturally sensitive approach, expressly desired by many human service agencies, which, as Smith (1989) and Rogler, et al. (1989) indicate, demands the use of techniques, which incorporate knowledge of ethnic group culture. Leininger (1985) supported this view when he referred to transcultural caring as, "using cultural knowledge and skills creatively to help people live and survive satisfactorily in a diverse and changing world" (p. 126).

It is clear that the literature stresses the importance of cultural knowledge in the mental health care of ethnically and culturally diverse groups. Nonetheless, there has been no serious attempt to learn what social workers know, and with the exception of a few studies with Latino clients (Canino and Canino 1982); Costantino, Malagady and Rogler, 1985), the evaluation of the use of cultural knowledge is lacking. In their study of migrant Puerto Rican families, Canino and Canino found that therapists' comprehension of various aspects of the clients' culture greatly enhanced their therapeutic effectiveness. Such understanding precluded ethnic stereotyping and prejudices. Costantino, et. al, conducted an exploratory study of 200 Latino clients, focusing on social workers' use of cuentos or folktales as a therapeutic tool. The knowledge and use of folktales, juxtaposed with cultural elements of the host society, it was found, had a positive effect on therapeutic outcome.

Szapocznic, Scopetta and King (1978) conducted an exploratory study on a culturally focused topic, in which they examined workers' cultural sensitivity in the treatment of Latino immigrants. They conducted interviews with counselors to determine their perceptions of treatment effectiveness with different outreach methods, intervention

approaches and client/worker relationship. The findings were used to conduct a more rigorous investigation.

The present study will attempt to explore the cultural knowledge base of social workers by examining mental health intervention with English-speaking Caribbean clients and to determine how that knowledge is utilized in practice.

#### The Acquisition of Cultural Knowledge

Since one of the objectives of this study is to determine the knowledge-base of social workers, it is important to explore the ways in which knowledge of another culture is learned. In his discussion on cross-cultural learning, Green (1982) states that, although the practitioner's personal qualities, such as warmth, empathy and style are needed for effective intervention, relevant knowledge, i.e., knowledge of values and customs, appears to be one of the main ingredients in working with "ethnic minorities". However, two key questions must be addressed on the issue of knowledge acquisition. (1) How is the knowledge acquired? (2). What must be considered in the process of acquiring knowledge of another culture? An examination of the steps for development of knowledge, as presented by Taft (1977) provides useful insight into the first question, while d'Ardenne and Mahtani (1990) in their discussion, of transcultural counseling, highlight the second.

The first conduit of learning is identified as "cognition," which is characterized by the learning of what members of a particular culture know about their own culture and more significantly, how they experience it. The task of the social worker is to attempt to understand the belief system and behavior patterns, as these are perceived by the group members, since cognitive processes are influenced by culture (Segall, 1979). The second type of cultural learning is referred to as "affective", in which knowledge of culture is learned experientially, through observation or actual participation, and can be acquired either through (1). overt expressions of the culture, such as dance, play, work and eating habits, or (2). other unique cultural characteristics, including interpersonal relations, facial expressions and demeanor.

Taylor, (1989) in identifying cultural items in the process of learning about another culture, refers to the need to acquire knowledge of inherited customs, such as taboo foods, typical dishes, preferred types of music, and dances. d'Ardenne and Mahtani, (1990), argues that information about other cultures is sometimes acquired from a curiosity and desire to make contact with these cultures. This occurs either by direct contact, e.g., through kinship, friendship or travel, or indirectly through literature, second-hand accounts or the media. Cultural information is also gained directly from clients by discussing with them

what is of significance in their culture. With reference to issues to be considered in acquiring cultural knowledge, the following were posited as important prerequisites, prior to engaging the client: Worker's range of intercultural experiences and information outside of therapy or counseling; the source of cultural information, i.e., actively, through reading or traveling, or by circumstance, by being born in multicultural community or being educated in multicultural institutions; specific knowledge the worker may have about the client's culture; and whether or not the worker's experiences and information will be used in intervention (d'Ardenne and Mahtani, 1990).

The above-mentioned characteristics of knowledge acquisition represent the essential elements in the cross-cultural learning process. This could be a measure of what the social worker knows and the extent to which he or she applies the knowledge in problem resolution of a cultural group. For Green (1982), this represents an assessment tool for cultural competence. It also reflects a culturally sensitive approach, which emphasizes the use of strategies which incorporate knowledge of the unique characteristics of a group. In their studies of barriers to cross-cultural communication, Kavanagh and Kennedy (1992) found that most health care professionals are educated to focus on individuals and not to think in terms of sub-populations.

They tend to believe that issues involving aggregates of people are not relevant to their practice.

### Psychosocial needs of English-speaking Caribbean Immigrants

A discussion of the psychosocial needs of English-speaking Caribbean clients, will set the stage for exploring the cultural information required to increase cultural knowledge and informed intervention. Caribbean immigrants by virtue of their racial and ethnic identity, have been placed within groups which are designated 'minority' status, in the United States. These are groups which have historically had a number of unmet social service needs, including the unavailability of adequate human service, high clinic drop-out rates and intervention by clinicians who are either insensitive or lack the knowledge about their culture (Jones and Korchin, 1982).

It was found that a multiplicity of culture-related adjustment problems and psychosocial needs arise for many immigrants in the new environment. These include the findings that those who had resided in the United States for two to five years were more at risk of having psychiatric problems, than were persons who had resided in the United States for more than five years (Canton, 1984). Further, there is a proliferation of communication obstacles when the client's psycho-history and cultural background are not

understood by the practitioner. These problems occur as a result of psychosocial difficulties which often accompany the immigration process. (McKenzie, 1984)

Many English-speaking Caribbean immigrants attempt to understand and handle their problems, including emotional distress, without professional help. Instead, they tend to use alternative resources such as family, friends, religion, folk beliefs, consulting with spiritualists or networking with others from their own culture. They try to cope by preserving strong cultural links with their homeland. Being able to go back home periodically and connecting with a customary way of life, fulfill an important psychological need which helps them to adapt to the new society. Nevertheless, the number of English-speaking Caribbean immigrants referred to mental health services, following re-settlement has markedly increased (McNicol, 1993; Personal Observation).

In an exploratory study of this population, Marco Mason (1984) examined some of the psychosocial problems related to health care. Several practitioners in the health and mental health field were interviewed. Among the problems Mason enumerated were those related to health characteristics; cultural attitudes toward mental health care; and social and linguistic differences. In addition, some clients' use of Creole terms such as "dem" for them, "tree" for three and

the dropping of the "h" sound in many words, has led to misunderstanding by many mental health practitioners.

An understanding of how English-speaking Caribbean immigrants conceptualize psychotherapy and the therapeutic relationship has been lacking. As a prerequisite to providing mental health care of this population, such a relationship has not been familiar in Caribbean social structure. McNicol notes,

West Indians generally do not understand or readily accept either psychotherapy or mental health professionals. They tend to seek help as a last resort and it is usually a child who is the identified patient. One reason for this reluctance is their lack of exposure to and unfamiliarity with the field of mental health in their home countries. Another reason is that their approach to solving problems are kept within the family and solved there. (1993, p. 103).

Other barriers reported by McNicol, as causing a lack of acceptance or resistance to psychotherapy include: The stigma attached to mental illness, since many West Indians believe that only "crazy" or "mad" people receive therapy; the belief that mental illness is inherited and, therefore seeking treatment would reflect negatively on family status; and the concept of time. Owing to the informality of many West Indians, some clients would miss appointments or arrive for appointments when they are not scheduled, expecting to be seen. Often the scheduled time of therapy conflicts with

their job or educational program, activities which are of extreme importance to the West Indian immigrant.

...it is typical for adults to hold at least two jobs. Therefore, the therapist may have to be flexible in scheduling treatment so that the therapy does not interfere with educational and work opportunities. If treatment result in the loss of wages, the family or individuals may become resistant and resentful (McNicol, 1993,p. 120).

The social workers' characteristics, such as gender, age, cultural background and knowledge of work, play an important role in the manner in which Caribbean immigrants relate to them. For instance, Brice reported that members of this population, "tend to respond best to an older male therapist because this is syntonetic with the cultural respect most feel for men and elders" (1982), p. 130). However, once the clients decide to meet and talk with the social worker, regardless of age or gender, he or she is generally treated with respect and viewed as a knowledgeable professional, similar to a medical doctor, teacher, or civil servant.

On the issue of racial or cultural compatibility between therapist and client, McNicol (1993) urges that mental health practitioners need to explore their own feelings, attitudes and stereotypes about English-speaking Caribbean immigrants, noting that:

A therapist of a different race and culture may encounter difficulties in working with West Indian families....Many therapists simply perceive them as Black and dismiss their immigrant status because they speak English, thus denying them the special considerations that are given to most immigrants. (1993, p. 115).

Similarity in cultural background and sensitivity of the social worker can promote a positive therapeutic environment, thus English-speaking Caribbean social workers may be ideal for working with this population. However, the author warns,

Since many West Indian therapists are not knowledgeable of their own culture, ...a sensitive non-West Indian is preferable to an insensitive West Indian... a degree of cultural understanding and similarity helps. A therapist who has experience with immigrant families in general and is aware of West Indian communication patterns (such as dialect, colloquialisms, and non-verbal expressions) has a greater chance of success... (1993, p. 177).

The psychosocial needs of Caribbean immigrants, especially the new arrivals, are viewed within the context of their immigrant experience. They are usually unfamiliar with social services and lack the information to access such services. Furthermore, adjustment rate and patterns are often influenced by education and social class, as well as pre-migration residence, i.e., urban or rural. For many immigrants, the "traditional views of morality are tested in the face of endless competition and economic rationalism" in the new society (Singh, 1993, p. 121).

Migration often results in the separation of family members, leaving children behind with other caretakers with whom they have become attached. Children may join their parents in the United States at a subsequent date (usually later than expected). By the time they are reunited with their natural parents, conflicts around such issues as interpersonal relationships, cultural differences and parental guilt, caused by perceived abandonment, have to be addressed. In their study of thirty English-speaking Caribbean families, Thrasher and Anderson (1988) reported that in every case, spouse and children were left in the home country, while children in 23 of the families were raised by extended family members. Pederson (1984) urged serious consideration and knowledge of such migration patterns and characteristics as part of the social workers' repertoire of cultural knowledge.

During the 1970's and early 1980's women from the Caribbean, rather than men from that region pioneered in their migration to the United States. This occurred primarily as a result of economic opportunities for women, restructuring of immigration laws, and changing gender roles. Caribbean women's heavy demand in service occupations, such as homemaker and their willingness to accept low wages, facilitated for them a central role in establishing "beach-heads" for subsequent migration of other

family members (Chaney, 1987; Department of City Planning, 1989). Invariably, the execution of that role has resulted in increased economic power and independence of Caribbean women, a situation which, for the most part is incongruent with that which existed in the Caribbean. Consequently, some Caribbean men have felt emasculated and in some instances, this has led to depression, loss of self-esteem, family conflict and divorce. In their pioneering role, however, some Caribbean women experienced a significant degree of physical and emotional stress, sometimes leading to severe mental illness (Rey, 1992).

Owing to the prominence of the extended family in the Caribbean, many close relatives left behind, often become an additional financial responsibility to both men and women who migrate to the United States. Cash remittances, barrels of foodstuff, clothing, and other items are regularly sent to relatives in the Caribbean.

In the Caribbean, mental illness or "nervous breakdown" is often seen as spiritual, and family dysfunction is typically perceived as caused by evil spirits. Folk beliefs tend to be deeply embedded in the culture and influence the peoples' lives (McNicol, 1993). It is not unusual to find immigrant spiritual healers practicing their craft in the United States, in neighborhoods where there is a high concentration of Caribbean immigrants.

The use of home remedies to treat "nervousness" is prevalent among English-speaking Caribbean immigrants. For example, the ingestion of herbs or folk medicines, concocted at home and used to treat somatic, as well as psychological illnesses, is not uncommon. Some of these remedies have reportedly had the desired effects on the consumers' mental health. Often, however, as a result of this practice, the condition of some persons may decompensate into serious mental distress, due to delays in obtaining professional help, if and when folk remedies fail. In this regard, Lui, (1993) found that, rather than ignore or reject traditional cultural health practices, an attempt should be made to integrate such practices with the knowledge and techniques acquired from western psychotherapeutic training. Failure to employ this integrative approach, is likely to result in resistance to any intervention.

Moreover, Taylor (1989) emphasizes the value of knowing about the existence and prevalence of folk beliefs and belief in spiritualism among different cultural groups. Recognizing the profound influence of folk beliefs among this population, Rey (1992) argues that clients should be allowed to go to spiritualists simultaneously with receiving psychotherapy.

As is the case with other immigrants, turning to formal social service agencies for assistance is usually to admit failure. One of the principal goals of migrating is economic advancement, but if this effort fails, the manifestation of problems such as depression, alcohol abuse, psychosomatic illness and marital conflict tend to escalate (Balgopal, 1988).

Psychosocial needs are frequently influenced by the level of acculturation and the assimilation process. It is, therefore, important to assess the normal acculturation problems of immigrants. Such problems are exemplified by the experiences of immigrant children. The children of English-speaking Caribbean immigrants, who were born in the Caribbean, are generally less assertive than their African-American counterparts. This is partly attributed to the child's experience in the new environment, which is not only different, but may be perceived as hostile, threatening and thus making the adjustment process difficult. Unfortunately, some of these children have been placed in special education classes, not because of a learning disability, but as a result of misunderstood cultural differences, including speech patterns and unassuming demeanor. Teachers, as well as social workers, are not sufficiently sensitive to cultural variations. Unrecognized resentment often result in behavioral problems in school and at home.

In one of the few studies on social work practice with this population, Sewell-Coker, Hamilton-Collins and Fein (1985) reported that self-consciousness about speech inhibit those immigrants, who are not yet familiar with the new culture, so that they appear shy and withdrawn. Further, social services, including mental health treatment, are usually sought because of parents' feeling of frustration and helplessness in their efforts to control their children, who are dealing with adjustment difficulties, especially in light of what is viewed by many immigrants as rigid child abuse laws. A high rate of child abuse among English-speaking Caribbean families has been reported by the New York City Department of City Planning (1989). Thrasher and Anderson (1988) found that corporal punishment was used to discipline children in 25 of the 30 families in their study. According to McNicol (1993),

many parents express anger, frustration and confusion that their system of discipline is in conflict with the dominant society and may even lead to allegations of child abuse by people unfamiliar with their cultural mores" (p. 110).

As a result of the above-mentioned stress producing factors, some immigrants, who are less able to cope with those changes, often send their children back to the Caribbean for a temporary stay with relatives there.

Balgopal, (1984) and Thrasher, (1988), found that attempts to cope with peer pressure and to assimilate the new culture may result in conflict with adult family members (first generation immigrants), who have internalized the traditional "West Indian" value system and strongly insist on its perpetuation. Consequently, some Caribbean immigrant children and adolescents, in trying to adapt, may begin to deny aspects of their culture, blame their parents for reinforcing their traditional customs, and act-out by over-identifying with various aspects of popular American culture.

Older adolescents tend to move away from parents or family of orientation earlier than they would in their home country. This may affect their parents' pride, hopes and expectations and stymie their desire to influence the lives of their children into adulthood, resulting in feelings of depression and anxiety or promote family conflicts. Such pressures, singly or combined, have been featured dynamics in the psychopathology of the child/adolescent, as well as the adult immigrant client. It is important to be knowledgeable of the social and psychological stressors which are experienced by this group and the way in which they are related to cultural factors.

Thrasher and Anderson (1988) in their study also found that these immigrants underutilized social services. Not

only is there a resistance to involvement with agencies, but often the institutions and the staff have not developed a frame of reference for understanding and appreciating the culturally determined choices these clients make. Comparably, the phenomenon of underutilization of mental health facilities among Latinos has been examined by Rogler et al (1989). The authors distinguished between alternative resource theory and barrier theory. The former describes the use of alternative sources of mental health care, such as family, friends, neighbors and folk healers, instead of the mental health agency system. In the second, two types of barriers to the utilization of mental health facilities are: (a) the cultural values and beliefs, such as familism, fatalism; (b) the value of trust.

Institutional barrier theory focuses on the incongruities between the norms of Latino culture and those of the mental health system, including prejudice and discrimination experienced by this group. It is not that Latinos do not wish to seek professional help, but they have been discouraged by institutional obstacles, such as the shortage of bi-cultural, or Spanish-speaking workers, who are able to understand the therapeutic function of folk beliefs.

The English-speaking Caribbean immigrant family has been known for its resilience, strength and adaptability

(Rambally, 1993). Nevertheless, as immigrants, they are faced with an unpredictable dilemma. For instance, some host relatives, unlike the situation and attitudes in an earlier period, seem to be unable or unwilling to assist the new arrivals during the crucial initial stages of resettlement. This is partly due to the fact that some host relatives have adopted values and attitudes of the new society. These include, being competitive instead of mutually supportive, and practicing individualism as opposed to communal activism. Intense competition among immigrant family members is not uncommon. Such attitudes are compounded by the fantasies about expectations in the United States, held by some immigrants. This in turn is fueled by misinformation about "the easy life" given by some who return to the Caribbean on vacation, and by the media. Unfortunately, disillusionment and disappointment are the inevitable outcome of such experiences by many new arrivals.

There is a significant number of undocumented Caribbean immigrants in New York City, who enter the United States, either unlawfully or overstayed their visas (Bogen, 1990). These individuals, because of their undocumented" immigrant status, are not entitled to the variety of social services available to others (Human Resources Administration, 1988). This situation invariably places heavy emotional and financial burden on those immigrants and their relatives. Because of uncertainties of institutional reaction to their

status, pertinent information relating to psychosocial problems is not shared voluntarily in human services settings. This may result in an exacerbation of any current or pre-existing illness.

There also exists a psychological barrier, characterized by the label "illegal aliens", to describe those who are undocumented. This designation inadvertently leads to social limitations and emotional stress, since groups are often treated and sometimes behave in accordance with how they are defined. Many undocumented immigrants are either unemployed, underemployed or they work "off the books", due to restrictions indicated in the Employment Eligibility policy of the Immigration and Naturalization Service, (E.R.C.A., 1986). As a result, they are ineligible for many health services and employee benefits. The New York City Department of Planning (1992) reported that a substantial number of immigrants lack health insurance coverage, many of them because of their undocumented resident status.

Another area of concern is tension caused by experiences of racism and negative stereotyping, which occur at an intensity unfamiliar to many Caribbean immigrants. This may lead, in some instances to emotional strain and social dysfunction. Immigrants are often considered a threat to some in the indigenous population, especially

within the context of economic hardships. Balgopal (1988) observes that newly arrived immigrants are often willing to work long hours for low wages under adverse conditions. For many of these immigrants, initial employment in the United States is characterized by occupational dissonance, whereby they take jobs, which in the Caribbean would be considered menial or degrading. An example of this would be a trained school teacher, who, after migrating to the United States, works as a security guard, or a civil servant (white collar government employee) who does home care. Inquiring about employment and work characteristics is central in Pedersen's (1989) categories of cultural items, namely: Is there a strong work ethic? Is multiple employment prevalent? Did occupation change? If so, how?

In his study of the major psychological concerns of Jamaican immigrants, Jama Adams, (1989) found that among their perceptions of the United States are: land of Opportunity; a place in the future; lacking a sense of community; and where it is difficult to develop an authentic self. The fear of losing one's self was a concern among the respondents in that study. Many felt marginalized, stating that they had to develop strategies to avail themselves to opportunities for personal development, while avoiding the many psychological pitfalls that could result in their leading false lives. Immigrants tend to cope with this

situation by one or a combination of the following: (a) nostalgic re-creation of past associations; (b) being critical of the new culture; (c) idealizing the home country; (d) superficial adjustment to the new reality (e.g. by adopting an American accent; (Marlin, 1993).

Owing to economic and political factors, there have been insufficient social service facilities in the English-speaking Caribbean countries and this has precluded adequate responses to many of the psychological and social needs of the citizens therein (Matthews, 1990). Indeed, that situation may have been the motivating migratory push factor for some immigrants. It is therefore, important to note that some Caribbean immigrants experienced a degree of social deprivation and/or psychological stress in their country of origin, where there has been a shortage of mental health services, and less than adequate human services. For some, the manifestation of symptoms of psychopathology became pronounced when they migrated to the United States, or shortly thereafter, when they are confronted with the values and unanticipated demands of the new society (Jenson, 1990).

Many Caribbean immigrants, soon after arriving, join the scrimmage of seeking employment and maintaining themselves. Not only are they surrounded by an unaccustomed volume of social violence and aggression in the streets, as

noted by Barrow-Luard (1982), but the decrease in service sector jobs created by budgetary cutbacks has been potentially stress producing, since many immigrants in New York City are employed in the municipal sector, (Department of City Planning, 1992).

Finally, the existence of so many unfamiliar cultures and ethnic groups in close proximity of one another, often produce stress, which is exacerbated in crisis situations. A classic example of this, is the 1991 ethnic clash in the Crown Heights section of Brooklyn, resident to a large English-speaking Caribbean population. In her discussion on cultural assessment, McNicol (1993) notes that Caribbean immigrants generally lived in homogeneous nations, where they were unaccustomed to racial and ethnic diversity and the flagrant racism often practiced in the United States. In this regard, the geographic and social transformation experienced by these immigrants influence psychological hardship and cultural conflict.

Based on the information found in the literature, as well as the researcher's own understanding of the culture and his clinical experience, the following are the areas of cultural knowledge needed by social workers, who provide mental health services to English-speaking Caribbean immigrants:

1. The role of the extended family:

Since the extended family is often involved in major decisions about individuals, it would be important to understand how it functions in this capacity.

2. Adjustment problems:

In their attempts to adjust to the new society, some immigrants experience social and psychological stress. For effective intervention, this must be understood within the context of service delivery.

3. Disciplinary practices:

These were found to present a particular concern for social workers. The methods of discipline used for children by Caribbean immigrants, including corporate punishment, often conflicted with what is normally acceptable in the United States.

4. Spiritualism and Folk Beliefs:

Since traditional folk beliefs were found to have a significant impact on the lives of many Caribbean immigrants, knowledge of such beliefs must be seriously considered.

5. Cultural celebrations; favorite foods; music and dance. These provide areas of cultural knowledge symbolizing the most essential overt expressions of the culture.
  
6. Communication patterns: These include words, accent, intonation and non-verbal messages that are characteristic of the population.

Summary of Studies on Social Work Intervention  
with English-speaking Caribbean Clients

Finally, although there has been some research on adjustment problems in social work intervention with this population, there has been no serious attempt to find out how the information is used in mental health care. A summary of the available literature on social work with English-speaking Caribbean clients, concludes this chapter. (See the Grid on pages 42 to 50).

Among the key findings in these studies are:

1. There are culture-specific characteristics of English-speaking Caribbean immigrants, which have bearing on the intervention process, on the outcome in

mental health care, and on the provision of other human services.

2. English-speaking Caribbean immigrants are reluctant to get involved with social services agencies. Cultural differences and the nature of provider receptivity contribute to that reluctance.
3. Practitioners in the human services, including mental health professionals, who work with this population, tend not to be culturally competent.
4. A multi-cultural approach would be most effective in working with this population.

However, no data is available on practitioners' cultural awareness, knowledge and skill. It is clear, therefore, that the social work profession and mental health practitioners first need to acquire an adequate amount of cultural knowledge i.e., knowledge of the client's customs, values, language peculiarities and migration experience. Secondly, they have to learn how to take what is known about the culture and formalize it, so that it can be used in intervention. This study

attempts to provide such information as it relates to English-speaking Caribbean clients.

Figure 1.

SUMMARY OF STUDIES ON SOCIAL WORK INTERVENTION  
WITH ENGLISH-SPEAKING CARIBBEAN IMMIGRANTS

<u>Study</u>	<u>Objectives</u>	<u>Sample</u>	<u>Method</u>	<u>Findings and Conclusions</u>
<p>I. "Cultural Readjustment, coping strategies and mental health status of West Indians residing in a U.S. metropolitan area" (D. Canton).</p>	<p>1. To identify cultural readjustment tasks that were most stressful to Caribbean immigrants.</p> <p>2. To identify coping strategies that were most frequently used.</p> <p>3. To describe relationships among perceived cultural readjustment stress, coping strategies and mental health status.</p>	<p>30 English-speaking Caribbean immigrant students.</p>	<p>Descriptive survey design; interview of students.</p>	<p>1. Married subjects had a higher level of mental health than did single subjects.</p> <p>2. Persons who resided in the U.S. for 2-5 years were most at risk for having psychiatric problems than were persons who resided here for more than 5 years.</p> <p>3. Cultural readjustment problems correlated with level of income</p>

Figure 1.  
(continued)

Study	Objectives	Sample	Method	Findings and Conclusion
<p>II. "The West Indian Family: Treatment Challenges" (S. Thrasher and G. Anderson)</p>	<p>1. To identify aspects of English-speaking Caribbean culture.</p> <p>2. To determine the effects of the immigrant experience on family functioning.</p>	<p>30 families of English-speaking Caribbean immigrants in a preventive social service program.</p>	<p>Exploratory-contents analysis; questionnaires and interviews of adult family members; interview of social workers; review of case records.</p>	<p>1. This population prefers to resolve problems within the family.</p> <p>2. Most referrals were as a result of reports on child abuse from child protection services and from the school about children having academic or behavioral difficulties.</p> <p>3. Subjects resist involvement with social services agencies and human service professionals.</p>

Figure 1.  
(continued)

Study	Objectives	Sample	Method	Findings and Conclusion
<p>III. "Ethno-cultural Factors in counseling with male West Indian-American adolescents" (V. McKenzie)</p>	<p>1. To bridge the gap in the literature on counseling Caribbean immigrants.</p> <p>2. To contribute to the beginnings of a theory of ethnocultural English-speaking Caribbean adolescents.</p> <p>3. To develop a list of ethnocultural factors that would be useful working with Caribbean immigrants.</p>	<p>Sample of 9 male English-speaking Caribbean adolescents; 10 counselors.</p>	<p>Exploratory study; qualitative design; interview of students, psychologist and counselors.</p>	<p>1. Immigrant adolescents are often reluctant to interact with professional counselors. This resistance arises from strong cultural beliefs against seeking outside help.</p> <p>2. Differences in linguistic codes and communication traditions for speaking and listening; create intervention problems.</p> <p>3. All participants in the study saw the need for improvement in counselor's attitude (positive, open, culturally sensitive and non-judgmental).</p> <p>4. That it is important to have accurate information about client's culture.</p>

Figure 1.  
(continued)

Study	Objectives	Sample	Method	Findings and Conclusion
<p>IV. "Social work Practice with West Indian Immigrants" (B. Sewell-Coker, B. Collins, E. Fein)</p>	<p>1. To examine migration patterns and problems of Caribbean clients. 2. To explore the advantages and disadvantages of ethnically matched clients and therapists.</p>	<p>Purposive sample of cases.</p>	<p>Descriptive case study examples; review of case records; interview of clients</p>	<p>1. English-speaking Caribbean clients value property and may work more than one job to acquire and maintain property. 2. Boys are allowed more freedom, but girls may be referred as clients when they rebel in an attempt to obtain more freedom and be like their American friends. 3. Self-consciousness about speech may inhibit those who are not yet familiar with the new culture, so that they appear shy and withdrawn. 4. Services are usually sought because of parents' feelings of frustration and helplessness in their efforts to control their children, who are dealing with transitional difficulties.</p>

Figure 1.  
(continued)

Study	Objectives	Sample	Method	Findings and Conclusion
<p>V. "The Role of Acculturation in the psychopathology of West Indian clients" (H. Barrow-Luard).</p>	<p>1. To assess the effects of acculturation on mental health problems among English-speaking Caribbean immigrants.</p> <p>2. To assess the potential influence of cross-cultural dynamics on the therapy situation.</p>	<p>A sample of 17 social workers; case records (random sample).</p>	<p>Exploratory; interview of social workers; review of case records.</p>	<p>1. 76% of the staff had little or no knowledge of English-speaking Caribbean culture.</p> <p>2. Stereotypes about clients' culture affected the way they were treated.</p> <p>3. The majority of staff members regarded the inability to successfully adapt to American culture as being the major factor in mental illness.</p>

Figure 1.  
(continued)

Study	Objectives	Sample	Method	Findings and Conclusion
VI. "Ethnographic interviews with West Indian families and a workshop for practitioners" (S. Thrasher).	<ol style="list-style-type: none"> <li>1. To describe English-speaking Caribbean families from their own prospective and experiences.</li> <li>2. To present information for culturally relevant intervention.</li> <li>3. To provide an empirical base for social work practice with this population.</li> <li>4. To develop a workshop designed for practitioners who work with Caribbean immigrants.</li> </ol>	30 English-speaking Caribbean families in a preventive program.	Qualitative; ethnographic interviews; content analysis.	<ol style="list-style-type: none"> <li>1. The English-speaking Caribbean adult immigrant migrates unaccompanied by children and spouse.</li> <li>2. There is very little or no contact with social service agencies.</li> <li>3. Preference for family resolution of problems.</li> <li>4. Motivation to seek help if child is experiencing difficulties at school.</li> </ol>

Figure 1.  
(continued)

Study	Objectives	Sample	Method	Findings and Conclusion
VII. "West Indian Families" (J. Brice)	<p>1. To identify and discuss the cultural factors instrumental in the treatment of English-speaking Caribbean immigrants.</p> <p>2. To outline the differences between English-speaking Caribbean families and African American families.</p>		A conceptual study; archival research method; case review.	<p>1. The need for cultural sensitivity by therapists treating English-speaking Caribbean clients.</p> <p>2. There is a need for therapists to have some knowledge of the West Indian family structure, as a tool to therapeutic intervention.</p>

Figure 1.  
(continued)

Study	Objective	Sample	Method	Findings and Conclusion
<p>VIII. Working with West Indian Families (S. McNicol)</p>	<p>1. To determine the impact of culture on assessment and treatment.</p> <p>2. To identify the cultural values of West Indian immigrants and the problems of adaptation in the U.S., Canada and Britain.</p> <p>3. To present techniques for working effectively with West Indian clients.</p>	<p>West Indian families from the author's practical, clinical and supervisory experiences. West Indian immigrants in the United States (236); the United Kingdom (87); and Canada (77); 390 West Indians living in the Caribbean.</p>	<p>Questionnaires to gain an understanding of the values that are unique to West Indian culture: The West Indian Attitude Survey; Immigrant self-concept scale; Immigrant Attitude survey; Informal interviews.</p>	<p>1. West Indians are more responsive to psychological help and educational services in culturally sensitive settings.</p> <p>2. The multi-cultural approach will increase the effectiveness of practitioners working with culturally diverse groups.</p>

Figure 1.  
(continued)

Study	Objectives	Sample	Method	Findings and Conclusion
<p>IX. "The Development of a framework for health care among Caribbean Immigrants." (M. Mason)</p>	<ol style="list-style-type: none"> <li>1. To provide an understanding of the cultural dynamics and the health characteristics of English-speaking Caribbean immigrants.</li> <li>2. To examine their health and mental health needs, barriers to the provision of health care services and the factors that influence how health care services are utilized by this population.</li> <li>3. To develop a model for effective health care with English-speaking Caribbean immigrants.</li> </ol>	<p>A purposive sample of health care agency managers and administrators. Case studies of English-speaking Caribbean recipients of health care services.</p>	<p>Exploratory research design. Field study approach.</p>	<ol style="list-style-type: none"> <li>1. Health care services to English-speaking Caribbean immigrants in New York are ineffective.</li> <li>2. Caribbean immigrant communities face social barriers to health care services.</li> <li>3. Barriers include their immigrants status, adjustment problems, folk beliefs, linguistic barriers and cultural attitudes toward health care.</li> <li>4. There exists a dearth of research on the psycho-social adjustment problems of English-speaking Caribbean immigrants.</li> </ol>

CHAPTER III  
RESEARCH METHODOLOGY

Introduction

Increasingly, social workers practice in settings composed of disparate populations. This makes it imperative that they understand cultural diversity and respond adequately to the psychosocial needs of clients, including newly arrived immigrants.

The knowledge and techniques of intervention utilized by social workers providing mental health services to English-speaking Caribbean immigrants are neither well-known nor documented. Practice theory, according to Siporin (1975) should be continuously checked and revised in relation to changing conditions and needs. This study of the nature and extent of cultural knowledge of social workers, is an attempt to examine an area of practice in which significant changes are occurring, changes in the need for sensitivity to the client population and the demand for culturally relevant intervention.

More specifically, the study seeks to assess social workers' behavior as it relates to the sequential stages of multicultural development, i.e., awareness, knowledge and skill (Pederson, 1988). The extent of the cultural

knowledge of social workers, the use of that knowledge in practice and how to increase both, is the essence of this research. Increased awareness and knowledge would lead to the development of informed skill, which is a function of cultural competence.

The delivery of mental health services to culturally diverse groups requires sensitivity, knowledge and culturally specific strategies (Sowers-Hoag and Siddharthan, 1992). Effective intervention with English-speaking Caribbean immigrants necessitates an understanding of social workers' cultural knowledge and the way in which they respond to clients in the process of providing mental health care. In order to achieve this understanding, it is important to explore the content of social workers' knowledge and the use of such knowledge in a mental health setting.

#### Purpose of the Research

The purpose of the research is to explore the nature and extent of social workers' cultural knowledge of English-speaking Caribbean clients in a mental health setting. Three research questions emerge. They are as follows:

1. What is known by social workers of the culture of English-speaking Caribbean clients in a mental health setting?
2. What cultural knowledge do social workers feel is most important in mental health service delivery to English-speaking Caribbean clients?
3. Do social workers utilize cultural knowledge of English-speaking Caribbean clients? If so, in what way is the knowledge transformed in intervention?

#### Research Plan

The overall goal of the research is to develop an understanding of the clinical use of cultural knowledge and its relationship to direct practice. The data for this study were collected from questionnaires completed by social workers. The questionnaires included demographic data and information about the workers' knowledge of the culture. Two focus groups were conducted as a follow-up to the questionnaires, in order to provide more insight into the data furnished by the workers. Charts were reviewed by social workers and information about their intervention with clients was reported on a questionnaire. Charts were also reviewed by the researcher to compare information reported

by social workers. This was followed by the analysis of data, using analytical categories, interpretation of data and a discussion of findings.

#### Design

This is a qualitative, exploratory study and the goal is to contribute to the social work profession's knowledge of the culture of English-speaking Caribbean immigrants and the ways in which that knowledge is used in mental health intervention.

Qualitative research emphasizes the detailed descriptions of events, people, interactions and observed behaviors (Patton, 1989). This study will examine the experience of social workers and their interaction with English-speaking Caribbean clients. Babbie (1983) states that an exploratory design is appropriate when the subject is relatively unstudied. Similarly, Atherton and Klemmack (1982) note that exploratory research is used to explore a phenomenon or problem area in which clear knowledge or usable ideas are not well developed.

One purpose of exploratory studies is to develop hypotheses for further investigation. Essential preliminary information is produced to increase familiarity with a topic and can be used as a springboard for more detailed, systematic, quantitative research. In exploratory studies,

it is appropriate to use different strategies to gather information, usually on a small number of cases (Fellin, 1988). The present study employs a variety of data collecting strategies, which will be discussed in the data analysis section.

In examining the topic of cultural knowledge, the intent is to collect information from individuals, who are continuously involved with work in this particular problem area. In this sense, instead of starting with hypothesis, this study has the purpose of formulating the problem, "for more precise investigation or for developing hypothesis" (Selitiz, 1976). Furthermore, the exploratory design allows for the raising of pertinent questions and development of a meaningful theoretical framework in an area of unexplored conditions and needs.

### Sample

#### 1. Workers/Respondents

In order to assess social workers' knowledge of Caribbean culture, a purposeful sample of twelve respondents, who provide direct mental health services to English-speaking Caribbean clients, was selected. A purposeful sample was used because of the small number of workers in the study from whom the needed data could be attained, and the fact that they share certain

characteristics. The sample comprised of social workers whose selection was based on their willingness to participate in the study and their access to English-speaking Caribbean clients. The workers are all employed by the Bedford Stuyvesant Community Mental Health Center, an outpatient facility which has been selected for the study. The clinic is located in the north eastern section of Brooklyn, New York and serves a large number of non-Latino, Caribbean immigrants. In particular, approximately one in every five clients registered in the clinic is a Caribbean immigrant. (Statistical Report, Bedford Stuyvesant, CMHC, 1993).

The twelve respondents represent 80% of the total staff of fifteen social workers. Each of them has a masters degree in social work. The workers vary in gender, age, years of employment at the clinic, and cultural background i.e., English-speaking Caribbean or non-English-speaking Caribbean. Their primary responsibilities were, screening and intake, individual therapy and case management.

## 2. Clients/Case Records

The clients included in this study were: (1) English-speaking Caribbeans, responding to: "Jamaican", "Barbadian", "Trinidadian", "Guyanese", "Antiguan", "Kittician", "Nevisian", "Vincencian", "Dominican", or "Montserratian", on the ethnicity/race item on the clinic

intake form, and (2) who have been residing in the United States for less than fifteen years.

The people from the above-mentioned Caribbean countries share a common history of English colonial government; in general, they experienced the same educational system, which, to a large degree defines their value system; and many of them have the same level of aspirations. The countries are members of a trade and economic entity known as the "Caricom Community," which forges economic interdependence and comparable structural adjustments.

Unlike many other immigrants from large sending, developing countries, who often have serious linguistic problems in the United States and are affected more by push factors of migration (economic hardship, political persecution, excessive governmental restrictions), English-speaking Caribbean immigrants do not only speak the same language as the host society, but also often have a greater sense of awareness of the realities of the host country. This is partly due to the closer geographical proximity to the United States than most other countries. This results in more frequent communication and travel between the United States and the Caribbean (McGlaughlin, 1981). For most English-speaking Caribbean immigrants, migration to the United States is planned or sponsored.

Many of the customs such as music, dance, sports and recreation, art forms, folk beliefs, dress and cultural celebrations, such as Carnival are similar. In addition, the socialization of children takes on similar patterns (Brice, 1982; McGlaughlin, 1981). The dissimilarities among the people of the English-speaking Caribbean, though they exist, are few. This study included newly arrived immigrants, who have been residing in the United States for fifteen years or less, since they were less likely to be well-integrated into the American society.

A total of thirty six cases were to be reviewed by the respondents, in order to inform their responses. Twelve social workers were asked to select every third English-speaking Caribbean client on their respective caseloads, for up to three cases for each worker. However, the actual number of cases reviewed by the workers was twenty one. Two factors contributed to this: (a) the number of English-speaking Caribbean clients on the social workers' caseloads varied and (b) a number of clients have resided in the United States for more than fifteen years and, therefore, were not selected for the study.

#### Protection of Human Subjects

In order to protect the participants from risks emanating from their involvement in the study, the following steps were taken:

1. Individual respondents were not identified by name. Instead, questionnaires were completed anonymously by all participants.
  
2. Participants were informed both orally and in writing (through a formal letter) that:
  - a. all information will be treated with the strictest confidence and will be used exclusively for academic purposes;
  
  - b. the research was needed as part of a study requirement and the researcher is interested in their professional views on the topic;
  
  - c. the information is given voluntarily and will have no bearing on their work performance rating. It will not be used for worker evaluation.
  
  - d. the final project will be made available for them to read, if they so desire.

### Data Collection

The primary source of data for this project is information provided by the social workers at the Outpatient clinic of the Bedford Stuyvesant Community Mental Health Center. The study utilizes an experience survey, in which data were obtained from social workers, who regularly work with a particular group or problem (Atherton and Klemmack, 1987) namely, English-speaking Caribbean clients. The following instruments were used to gather information:

1. A questionnaire for social workers, consisting of variables on:
  - a. age, gender, place of birth and ethnicity of the worker;
  - b. knowledge of English-speaking Caribbean culture. In the formulation of descriptive questions for use in ethnographic interviewing, James Spradley (1979) points to the value of "native language" questions. In order to assess the social workers' understanding of English-speaking Caribbean terminology and customs, questions included examples of how particular terms and concepts are understood by the social workers, since meaning often varies according to context or culture; and

- c. intervention with English-speaking Caribbean clients.

2. A second questionnaire focused on the respondents' knowledge of the characteristics of Caribbean clients. The significance of such knowledge lies in the assumption that the way in which these clients relate to mental health services and to the practitioners, is influenced by cultural factors and their experiences as immigrants. Social Workers were asked to randomly select and review three cases of English-speaking Caribbean clients and to answer several experiential and culture-related questions. The purpose of this questionnaire was: a) to obtain the social workers' views in relation to intervention with English-speaking Caribbean clients, and b) to learn from these social workers how they intervene with Caribbean clients and their families i.e., approaches, effectiveness and frustrations.

3. Focus Groups. Two focus groups were conducted by a trained interviewer from outside of the agency center. He is a graduate student, holds a Masters degree in Human Resource Management, and a Bachelor's degree in Social Work. He has done interviewing for marketing research and is knowledgeable of English-speaking Caribbean culture. By selecting this interviewer, the researcher was able to

protect against familiarity between interviewer and participants.

One focus group was comprised of social workers from the English-speaking Caribbean and the other, social workers who were non-Caribbean. The intent was to have two culturally homogeneous groups, since dealing with culturally sensitive issues would tend to inhibit disclosure in a single diverse group. The English-speaking Caribbean group had five members, while the non-English speaking Caribbean workers numbered seven. The group sessions were tape recorded. Focus groups are useful as a type of qualitative method and participants are encouraged to tell their stories (Morgan, 1988). The purpose of the focus groups, as a data collecting tool in this study, was to acquire more detailed information and insight from social workers on their experiences in working with English-speaking Caribbean clients.

4. Researcher review of case records. These chart reviews were conducted at the Bedford Stuyvesant Community Mental Health Center. The researcher selected five of the most recently registered English-speaking cases that were unassigned and five cases that were terminated within the last three years. He conducted an independent review of those ten charts. This was done in order to gather more data, to get a third perspective of the data and to see how

the information compared to that provided by the social workers. For example, whether assessment and treatment plans included documentation of cultural information, whether the knowledge is used in practice, and how such knowledge is used. Given this information, the review assessed what cultural knowledge provided practitioners with information that made their intervention effective. Furthermore, the researcher's experiences as a clinician and his knowledge of Caribbean culture, were integral to his ability to conduct the assessment. It was felt that his training and experience provided the knowledge, accessibility and skill required for collecting data in a sensitive area.

#### Data Analysis

This project employs inductive analysis, in which the analytic categories emerge from the data (Patton, 1989). The design is also viewed as anthropological because the study was based on observational data, seeking systematized and reliable knowledge about aspects of culture (Pelto, 1970). As such, there is strong reliance on the experience of the respondents in developing categories of analysis. As indicated above, the sources of information were social workers and selected case records.

The data were first organized in accordance with the methodology i.e., questionnaires, focus groups and review of

charts. This was followed by the description of patterns, characteristics, trends, and experiences of the respondents. Of importance was the development of systematic categories, which were determined by "recurring regularities" (Patton, 1989) in the data. According to Patton, the

regularities represent patterns that can be sorted into categories...which would then be judged by the criteria: internal homogeneity and external homogeneity. The first refers to the extent to which the data that belong to a certain category hold together in a meaningful way, while the second criterion has to do with the extent to which differences among categories are bold and clear (p. 311).

The social workers' response to the items on knowledge of English-speaking Caribbean culture, for example, was examined by putting the reported data into categories which allowed for generalization of the findings.

Four categories were developed, as follows:

1. social workers' knowledge of English-speaking Caribbean culture
2. sources of social workers' knowledge of English-speaking Caribbean culture
3. social workers' use of cultural knowledge and outcome of that use

4. obstacles to the acquisition and use of cultural knowledge.

The categories included quotes from the participants and descriptive summary statements. The purpose was to provide insight into typical, common or usual ways in which respondents respond (Krueger, 1988). Summary information on the extent of cultural knowledge, its use by social workers in intervention and outcomes were presented, following the analysis. In order to evaluate outcome, the researcher must "describe what actually happens to people in the program and what they say happen to them" (Patton, 1989, p. 322). For those respondents who used cultural knowledge, what they did with that knowledge in practice and the outcomes were examined.

#### Interpretation

Interpretation of the data, including ideas about causal linkages and the formulation of hypothesis, was made upon completion of the tasks of organizing and describing the data (Patton, 1989). Themes and explanations, relating to cultural knowledge and its use by social workers were presented, as they emerged from the analysis. It is hoped that the information acquired will provide an understanding and a basis for practice skills in working with diverse

populations in general and English-speaking Caribbean immigrants in particular

### Validity and Reliability

Validity refers to the extent to which the research instruments ask the intended questions (Grinnel, 1988). In order to ascertain content validity, the instrument must provide an adequate sample of items or questions, which represent a given concept and should measure the concept it assumes to be measuring. In this project, the questionnaire and focus groups were used to acquire social workers' knowledge of Caribbean culture. Cultural knowledge was operationally defined as knowledge of the values, beliefs, customs and lifestyles of English-speaking Caribbean immigrant clients.

Prior to administering the questionnaire, several colleagues in the field of social work, psychology and sociology, who are considered experts on Caribbean culture, were asked to review the contents of the questionnaires. They included a social worker from Kings County Psychiatric Hospital in Brooklyn, New York, a psychiatrist attached to Woodhull Hospital, Outpatient Psychiatric Unit in New York City and a Sociologist, who lectured at the University of Guyana and subsequently employed with the Department of City Planning, New York. They were all Caribbean-born.

Terminology was either verified or changed by the input of those experts.

For the purpose of this study, reliability is construed as "the extent to which independent administrations of the same instruments, consistently yield the same results under equivalent conditions" (Grimes, 1988). Questionnaires were used to acquire information from social workers at different intervals (approximately three weeks). The responses were compared for consistency (i.e., to see whether the responses were similar or dissimilar) by the researcher and the trained interviewer. There was very little variation in the results.

#### Generalization

Generalization emphasizes the extent to which the results hold true for the sample or group in the study, also hold true for the population from which it was drawn. The social workers in this study can be viewed as representatives of social workers, who work with English-speaking Caribbean clients. They are not an exotic population, are not unique in any way, and have basically the same credentials. The psychiatric social workers who practice in city and state-funded agencies are required to have a masters degree in social work and most of them have

worked with diverse ethnic populations, due to the ethnic variations of their clientele.

#### Limitations of the Study

There are several limitations of the study. The first is the sample size of twelve social workers. This was necessary because the clinic's total social workers numbered fifteen, but three of them did not wish to participate in the study. However, the small size allowed for in-depth analysis. The second limitation is that other mental health professionals, such as psychiatrists and mental health workers (para-professionals) were not included in the study, although they formed part of the clinical staff. However, given the lack of prior investigation of those groups in the area of mental health, this approach seems reasonable and meaningful as a starting point for further investigation. Another limitation is that only adult clients were considered in the study. The clinic where the study was conducted, treats adult clients only.

#### Implications for Social Work

This study is viewed as a meaningful contribution to the literature on cross-cultural social work, with significant practice and policy implications. Patton (1989) states that program implementation, including that which derives from research, is usually characterized by

adaptation to local conditions, needs and interests, and is directly related to the operationalizing of program policy.

Policy makers, administrators and educators in the field of mental health, have emphasized the growing need for the mental health service delivery system to be equipped with awareness, knowledge, skill and overall competency. This is essential in order to adequately intervene with multi-cultural groups. Special populations, such as newly arrived immigrants, have been prioritized for treatment in programs funded by public agencies. This study provides a framework for responding to the needs and some of the crucial requirements for mental health care of Caribbean clients. It is also intended to be a practice-related research, designed to help practitioners and policy makers in the delivery of mental hygiene services.

Agencies which provide mental health services to culturally diverse groups, will benefit from the findings of this study. Furthermore, communities in which there is a large immigrant population, can utilize mental hygiene intervention strategies which recognize the importance of cultural knowledge and its application, in the attempts to provide adequate social services.

Finally, the information generated in this study will be shared with: a) mental health professionals and those

engaged in cross-cultural social work practice, to help enhance their therapeutic effectiveness; b) training and education institutions; c) sponsoring agencies and funding sources; d) Caribbean organizations, which have an interest in accessing services to immigrants; and e) policy makers, who make decisions affecting the provision of mental hygiene services to this population. Presentations will also be made at conferences and in the professional literature, as a way of disseminating information from the study.

#### Definition of Terms

For the purpose of this study the terms are defined as follows:

English-speaking Caribbean immigrants

Theoretical. Immigrants from the non-Hispanic, ex-British colonial Caribbean, stretching from the coast of Venezuela in the south to Florida in the north, Central America on the west, to the eastern tip of the Yucatan Peninsula. They are often referred to as West Indians and are admitted to the United States as actual or prospective permanent residents.

Operational. Persons residing in New York with origin in one of the following Caribbean countries: Jamaica; Trinidad and Tobago; Guyana; Barbados; Grenada; Antigua; St. Lucia;

St. Vincent and the Grenadines; St. Kitts-Nevis; Anguilla; Dominica; and Montserrat.

Cultural Knowledge.

Theoretical. Knowledge of the history, values, beliefs, customs and lifestyles of different cultural or ethnic groups.

Operational. Knowledge of the history, values, beliefs, customs and lifestyles of English-speaking Caribbean immigrants.

Utilization of Cultural Knowledge:

Theoretical. The capacity to identify a cultural group's differences in communication styles, patterns of relationships and customs, and knowing how to use them appropriately in mental health service delivery.

Operational. The ability of social workers to (1) identify the cultural characteristics of English-speaking Caribbean clients, such as family structure, immigration patterns, role relationships, folk beliefs, and help-seeking behaviors; (2) use the knowledge of folk beliefs, family structure, immigration patterns, role relationships and

help-seeking behaviors in assessment and treatment in a mental health setting.

Social Worker:

Theoretical. A person with a Masters degree in social work (M.S.W.).

Operational. A person with an M.S.W. who works in a mental health clinic, where the client population includes English-speaking Caribbean immigrants.

Mental Health Care.

Theoretical. The support and assistance of individuals, through psycho-therapeutic intervention, in resolving emotional problems, which impede social functioning.

Operational. The support and assistance of English-speaking Caribbean clients, in a mental health setting, to help resolve emotional problems and adjustment difficulties which impede their functioning.

CHAPTER IV  
FINDINGS

This study was undertaken to find out what social workers, who work with English-speaking Caribbean clients, know about Caribbean culture and to learn about how that knowledge is used in mental health care. Findings from the worker questionnaire and focus groups are presented below in four categories.

SOCIAL WORKERS' KNOWLEDGE OF  
ENGLISH-SPEAKING CARIBBEAN CULTURE

Ten of the twelve social workers felt that the acquisition of cultural knowledge is very important to mental health care, while two of them said that culture was not important. The following responses show the importance some workers attached to cultural knowledge:

"knowing specifically about the client's background is important" (Questionnaire)

"Knowing the difference in values between the different generations of immigrants is significant" (focus group)

"Cultural knowledge made contracting and developing of relationship with the clients easier" (focus group)

"Culture provides insight into how clients view themselves" (Questionnaire)

"Cultural knowledge promotes the willingness to accept/discuss cultural differences" (focus group)

"Culture determines and influences attitude"(Questionnaire)

"I think my treatment could be enhanced by more knowledge about Caribbean culture, but I think my understanding of this as an issue and openness to the patient's interpretations, sharing about culture helped compensate, if not completely, for my lack of knowledge". (focus group)

"If one's cultural background is known, it would help more in deciding the individual's environment" (focus group)

"The psychosocial aspects of each person's experience is influenced by their culture, therefore culture plays a very important role in the good mental health of a person" (Questionnaire).

The respondents who felt that culture was not very important stated,

"It would seem that basic human needs i.e. respect and appreciation, transcend culture. People do feel stress when confronted with a new and different culture. But their human values remain the same"(Questionnaire)

"Information about the clients' cultural background did not impact on my clinical assessment" (Questionnaire).

Ten respondents expressed the belief that knowledge of culture fostered the development of sensitivity to, and awareness of the clients and their problems.

"It (cultural knowledge) is the key to establishing and maintaining rapport with clients"(Questionnaire)

"It allows a more open interpretation because of the therapist's understanding of the patients' culture; it allows the patient to feel more relaxed and respond better during sessions, with less stress" (focus group)

"It heightened my awareness of what I needed to work on with the patient without upsetting the balance in her household" (Questionnaire)

"Knowing the culture heightened my sensitivity" (Questionnaire)

"Culture helps measure behavior" (Questionnaire)

"Knowing about the people of Barbados may have helped me to help keep the patient in treatment" (Questionnaire)

"Understanding of Caribbean and American culture and blending the two to meet the needs of the patient in current situation, appear to be effective" (focus group)

In summary, these ten workers felt that (a) it was essential to understand the role of culture in assessment and treatment, (b) culture was central to the identification of emotional stressors; (c) cultural knowledge assures the sensitivity needed for effective practice; and (d) there should be more emphasis on cultural education.

#### Knowledge of Traditions and Customs

More than half of the social workers (seven out of twelve) reported that they understood various aspects of English-speaking Caribbean culture. These include: language; traditional folk beliefs; and customs such as

cultural celebrations. They felt that that such knowledge enhanced their abilities to intervene with this population.

"Knowledge of aspects of cultural history allowed the intervention to move from the general to specific (Questionnaire)

"I am completely at home with people from the English-speaking Caribbean because I can identify people, things and their immediate neighborhood. More importantly, similarity in our upbringing, sameness in cultural mores and norms and childhood training equipped me with an array of tools and to easy rapport and establish the therapeutic climate" (Questionnaire)

A number of respondents (five) however, felt that their knowledge of the culture was inadequate and that diminished their capacity to provide culturally sensitive mental health care.

"I do recognize that there are differences among Caribbean immigrants, but these differences are not understood, due to lack of cultural information" (Questionnaire)

"I could be doing something wrong or offensive to make the patient leave" (Questionnaire)

"I thought that I appeared incompetent and insensitive" (Questionnaire)

#### Language

Nevertheless, most of the respondents (eight), stated that they had heard the clients using words and terms with which they were not familiar. In assessing their

understanding of native Caribbean terminology, the examples given indicate a lack of comprehension of the context within which words are used. The workers' response to the question on terms and concepts which they misinterpreted or were incomprehensible to them, include:

"Going for grub" (going to have a meal)  
 "Dare" (expensive)  
 "Irie" (alright; splendid)  
 "I don't always understand the terminology the client uses. I find it fascinating, how through emphasis, the client helps me understand her"  
 "I cannot recall specifically, but I can recall having a 'what'? reaction"  
 "Fine" (thin)  
 "A big man or a big woman" (an older person)  
 (All answers from worker Questionnaire)

The responses also indicate that although the majority of the social workers stated that they understood some aspects of the clients' culture, they did not understand many terms and they tended not to check out meanings with the clients.

"I don't remember the words, but I would hear sentences with English words and words from another language mixed in, or else popular slang words and phrases I don't know"  
 (Questionnaire)

"At times there are language issues that come to mind. These issues are related to meanings and regionalisms that are sometimes misunderstood, and I don't know how to respond"  
 (Questionnaire)

Another worker who admitted that she had heard clients use words which she did not understand, reported that,

"most of the time I understand what they are saying, but unable to say it in the same way.

I have difficulty understanding the accent"  
(focus group)

The above responses demonstrate a discrepancy between the admission by social workers of their knowledge of Caribbean culture and their actual familiarity with words and concepts of the culture. In cases where both worker and client were English-speaking Caribbean, that may indicate that they did not adhere to the same linguistic principles. This also suggested that there was some dissonance between what the workers said they know and what they actually knew about the clients' culture.

TABLE 1

SOCIAL WORKERS' ADMISSION OF CULTURAL KNOWLEDGE  
VS. FAMILIARITY WITH WORDS AND CONCEPTS

Social Workers' Admission of Knowing Aspects of Culture	Social Workers Familiarity with Words and Concepts of Culture
Admission of cultural knowledge	knowledgeable of words and concepts
yes                      No	Yes                      No
7                              5	3                              9

The social workers reported an awareness of various dimensions of Caribbean culture, but were deficient in their knowledge of many of the linguistic characteristics.

Applying Pedersen's concept of multicultural development (1984), this represents the awareness stage and not the knowledge stage.

#### Folk Beliefs

The respondents' knowledge of traditional folk beliefs and spiritualism was explored and some of them report familiarity with concepts and practices in Caribbean folk beliefs. Twenty four percent of them reported that they were aware of traditional folk beliefs, which centered around the supernatural or spiritualism. 46% of the charts reviewed by workers included information about folk beliefs. Clients did not generally report any link between the supernatural and their emotional problems. In 76% of the cases reviewed, workers had no knowledge of the clients' belief in a traditional "West Indian healing system". 14% of the clients were known not to believe and only 10% were known to believe in such a system.

Five respondents, who stated that they were aware of some of the traditional folk beliefs, reported the following:

"Obeah" (Witchcraft. Prevalent in the English-speaking Caribbean countries. A syncretism of African Ashanti religious belief and Protestant Christian influence)

"Shango" (A form of religion in which Shango, the West African god of lightning, who bears overwhelming suffering, is worshipped)

"Another person who has a grudge against you can work Obeah on you and cause you to be sick" (Questionnaire)

"When babies die without Baptism, they turn into a demon, which lives in forested areas. It (the demon) is a child that is naked with feet turned backwards and wears a large straw hat" (Questionnaire)

"A dark spot on the body indicate that you may have been sucked by a Soucuyant, which flies around and is able to enter closed houses. The best protection is to eat salt and sprinkle some in your doorway" (Questionnaire)

"People who may be acting weird. Someone may have worked Obeah on them. It is a kind of spell involving spiritualism, certain herbs, foods and baths" (Questionnaire)

Nine of the twenty-one charts reviewed by the social workers contained information about traditional folk beliefs, either as part of the presenting problem or in the family history. However, only two charts had any evidence of clients reporting that their mental health problems were directly linked to spiritualism or the supernatural.

"A couple of clients referred to their nervous problems as caused or influenced by evil spirits or the Devil" (Questionnaire)

"Client did not discuss any specific healing system, but did express belief that her illness may have been caused by 'evil eye' or Voodoo type practice by relative" (Questionnaire)

"Patient believed that 'bush medicine' would help relieve her illness" (Questionnaire)

Some social workers reported that they have asked clients about issues relating to folk beliefs, based on the relevance of this topic to the presenting problem. However, of the twenty one cases reviewed by the workers, knowledge of the clients' belief in a traditional 'West Indian' healing system was reported in two cases. Knowledge of clients' non-belief was reported in three cases and sixteen were unknown. Those respondents who had no knowledge (unknown) of the clients' folk beliefs, reported that the clients did not volunteer the information or the social workers themselves were hesitant to ask for information on that topic. In this regard, some workers have expressed apprehension in discussing folk beliefs or topics relating to spiritualism, either as a result of their own fears and lack of knowledge on the subject,

"I do not know anything about voodoo, etc., and I do not feel comfortable discussing it" (Questionnaire)

or because of ambivalence about the impact on treatment,

"it affected my helping the patient through cognitive therapeutic relationship. It blocks the patient's absorbing vital information that would aid in the treatment and speedy recovery" (Questionnaire)

"I knew the client believed in spirits and I assumed that she believed her child that she killed, was a spirit now" (Questionnaire)

These findings would suggest that if social workers did acquire knowledge about the clients' traditional folk beliefs, they would be concerned about how and when to use the knowledge appropriately in practice.

From the researcher's review of ten cases, it was learned that some clients have been to indigenous Caribbean spiritualists for advice, prior to seeking professional help. The social workers did not report this finding, but they reported some clients' strong commitment to the Christian church,

"I am a Christian, I believe in God and I leave everything in his hands. I go to my minister for help" (Questionnaire)

TABLE 2

Workers' Knowledge of Clients Belief  
in Traditional Healing System (N=21)

<u>Workers' Knowledge</u>	<u>Frequency</u>	<u>Percentage of Cases</u>
Clients believe	2	10
Clients did not believe	3	14
No knowledge of clients' belief	16	76

Several reasons were given for the respondents' lack of knowledge of their clients' belief in a traditional healing system: (1) clients did not normally volunteer that information; (2) Social workers were usually apprehensive to initiate discussion on topics relating to the supernatural; (3) some social workers were concerned about the negative impact on treatment and therefore, did not ask questions about spiritualism.

Ninety percent of the respondents reported that they were knowledgeable of cultural foods and dishes, while 10% had no knowledge of customary foods/dishes. 65% were able to identify English-speaking Caribbean dances and music and 65% of them indicated an awareness of cultural celebrations, although the symbolism of those celebrations were not known.

#### Food/Dishes

Food, dance and cultural celebrations are viewed as essential cultural elements. The workers' knowledge of these basic elements and use of that knowledge, could have bearing on developing rapport and intervention with immigrant clients (Taylor, 1989).

Ten of the twelve respondents listed foods or dishes, which they knew as typical among this population. These include:

rice and peas	cook-up rice	curried foods
green bananas	coconut sweet bread	coconut bread
yams	sweet bread	pastries
coo coo (a soft mixture of corn meal and okra)	bakes and salt-fish pone (a type of cake)	foo foo (crushed plantains)
fish broth		

While the ten respondents were able to give the names of foods and dishes commonly found in the general English-speaking Caribbean region, only one of the ten workers noted the food/dishes characteristically used in specific countries.

Jamaica: ackee (a fruit) and cod fish; callaloo (a mixture of green vegetables and other selected food products)

Guyana: pepper pot (a dark stew cooked with meat); meta gee (ground provisions, boiled in coconut milk)

Barbados: flying fish and coo coo

Trinidad: Rhoti; paleau (a combination of flavored peas and rice); callaloo and crab

Although specific foods may be found in several Caribbean countries, a particular food/dish, such as ackee (Jamaica) is known by a different name, pear/avocado (Guyana) in another country. Two respondents reported that they did not know of any foods common to this population.

Even though the foods that were named represented the major indigenous Caribbean dishes, other foods not listed, but are also regularly prepared include, a variety of Chinese and European originated dishes, such as chow mein, spaghetti and meat balls, and beef stew.

#### Music and Dance

Seven of the respondents named some of the characteristic music and dances practiced, while five of them stated that they were not familiar with these aspects of culture. Those identified indeed reflected the music and dances most common among the immigrants. They were:

Reggae; calypso; soca ( a form of Calypso music); steelband sound; drumming.

### Cultural Celebrations

More than half of the respondents, (five Caribbean-born and two non-Caribbean) stated that they were aware of cultural celebrations observed by this population. Those mentioned were,

"Carnival" (originally a celebration of freedom from slavery. Currently an annual cultural event in most Caribbean countries).

"West Indian Labor Day Parade" (an annual festivity of cultural activities held in New York on Labor Day)

"Mashramani" (Guyanese carnival)

"Boxing Day" (a holiday of British origin celebrated on December 26th)

"Independence Day" (a celebration of independence from English colonial rule)

"Mardi Gras" (a carnival celebrated in French-speaking Caribbean countries. It is not celebrated in the English-speaking Caribbean, but was mentioned)

One worker could not give the names of any specific cultural celebration, but was general in the response to this question.

"The celebrations consist of indigenous steelband music, calypso music, live and recorded. Calypso competition, pageants and a whole lot of celebrating activities, which include dancing in the streets. It is a time when inter-group conflicts and 'hang-ups' are put aside and all celebrate in the spirit of one life" (Questionnaire)

Five workers stated that they were not aware nor had any knowledge of cultural celebrations. One worker reported,

"I'm not clear on the name and/or meaning"  
(Questionnaire)

It is important to note that of those workers who named the celebrations, five out of seven had little or no knowledge of the symbolism or cultural significance of the events. Knowing the names of the celebrations did not necessarily mean knowing what they represented.

#### KNOWLEDGE OF THE RELATIONSHIP BETWEEN THE STRESSES OF MIGRATION AND MENTAL HEALTH PROBLEMS

The respondents mentioned a number of factors, which they thought contributed to mental health problems. Most of these factors centered around adjustment difficulties and coping strategies. They are listed in descending order of stated frequency.

##### Factors Causing Mental Health Problems (N=21)

1. Adjustment to the new culture (10)
2. Family separation (5)
3. Racism/discrimination (3)
4. Differences in values (2)
5. Drug and alcohol abuse (1)

## 1. Adjustment to new culture

Responses were principally focused on the isolation and stress often associated with adaptation and adjustment to the new environment. They included.

"The client was fearful of the unknown. Though anxious about coming to New York, he did not know what to expect" (focus Group)

"Culture shock. The client was totally overwhelmed by the contrast between her home and what she saw upon arrival" (Focus Group)

"The client's presenting problem and difficulty in dealing with various social systems in the New York City area is understandable, given her Caribbean cultural background and her maintenance of certain aspects of culture" (Questionnaire)

"It became very stressful when the client attempted to adapt to the norms of American society" (Questionnaire)

"The client felt that she did not have the support systems she had back home" (focus group)

"The lifestyle was different. Fast pace and so much more to do" (Focus Group)

"Pressures of the social system to conform to a way of life to which clients were not accustomed" (Questionnaire)

"A feeling of being isolated from peers, due to multiple employment and less opportunity to socialize. Less face-to-face contact and more phone contact" (focus group)

"Relocation to a new country would bring up new stress/difficulties, acculturating, while seeking to maintain one's own cultural ties and values, seeking to become secure economically" (Questionnaire)

"Fast pace and violence of Brooklyn life, which resulted in much anxiety and fear" (Questionnaire)

"Most of them come to the U.S. with the quest and determination to achieve and it is in this quest, that is found most of their problems. There seems not to be as many stressors in the West Indies" (Focus Group)

## 2. Family separation

Some social workers felt that emotional problems among immigrants were caused by disruptions in family cohesion, due to unanticipated, extended separation and intergenerational conflict.

"Client's son was left in the Caribbean for two years. Relationship was conflictual following reunion in New York" (focus group)

"Separation from family of origin, extended family and nuclear family, among some clients, have weakened family relations and caused stress" (Questionnaire)

"Lack of strong family relationship between parents and among parents and children; as a result of migration: (Questionnaire)

"Intergenerational differences. Patient's grandmother adheres to the traditional Caribbean values and this has caused strained relations in the family" (Questionnaire)

## 3. Racism/Discrimination:

The social workers, who identified racism or discrimination as a causal factor, linked mental health problems to discrimination common to 'ethnic minority groups.' Typical responses were:

"exposure to American style racism. Clients reported discrimination in employment and housing and felt it was because they were either foreign or Black" (Questionnaire)

"Conflict with other ethnic groups was viewed by some clients as resulting from racial discrimination" (Focus Group)

"Some clients felt that an earnest attempt was not made to understand the stresses caused by migration and that no one cares" (Focus Group)

"The fear of being labeled crazy and treated as such has stigmatized, frustrate and isolate many Caribbean clients" (Questionnaire)

"Racism, which they were not accustomed to. Some clients felt inferior to other ethnic groups, as compared to feeling equal to other groups in the Caribbean" (Questionnaire)

#### 4. Differences in Values

Responses also centered on value conflicts, which sometimes occur as a consequence of migration

"Value conflict experienced and the resulting intra-familial conflict. For example, the patient was confused about her sexual identity and may be homosexual, something not readily accepted in the Caribbean community. Culturally, a single woman living at home is expected to abide by the rules of her parents" (Questionnaire)

"Mental illness (in the Caribbean) is still considered a taboo) (Questionnaire)

"People from the Caribbean are rules-oriented, but the flexibility and level of permissiveness found in the new society have caused interpersonal conflicts" (Questionnaire)

"There is cultural conflict between what people are accustomed to in the past and what they find in New York" (Focus Group)

#### 5. Drug and alcohol abuse

It was felt that there is much "social drinking" among English-speaking Caribbean immigrants. In addition, with the spread of drug use in the Caribbean and the United States, there is likely to be an increase in the number of dually diagnosed clients (i.e. mental illness and substance abuse) from the region.

"Drug and alcohol abuse, more so drug abuse is also a cause of emotional problems among Caribbean immigrants" (Questionnaire)

Exploration of the respondents' knowledge of the relationship between presenting problems and adjustment difficulties, revealed a number of significant cross-cultural issues. The psychosocial stressors were principally influenced by the clients' experiences as immigrants and secondarily related directly to cultural factors, i.e., differences in customs and values, or intrapsychic problems. Sixteen of the twenty cases reviewed by the social workers and six of the ten cases reviewed by the researcher, had presenting problems precipitated by the impact of cultural differences on adjustment. Several psychosocial stressors relating to presenting problems were reported. The stressful migratory influences were: illegal immigrant status of some clients; post-migration changes in

occupation; change in climate from predominantly tropical to temperate; the behavioral transformations required of being in a new environment; being left in the Caribbean by biological parents for an extended period of time and the fear and stigma of bringing shame on the family. Examples are presented below, with notes taken from the case records.

## PRESENTING PROBLEMS

1. Panic Attacks  
Anxious, very nervous

## PSYCHOSOCIAL STRESSORS

1. Fear due to illegal status (undocumented)

The patient lived in the United States for many years without legal status....Patient was informed by people from her home country that when caught by immigration, 'aliens' are sent back to their homeland in a marked Aircraft. Hence the patient began panicking in crowded places, especially so in check-cashing stores, where a camera focused on her.

2. Patient was depressed and isolated
2. Disappointment from forced occupational change in U.S.

The high expectations of obtaining employment, and failure to understand the intricacies of multicultural differences affecting adjustment. The patient took a job that did not utilize his training from his country of birth and this caused much of his sadness and isolation".

3. Patient feared that she      3. Stigma and fear of  
had a contagious disease      'shaming' her parents

The patient feared she had contracted a deadly disease on her job. The fear of being stigmatized, traumatized the patient. 'What will people think about me and my family? I will make my family shame.'

4. Patient was withdrawn and      4. Discomfort due to change  
'not very happy'      in climate

Adjustment from warm tropical temperatures to cold temperatures was disconcerting to the patient. She isolated herself from others. Most of her relatives were in the Caribbean and she reported that she was anxiously awaiting their arrival. She states that the cold temperature and loneliness made her depressed.

5. Patient suffered from      5. Extended grieving follow-  
major depression      ing death of son

Patient reported that mothers from her country are very attached to their children and this was a factor, which inhibited her from getting over the death of her son.

6. Patient had a history of emotional problems, which became acute after migration to U.S.
6. Living in new environment increased anxiety

Patient in U.S. for 12 years, but difficulties began 20 years ago in home country. Treatment was received in the Caribbean (diagnosis unknown). However, the additional stress of relocating and seeking employment in the U.S. have exacerbated her mental illness....Stress between family members was possibly influenced by culture clash/dissonance, which made the patient sense that she was not a good mother....Financial struggles in the U.S. added stress and severity of the symptoms. The patient was diagnosed as having an anxiety disorder.

7. Behavioral problems Parent/child conflict
7. Resentment of being left in Caribbean by parents at an early age

Patient felt resentment towards his mother for 'abandoning him'. He was very angry with his parents. His mother migrated to the United States when he was 5 years of age, leaving him with his aunt (in the Caribbean). He had difficulty adjusting to school in the U.S. due to his foreign accent. Patient's diagnosis was adjustment disorder with mixed emotional features.

8. Anxiety. Feelings of frustration
8. Stress from accusation of physically abusing

children

"The patient reportedly spanked his teenage daughter and was referred by Family Court for counseling....He thought that his actions were 'normal', since they were so considered in the Caribbean".

These findings show that some of the social workers were able to link adjustment issues, as well as cultural differences to presenting problems, in their assessment of the clients. This was consistent with the researcher's findings in his review of charts.

The following are case examples from the researcher's chart review:

Example #1

The client was depressed, due to his undocumented (illegal) status. He also reported that he was hospitalized in the Caribbean for "emotional problems" (diagnosis unknown). In addition to not having a green card, he reported that he had asked his girlfriend to marry him, as a way of legalizing his status, but she refused. He wanted to talk about the difficulties he experienced in obtaining his green card, that some of his friends had paid enormous sums of money for theirs and he was looking into the possibility of obtaining his the same way. However, he was afraid to inform his girlfriend of his mental illness for fear that she would not marry him.

## Example #2

The client was a 34 year old female immigrant, whose mother migrated from the Caribbean when the client was 4 years of age. She was left in the care of her maternal uncle who was reportedly an alcoholic and abusive to her. She joined her mother in the United States when she was in her late teens. The client was angry with her mother and often expressed much hostility towards her.

### Knowledge of cultural Factors Enhancing Mental Health Care

The majority (75%) of respondents (nine out of twelve), felt that there were cultural factors which impacted positively on mental health care. Below are the most frequently reported cultural factors and the ways in which workers felt that knowledge of those factors enhanced mental health care.

#### 1. Focus on Family (5)

Those who referred to the focus on family as an important factor, felt that Caribbean immigrants are very family-oriented. In particular, the extended family plays an instrumental role, exhibiting strength and resiliency within the context of the immigrant experience, particularly in trying to ameliorate adjustment to the new environment. Workers stated that they developed effective treatment plans, as a result of their understanding of clients.

"Belief in the unity of the family, on  
collective aspiration...emphasis on

education, upward mobility and dreams which involve the entire family" (Questionnaire)

"According to their culture, they believe in a strong family relationship and people are mostly educated. As a result, Caribbean clients are motivated and involved in treatment".

"There is still the extended family concept in the Caribbean, but replaced by the 'I' or 'me' concept (Focus Group)

"My patient is very family oriented, though he was very close to his mother, as well as his wife....Sharing the same closeness to family I believed helped to engage patient in the therapy process" (Questionnaire)

"The West Indian family has strong family ties, and family therapy becomes a useful tool of intervention" (Focus Group)

Other workers reported that it was important to understand that women in the Caribbean are very attached to their children, even in adulthood and adult children in turn feel a strong obligation toward their parents.

"I have observed a closeness of patient to his mother, yet there was a desire to be independent at times. Patient seemed to be more passive as head of household and allowed his wife (who was older) and mother to assume a more directive role". (Questionnaire)

With the knowledge of this information, the worker stated that he assumed a directive role when talking to the patient. He felt that the client needed support in setting and implementing goals.

## 2. Work Ethic (3)

It was felt by some social workers that knowledge of the client's attitude toward work was in some instances helpful in assessing the clients' needs and in developing treatment goals.

"One cultural factor is the need to be working on having a job, and pursuing a career. Patient has looked into different ways and areas, whereby he can be employed and provide for his wife....Worker attempted to provide contacts for patient as to appropriate plans for employment"  
(Questionnaire)

The respondents felt that many of these immigrants appear to be industrious and prioritized work and education as means of attaining their goals in the new society.

### 3. Linkages with English-speaking Caribbean groups (2)

Contact and association with cultural groups were viewed as beneficial practices, which enhanced mental health care of Caribbean clients.

"I encourage Caribbean clients, especially those who tend to be isolated in the big city, to maintain contact with relatives in the Caribbean. I encourage clients to socialize with their countrymen on weekends"  
(Focus Group)

This seems to indicate the respondents' belief in the importance of cultural connectedness to the familiar, by encouraging the clients to return to their country of origin

periodically and to keep in touch with friends and family. These respondents also felt that the maintenance of such attachments assisted in self-development and adaptation to the new environment. The cultural factors reported as enhancing mental health care and the frequency are illustrated in Table 2.

TABLE 3

Cultural Factors enhancing Mental health Care (N=12)

<u>Cultural Factors</u>	<u>Frequency</u>	<u>Percentage of Respondents</u>
Focus on Family	5	42
Work Ethic	3	25
Linkage with Cultural Groups	2	17
Did not know	2	17

SOURCES OF SOCIAL WORKERS' CULTURAL KNOWLEDGE

Knowledge of the culture was acquired from a variety of sources. The most predominant source of cultural knowledge (29%) of the cases was the clients themselves, while the least mentioned sources were colleagues and living in the community or travel to the clients' country of origin (10%).

A distribution of respondents' sources of acquiring cultural knowledge, based on the review of the twenty one cases is outlined below. Some workers gave more than one response.

1. Clients and their relatives (6)
2. Personal and family heritage (5)
3. Training programs on cultural issues (3)
4. Reading (books, articles, news media) (3)
5. Living in the community or traveling to the country (2)
6. Colleagues (2)

1. Clients and Relatives

The most frequently reported sources of cultural knowledge (six) were the clients and their relatives. Not only did the respondents find the information from these sources helpful in understanding the client's problem, but it provided meaningful data about the culture.

"Caribbean culture is learned from the clients themselves, by the worker asking the client to tell about his or her culture" (Questionnaire)

"I learned that the culture is no different from Jamaica to Trinidad" (Questionnaire)

"Initially, many workers are ignorant about the culture, but it is important to be open, for this is the best way to learn about

another culture and to gain respect of the client" (Focus Group)

"In my assessment I would ask the client what it's like being a West Indian. The client would usually talk about aspects of his culture and this is also a way of sharing emotions through cultural content" (Focus Group)

"I learn about the culture by relating to relatives and friends of the client" (Focus Group)

"I definitely learned most that I know about the culture from the client, then my knowledge was expanded by other sources, such as reading" (Focus Group)

"Speaking with patient's wife and mother. Also spoke with patient's brother and cousin. I had a meeting with his mother and spoke with her about her son, and have had collateral meetings with the patient's relatives. I obtained information from them that was helpful" (Questionnaire)

"Sister was invited to therapy with patient and was encouraged to be supportive to the patient" (Questionnaire)

"I asked the patient what she believed caused her illness, and what could cure it and what kind of treatment they had in her country. Did she find them helpful etc.? These beliefs may have cultural significance and potential to incorporate in a treatment plan". (Questionnaire)

One respondent stated that by working with the clients' family, she found that,

"most of these mental health problems have their origin in the family, social or cultural background". (Questionnaire)

This method of acquiring information directly from the client through verbal communication represents an intrinsic step in development of cultural knowledge, whereby the practitioner learns from the clients what they know about their own culture and how they experience it. (Taft, 1977). The client as a source of cultural information has also supported the suggestion of Ardenne and Mahtani, that practitioners use "sensitivity when asking clients questions in order to gain information about their culture.... discuss with clients what is of significance about their own culture" (1990, p.32).

## 2. Personal and Family Heritage

Those respondents who learned about the culture through their own personal family heritage were all Caribbean-born. They felt that since they were socialized into the culture, they would be more knowledgeable of it than those who were not.

"I was born in the Caribbean, so my cultural learning was natural (Questionnaire)

"I know about the culture because I have a similar background to the client".  
(Questionnaire)

This, however, assumes uniformity in the cultural practices of Caribbean-born social workers, some of whom are

not familiar with beliefs and practices of their own island/country nor other Caribbean countries.

### 3. Training Programs on Cultural Issues

Another source of cultural knowledge reported was cultural sensitivity training programs on cultural issues. Three respondents stated that they participated in, or attended conferences or workshops, which focused on Caribbean culture and treatment issues in mental health. Those workers felt that workshop or conference attendance had a positive impact on their intervention with Caribbean clients, primarily by increasing their cultural sensitivity.

"It helped to develop sensitivity to cultural differences". (Questionnaire)

"The workshop made me sensitive to the culture". (Questionnaire)

"It taught me to use treatment goals that are related to the culture providing they are not bad for the client". (Questionnaire)

"It fortified my knowledge of Caribbean culture". (Questionnaire)

"I learned in the workshop that you cannot work with a client and use a generic model without relating to the culture of the client". (Questionnaire)

The findings show that participation in cultural education programs was not a frequently used source, although mental health providers have been encouraged by the department for Mental Health to send representatives to

cross-cultural conferences. Both the New York City Department of Mental Health and the New York State Office of Mental Health have sponsored numerous workshops geared toward developing the knowledge and skills of practitioners, who work with ethnically diverse populations. For example, from May 1991 to December 1993 more than six cross cultural education conferences were sponsored or co-sponsored by the department of Mental Health. Examples of the conferences/workshops held were:

Developing Culturally Competent Programs, held at the Lutheran Hospital Center, Brooklyn, New York in May 1991;

Training Program in Cross-cultural Social Work, conducted at Hunter College School of Social Work in February 1991;

Immigration Planning for the future, a conference to assist mental health service providers plan for the needs of immigrant clients, held at the New York City Department of Planning in December 1992;

Cultural Sensitivity as it relates to Mental Health and Delivery of Services, Family Life Center, Jamaica, New York, May 1993;

Conference on cultural Competence, held at Hunter College School of Social Work, December 1993.

However, the focus of such programs has been on cultural sensitivity training and not a holistic attempt to develop knowledge and provide skills in working with diverse populations. If the latter objective was intended, it was not achieved among the social workers in this study, who attended. Nine of the respondents stated that they had never participated in a conference or training program, which addressed the cultural dimension on social work intervention. Most expressed concern over the lack of cultural resources on English-speaking Caribbean immigrants.

"There isn't enough emphasis on cultural education when dealing with people from outside of this country" (Questionnaire)

"No resources were used because there are no known cultural resources, which could have enhanced treatment of West Indians (Questionnaire)

#### 4. Reading/Media

In addition to workshop attendance, learning about Caribbean culture through the news media (newspapers, professional journals, magazines and television), represented another source of knowledge. The media has been an increasingly commonly used vehicle for information on English-speaking Caribbean culture. A number of weekly newspapers have become popular in the immigrant Caribbean

community. They include: Carib News; Amsterdam News; Day Light and Caribbean Life. In addition, several daily and weekly newspapers printed in the Caribbean are distributed in the United States. Two radio stations, WLIB: BlackTalk and Caribbean Music (1190 AM) and WNEW multicultural Broadcasting Services, (105.9 FM) broadcast news and information from and about the English-speaking Caribbean. Three respondents have identified one or several of these sources as enhancing their knowledge of the culture.

"I get information about the Caribbean through reading" (Questionnaire)

"I have read magazines and newspapers e.g. Carib News" (Questionnaire)

"Through magazines, schools, learning of history of the culture" (Questionnaire)

##### 5. Living in Community/Travel

Two workers reported living in the community or visiting the clients' country of origin, as their major sources of learning about the culture. The above findings are supported by those of d'Ardenne and Mahtani (1990) with regard to acquiring specific information about the client's culture.

"This kind of knowledge often comes from a curiosity and a desire to make contact with these cultures. This is one type of information; there are of course different levels and types of information. Direct contact through kinship, friendship or travel, is bound to be a very different

experience than direct contact with culture, for example, through reading second-hand accounts or the media" (1990, p.32).

## 6. Colleagues

Respondents indicated that they also learned about Caribbean culture from colleagues, who were Caribbean-born. Those colleagues provided vital information, which could be used efficaciously to understand the dynamics of the clients' problems and ultimately to develop treatment plans. Specifically, one U.S. born worker reported that he learned from a Caribbean-born colleague that

"people from the English-speaking Caribbean are very sensitive, less assertive and more trusting than many other groups, with the information received from doctors".

Another worker emphasized the value of staff conferences and peer group interaction in facilitating cultural learning.

"Communication between staff of various backgrounds, via agency conferences.... was essential in enhancing cultural interpretation, which can only be made clearer by the staff or person experiencing their own cultural assumptions and by others hearing and repeating what is being said".(Questionnaire)

Table 3 below shows where the respondents gained their knowledge of the culture, from the most common to the least common source

TABLE 4

## SOURCES OF SOCIAL WORKERS' CULTURAL KNOWLEDGE (N=21)

<u>Source of Knowledge</u>	<u>Frequency</u>	<u>Percentage of Cases</u>
Clients and their relatives	6	29
Personal and family heritage	5	24
Training programs on cultural issues	3	14
Reading (books, articles, magazines) and other news media	3	14
Living in the community or travel	2	10
Colleagues	2	10

CHAPTER 5SOCIAL WORKERS' USE OF CULTURAL KNOWLEDGE

The purpose of this section is to examine the social worker's use of cultural knowledge. The workers' characteristics i.e., cultural background, the number of years in social work practice, the method of cultural knowledge acquisition, and the number of English-speaking Caribbean clients treated, will be compared to their utilization of cultural knowledge. Utilization of cultural knowledge in this study refers to the extent to which social workers are able to: (a) identify cultural values/customs, such as the role of the extended family, discipline of children, bereavement, and folk belief and (b) use the knowledge of these values/customs, as evidenced by the inclusion of the clients' culture-specific characteristics in the psychosocial assessment and treatment.

A summary of how the respondents used cultural knowledge in practice and the outcome, will be presented. This will be followed by an explanation of workers' choice of treatment approaches and their reasons for using these approaches. Finally, obstacles to the acquisition and use of cultural knowledge will be identified and discussed.

Table 5 below compares the respondents' place of birth, reported use of cultural knowledge and reasons given for use or non-use of cultural knowledge.

TABLE 5

<u>*Place of Birth</u>		<u>Use of Cultural Knowledge</u>		<u>Reasons given for use or non-use</u>
<u>Non-Carib.</u>	<u>Carib-bean</u>	<u>Yes</u>	<u>No</u>	
	1	1		Familiarity with the culture
	1	1		Familiarity with the culture
	1	1		Familiarity with the culture
	1	1		Familiarity with the culture
	1	1		Familiarity with the culture

*Place of <u>Birth</u> _____	Use of Cultural <u>Knowledge</u> _____	Reasons given for use <u>or non-use</u>
Non- <u>Carib.</u>	Carib- <u>bean</u> __	
	<u>Yes</u>	<u>No</u>
1(A/A)	1	No knowledge of the culture
1(A/A)	1	Presenting problem did not require use of culture
1(A/A)	1	Had some knowledge of folk beliefs and cultural history, but did not use it
1(Cau.)	1	Does not know enough about culture
!(A/A)	1	Presenting problem did not require use of culture
1(A/A)	1	Had some knowledge of culture, but did not use it

*Place of Birth _____		Use of Cultural Knowledge _____		Reasons given for use or non-use
Non-Carib- Carib.	Carib- bean	Yes	No	

1(Cau.)		1		No knowledge of culture
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\*A/A refers to African-American Social Workers

Cau. refers to Caucasian-American Social Workers

The efficacy of using cultural knowledge in practice is determined by certain prerequisites, which include the sources of the practitioners' cultural information and his or her cross-cultural experience, (d'Ardene and Mahtani, 1990). Six of the seven United States born social workers reported that they did not use cultural knowledge in treatment, either because of their lack of such knowledge or they felt that the presenting problem did not require its use.

"I do not feel that I know enough about the culture" (Questionnaire)

"The nature of the patient's problem did not, in my opinion, warrant a specific or cultural resource to deal with it" (Questionnaire)

Two of the respondents expressed an interest in learning about the culture and had asked clients about their customs, but indicated that they did not feel competent enough to appropriately use in practice what they had learned.

"I think that, although I'm aware of some customs, I am at a loss for knowing how to engage and keep a (Caribbean) patient in treatment". (Focus Group)

"I try to learn from each person in terms of what they need, and look out for cultural values, so as not to work at odds with them". (Focus Group)

Another non-Caribbean worker viewed the use of cultural knowledge, when working with this group, as both an inhibiting and facilitating factor. She reported that, "knowledge of the culture helped me and also hampered the professional relationship". That worker thought that English-speaking Caribbean culture demanded that females should be treated differently from men and this, she felt, affected the way clients related to the worker.

Six of the social workers stated that they used cultural knowledge in practice. Most of them felt that it helped to enhance the professional relationship and assisted them in establishing treatment goals. Specifically, knowledge application helped to bridge communication gaps that may have existed and contributed to the development of

focused, comprehensive treatment planning. For instance, those workers reported that they spoke about popular Caribbean music, performers or sports personalities, food, dance or Caribbean politics. It was felt that discussions on such topics served to:

"ease the tension"

"develop rapport and trust and help the client express himself in dealing with other issues" (Questionnaire)

Some respondents reported that they needed to know more about the culture, tried to learn from the client and drew upon different elements of the customs and practices, while conducting the interview. Unlike the findings of Kavanaugh and Kennedy (1992), who reported that workers usually fail to view individual clients as part of a cultural group, some of these respondents attempted to relate to the clients within the context of their culture.

"I use what I learn from the client about his or her culture, as a medium of communication, developing rapport and also helping to resolve problems". (Focus Group)

"Respect for the cultural beliefs of the client has helped in developing rapport, and understanding clients better" (Questionnaire)

Of all of the Caribbean-born social workers, five reported that they used cultural knowledge in treatment. Of the seven non-Caribbean workers, three - one African-

American and two Caucasians), did not use cultural knowledge in treatment, due to their lack of such knowledge. Two of them also felt that in many cases the clients' problem did not require its use. One worker reported use of cultural knowledge in treatment and felt that its use facilitated problem solving for the clients, while another African-American respondent expressed that he had some knowledge of the customs but did not feel confident that he would "use the knowledge in the right way".

TABLE 6

Correlation between social workers' characteristics (i.e. years of practice; method of knowledge acquisition; number of clients treated) and use of cultural knowledge in practice

<u>Worker #</u>	<u>Years of Practice</u>	<u>Methods of Knowledge Acquisition</u>	<u>No. of Carib. Clients seen since in Practice</u>	<u>Use of Cultural Knowledge</u>
1	6+	Personal/Family/Heritage	11-30	Yes
2	4-6	Personal/Family/Heritage	-10	Yes
3	6+	None	11-30	No
4	2-4	None	-10	No
5	2-4	None	-10	No

<u>Worker #</u>	<u>Years of Practice</u>	<u>Methods of Knowledge Acquisition</u>	<u>No. of Carib. Clients seen since in Practice</u>	<u>Use of Cultural Knowledge</u>
6	6+	workshop/friends/clients	11-30	Yes
7	-1	None	-10	No
8	2-4	Personal/Family heritage	-10	Yes
9	4-6	Personal/family heritage	-10	Yes
10	1-2	None	11-30	No
11.	6+	Personal/family heritage	11-30	Yes
12.	1-2	Friends/relatives/clients	11-30	No

Of the six workers who reported using cultural knowledge in practice, four of them had six or more years of practice experience and three had treated less than ten English-speaking Caribbean clients. These workers were more likely to be Caribbean-born and as such, their sources of knowledge were: Birth/nationality or relatives/friends. In addition, they did not have any special training to work with Caribbean populations, nor did they attend workshops on Caribbean culture.

Among the six respondents who did not use cultural knowledge in their intervention, five of them had four or less years practice experience. Three had treated less than ten clients from this population and three treated between eleven and thirty clients.

A significant finding is that two non-Caribbean workers, who had a total of eight years practice experience and had treated eleven to thirty Caribbean clients, respectively, did not use cultural knowledge. This would indicate that large numbers of Caribbean clients have been assessed and treated by social workers with many years of practice experience, but who did not acquire nor utilize cultural knowledge.

Some workers stated that it was essential to openly convey reassurances of positive, unconditional regard for the clients, as individuals and for their culture.

"I sometimes tell the clients that nothing is wrong with their culture" (Focus Group)

"I insist that the clients keep their cultural identities". (Focus Group)

Other workers reported that they were cognizant of cultural conflicts (in customs and values) experienced by clients and have discussed them with the clients in the course of treatment.

"If what they are doing or their cultural practices are detrimental to them and others in the new environment, I let them know there is another life". (Focus Group)

"In formulating treatment plans, you have to consider that some Caribbean people who came here second and third generations, have different ideas about things" (Focus Group)

"It is helpful to openly acknowledge differences so that clients can see that you respect their culture. It is helpful to ask questions about a client's culture when it facilitates your understanding of the client's concerns. Such an approach at the beginning helps lessen the tension". (Focus Group)

The following are examples of Social Workers' use of cultural knowledge in practice

### Bereavement

Six of the twelve workers (three Caribbean-born, three non-Caribbean) indicated that they knew that English-speaking Caribbean clients exhibited an extended bereavement period. The Caribbean-born workers and one African-American worker said that they could work comfortably with the cultural practice of extended grieving, among this population and therefore, they did not feel "culturally locked out", when it occurred among clients.

"I'm aware of the way Caribbean people mourn, as against Black Americans and how they attempt to deal with issues surrounding death". (Focus Group)

This worker explained that English-speaking Caribbean clients continue bereavement rituals for months or even years. Such rituals include family members crying together, regular graveside visits, talking to the deceased relative and leaving an 'imaginary seat' in the home for the deceased person. However, he notes that African-Americans do not seem to grieve as openly nor do they mourn for such a long period of time.

"I allowed the client to grieve in a way she is accustomed to, and set goals specific to the culture. For several sessions she talked about her deceased son, describing the things she did in his memory. This information was

used to set treatment goals in helping the client to overcome her grief". (Focus Group)

"I let the client know that I respect that for her, the way she is grieving is natural. My work focused on how she, as a Caribbean woman mourns. Initially I encouraged her indulgence in bereavement rituals, indicating to her that this was alright. That approach appeared to help in her participation in setting treatment goals". (Focus Group)

However, the two Caucasian workers stated that they found it difficult to accept and deal with the characteristic, lengthy Caribbean bereavement process. Comparatively, they found that mourning the loss of a relative or loved one was much less extended among clients born in the United States.

"I was not as tolerant and understanding of the grief pattern in the Caribbean and this affected my helping the client".(Focus Group)

These workers (Caucasians) reported that they were frustrated by the long grieving period practiced by English-speaking Caribbean clients and could not help clients overcome their grief or depression.

#### DISCIPLINE OF CHILDREN

Caribbean-born workers expressed awareness of Caribbean immigrants' approach to discipline and the problems related to this issue.

"parents are generally stern. They frequently use corporal punishment". (Focus Group)

"As immigrants, they are frustrated by the values and laws of the United States, relating to child abuse. I help clients deal with those frustrations". (Focus Group)

This worker reported that he discussed with the client, alternative ways of disciplining children. Clients have expressed the fear of "losing" their children if they used less severe disciplinary methods. The worker acknowledged this concern and worked with the client to develop other disciplinary methods, without the feeling of losing control.

"Some stress associated with discipline is attributed to the differences in values between first and second generation immigrants. As a result, conflict ensued and this is often an area of intervention in mental health treatment". (Focus Group)

"I worked with what was considered appropriate in the client's culture and then discuss what is appropriate and acceptable in the American culture". (Focus Group)

"This case involved child abuse, I understood that some of the traditional ways of disciplining children in the clients' country would be considered abusive here. For this reason, the client's insight concerning how she beat her child, seemed severely limited, but her judgment was based on her own cultural beliefs". (Questionnaire)

One worker reported that, although her own values interfered with her ability to be objective initially, she used her knowledge about the culture in trying to set goals to improve the clients' insight and judgments, regarding her parental responsibilities.

"I think my willingness to accept and discuss cultural differences facilitated progress in treatment. I asked questions about how the client's concerns would be handled in her country. This helped me to see how cultural differences impacted on the case". (Focus Group)

The U.S. born respondents had no knowledge of disciplinary approaches that were common to this population.

"I do not know how they discipline their children"

"On the issue of child abuse, I understood that the (West Indian) culture tolerated it". (Focus Group)

#### Role of the Extended Family

Nine of the twelve respondents acknowledged the significance of the extended family in Caribbean culture and indicated that they understood its role among immigrants. However, there was a difference between Caribbean and non-Caribbean workers in their application of that knowledge. The Caribbean-born workers stated that they were generally able to apply this knowledge in practice.

"Understanding the important role of the extended family system among English-speaking Caribbean immigrants was helpful in setting treatment goals. I would find out who are the decision-makers in the family and try to involve them in therapy. Sometimes this may include an aunt, uncle or a grandparent". (Focus Group)

"I used my knowledge of the extended family to enjoin family bonds, to interpret for diagnosis and to help with treatment goals" (Focus Group)

"I allow the clients to 'explain' their resistances when coming from family of origin, listening for built-in cultural resistances inherent in a specific world view; not going outside of their taboos" (Focus Group)

"In setting treatment goals, I use my knowledge of how the dynamics of the extended family impacted upon how patients interact with others".(Questionnaire)

Some of the (Caribbean) workers stated that members of the extended family did not only influence the decision of clients to attend the clinic, but could determine the success or failure of treatment. They also felt that the extended family was a potentially reliable source of information about the clients.

"I had a meeting with the patient's mother and spoke to her with regards to her son, and have had collateral meetings with the patient's cousins and grandmother. This helped me to understand the problem better". (Questionnaire)

"Understanding the important role of the extended family system was helpful in setting treatment goals, which included developing decision-making skills; clarifying and improving role relationships". (Questionnaire)

Four of the non-Caribbean workers reported that they did not discern any significant differences between the family structure of Caribbean clients and African-American clients:

"The culture gets mixed with the American culture". (Questionnaire)

It is hard to see the difference between native Black American family and Caribbean family and culture. Both cultures have similarities". (Focus Group)

"Information which they had about clients' extended family was not used in treatment information since it did not have any impact in treatment and has not been a factor in providing mental health care". (Questionnaire)

### Folk Beliefs

Although some of the respondents indicated that they had heard about folk beliefs of the Caribbean, they were not familiar with the cultural meanings of those beliefs. Only two workers (both Caribbean-born) attempted to integrate what was learned about folk beliefs into practice.

"The client's spiritual beliefs i.e., that the devil influenced the course of her 'nervousness' and inserted bad thoughts, bad dreams, etc., guided my framework for treatment. Such beliefs have cultural significance and potential to incorporate into the treatment". (Questionnaire)

Case Example: Mr. M, age 48, was partially blind and had to stop working as a projectionist in the Caribbean after 30 years, because of his disability. He stated that "something evil is inside of me". He thought that this evil element prevented him from seeing and was resistant to eye surgery recommended by his doctor. Instead, he stated that he would

pray, as a means of regaining his sight. In developing the treatment plan, the worker explored the extent of the client's belief in evil spirits, assessed his relationships with others and set goals based on his perception that others were or were not really attempting to harm him.

"I think it's very important to work with what the patient believes is causing the illness, because we really don't know all that is involved in mental illness and should try different theories" (focus Group)

"I worked from both a spiritual and psychological morality, re: How can we get rid of the devil and what do these thoughts mean to the client in her life". (Questionnaire).

Summary of Social Workers' Use of Cultural  
Knowledge and Outcomes

Bereavement

<u>Use of Knowledge</u> (What the workers did)	<u>Outcome</u>
Allowed grieving within the client's cultural time-frame	Improved therapeutic alliance
Supported client's engagement in bereavement rituals (e.g. talking extensively about deceased relative, in therapy)	Client was more open in her interaction with the social worker
	Treatment was on-going i.e., attendance improved

Resolution of feelings around  
grieving

Client was able to resolve  
problems in other areas of  
her life

### Discipline of Children

<u>Use of Knowledge</u>	<u>Outcome</u>
<p>Helped the clients understand the difference between disciplinary methods in their country and in the United States  (used therapy as education)</p>	<p>Client gained knowledge about cultural differences in disciplinary practices</p> <p>Client avoided behavior which could be labeled as 'abusive' and expressed fear of consequences for not adapting new behaviors</p>
<p>Worked with the client to accept and practice what is considered appropriate disciplinary measures and to discard traditional methods</p>	<p>Parent-child relationship improved</p>

Use of Knowledge

Helped the client develop alternative methods of disciplining, without a sense of losing control over her children (used therapy as education)

Outcome

The client became less anxious and frustrated about her capacity to be a 'good' parent.

Role of the Extended FamilyUse of Knowledge

The worker engaged extended family members in therapy  
The worker identified the influential extended members and encouraged input from them, in the development of treatment plan

Outcome

There was less resistance to therapy  
Clarification and improvement of role relationships among family members.  
Improvement in the decision-making skills of the client and family as a unit.

Folk BeliefsUse of Knowledge

The social worker encouraged the client to verbally

Outcome

Clarification of the meaning of such beliefs and thoughts

express traditional folk beliefs, including belief in the supernatural and the use of 'home remedies' to cure maladies	in the client's life  The client spoke more openly about other problematic areas in her life
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These respondents felt that their use of cultural knowledge had good treatment outcome, since the clients' overall psychiatric condition improved.

"I am convinced that the changes in this client was a result of my using the knowledge of her culture to help resolve problems". (Focus Group)

"It seems clear to me that what I know about the client's cultural background, made treatment a success". (Questionnaire)

However, in most of the cases reviewed by the researcher, evidence of workers (both Caribbean and non-Caribbean) using cultural knowledge in treatment planning was minimal. This suggests that, although there was admission of cultural awareness and knowledge, the workers did not consistently document the integration of cultural knowledge into the course of treatment.

### TREATMENT APPROACHES AND CULTURAL KNOWLEDGE

The selection of treatment approaches in mental health care is usually determined by the practitioners' specific theoretical orientation, acquired through formal education and training. Nevertheless, the integration of learned theoretical frameworks with knowledge about the clients' culture would inform purposeful intervention. The most commonly used treatment approach by respondents was supportive therapy, reflected in 40% of the cases reviewed. Other approaches mentioned were family therapy, cognitive therapy, non-directive therapy, psychodynamic psychotherapy, rational therapy and group therapy. Supportive therapy was reported as the most successful with this population, while group therapy was the least effective.

The treatment approaches employed by the respondents were principally based on their range of cultural knowledge or experience in working with Caribbean clients. The number and frequency of treatment techniques used by the respondents in the twenty one cases they reviewed are illustrated in Table seven.

TABLE 7 (N=21)TREATMENT TECHNIQUES

<u>Treatment Technique</u>	<u>Frequency</u>	<u>Percentage of Cases</u>
Supportive therapy	7	33%
Family therapy	3	14
Cognitive therapy	3	14
Non-directive therapy	2	10
Psychodynamic psychotherapy	2	10
No specific technique	2	10
Rational therapy	1	5
Group therapy	1	5

Among the reasons given for using supportive therapy was that it allowed clients to express themselves:

"without feeling pressured or labeled culturally" (Questionnaire)

"It was more acceptable by Caribbean clients, than probing into feelings or intrapsychic analysis". (Questionnaire)

Those who used cognitive therapy stated that:

"it seemed attractive. The clients were engaged, shared feelings, thought; were able to work through feelings, seek solutions and improve self esteem". (Questionnaire)

"this technique was used with openness to prayer to combat evil sorcery or other forms of evil spirits". (Questionnaire)

Family therapy was effective because:

"input from the extended family was helpful in resolving the client's problem".  
(Questionnaire)

"strong family ties facilitated the achievement of therapeutic goals".  
(Questionnaire)

Group therapy was found to be ineffective:

"because clients were fearful of the stigma of their illness being known by strangers".  
(Questionnaire)

These findings point to the need for mental health providers to recognize the limitations of existing models when working with diverse populations and the importance of understanding which approaches are most likely to work.

#### Obstacles to the Acquisition and use of Cultural Knowledge

Several obstacles to the acquisition and effective use of cultural knowledge of this population were identified by the respondents. These obstacles are placed into two categories, namely: Professional Relationship and Programmatic Obstacles.

##### Professional Relationship Obstacles

Clients themselves were viewed as a key source of cultural knowledge. However, respondents found that certain cultural and experiential factors precluded clients, as a

dependable source of knowledge and this minimized some workers' acquisition and effective use of cultural knowledge. They felt that English-speaking Caribbean people have a negative conceptualization of mental illness, which creates some difficulty in the acquisition of cultural knowledge and is responsible for resistance to therapy.

"To them, mental illness is worse than physical ailment. People with emotional problems are considered 'mad' or 'crazy' and are usually ostracized. (Focus Group)

It was reported by one respondent that during an initial assessment of a client he was told:

"If I come to therapy, people would say that I am crazy. Back home that is a big disgrace". (Focus Group)

It was also reported that members of this population appeared not to be oriented toward psychiatric care. Instead, they attempt to deal with stress by soliciting the assistance of family and friendship networks. Furthermore, they normally see mental illness as:

"fate, related to spiritualism, or as something that is caused by the environment". (Focus Group)

"For those who migrate, once they understand the concept of mental health in the United States, they generally become less resistant to therapy".

Three of the respondents reported that some English-speaking Caribbean clients were especially resistant when treatment goals were being established. Those clients felt that they were forced into setting goals and following the rules of therapy. This demonstrates that some clients felt that those who provide mental health services were not culturally sensitive. These clients also had little trust for the worker and many clients have an initial fear of allowing the therapist to "know who I am". One worker reported that some clients appear to be less comfortable with therapists, who do not share a common cultural background with them. A non-Caribbean worker was told by a client:

"Why should I tell you my problems? How are you going to help me? I am from Trinidad you know!". (Questionnaire)

Client trust and worker credibility, therefore, were found to be lacking between respondents and clients.

The clients' attitude toward privacy (i.e. confidentiality) and family secrets emerged as obstacles in working with English-speaking Caribbean immigrants. The majority of respondents reported that the clients placed high value in their privacy (personal life history) and workers had to deal with this as an issue in their intervention.

"There is generally resistance to therapy by the West Indian immigrant and the reason is that it is normally taboo to discuss family business with strangers". (Questionnaire)

"Caribbean people have a problem talking about family secrets. It is taboo to talk about family problems". (Focus Group)

"one patient said that she will not tell the therapist about her personal life." (Focus Group)

One respondent reported that long hours of work, not uncommon among immigrants, was an additional obstacle to clients' involvement with mental health services. This has resulted in case termination by workers, for non-compliance.

"Parents were resistant to family therapy. Mother worked twenty four hours as home attendant and father thought of difficulties, as family matters were subject to 'outside' intervention".

#### Programmatic Obstacles

The social workers identified other factors of interference. The presence of these obstacles demonstrate cultural insensitivity and innocuous planning within the mental health system. They were:

Insufficient mental health practitioners in the Caribbean and lack of training in cross-cultural social work:

"There are not enough mental health professionals in the Caribbean to educate

others about mental illness and to treat the mentally ill". (Focus Group).

The lack of knowledge of aspects of Caribbean cultural differences in values and language (accent, intonation):

"I feel that more knowledge of Caribbean culture would have helped my insight into clients' discussions". (Questionnaire)

"Because I am trained to accept sharing of personal issues, it was difficult working with Caribbean clients, among whom, privacy is protected and becomes a barrier to therapy. I am unable to penetrate that barrier because I do not feel that I know enough about the culture". (Focus Group)

"I also have difficulty understanding the clients because of their accent" (Focus Group).

"My own values interfered with my objectivity". (Questionnaire)

For example, one worker reported that he could not comprehend the need for physical punishment by parents and teachers in the Caribbean. That worker felt that the awareness of that practice interfered with his intervention.

Policy and physical environment did not reflect cultural diversity:

"The agency does not have any clear procedures for working with immigrants, who often are not eligible for benefits" (Focus Group)

TABLE 8Professional Relationship Obstacles (N=12)

<u>Obstacles</u>	<u>Frequency</u>	<u>Percentage of Respondents</u>
Privacy and family secrets	5	42
Preference for traditional remedies	2	17
Not trusting worker	2	17
Negative concept of mental health	3	25

TABLE 9Programmatic Obstacles (N=12)

<u>Obstacles</u>	<u>Frequency</u>	<u>Percentage of Respondents</u>
Small number of mental health professionals	3	25

<u>Obstacles</u>	<u>Frequency</u>	<u>Percentage of Respondents</u>
Lack of cultural knowledge	3	25
Differences in values and language	2	17
Policy and physical environment	1	8
No obstacles identified	3	25

MANAGING OBSTACLES TO THE ACQUISITION  
AND USE OF CULTURAL KNOWLEDGE

Some of the social workers, in their attempts to manage or overcome the above-mentioned obstacles, tend to focus on establishing trust, respect and cultural sensitivity.

"I discuss cultural differences with the client as a way of trying to understand the client's problems".  
(Questionnaire)

"I am usually seen as a person who has achieved professional status through hard work, and often by the Caribbean client as a role model. This has some therapeutic value. It helps in the development of trust. The client then appears to be willing to disclose more. I can explore more and I use my professional self in therapy". (Focus Group)

## CHAPTER VI

### DISCUSSION

#### Knowledge of Culture

The emphasis on the need for awareness of the clients' culture, a core component of the stages of multicultural development, was reflected in the respondents' general responses. This finding is consistent with the original premise that culture is significant in mental health treatment and is supported by Foulks (1980), when he states, "culture provides guidelines and rules for recognizing and diagnosing and for its management, and sometimes, treatment" (1980, p. 812)

Overall, 56% of the respondents indicated that they were aware of some of the language characteristics, traditional folk beliefs, and other customs. However, many words and concepts were not understood by 60% of the respondents. This suggests that respondents were aware, but not knowledgeable (i.e., knowing meanings and context of use), of language characteristics. This finding appears to correlate closely with the first stage of multicultural development, (Pedersen, 1983) i.e. awareness, which is

characterized by assumptions about behavior and values of a cultural group, including language. The knowledge stage, in which information about culturally learned assumptions is expanded and integrated into practice, was not evident among these workers.

Many of the respondents too, did not document nor made direct reference to using knowledge of culture in helping to resolve clients' problems. This may be so, either because some respondents felt culturally unequipped, or as Perlman states: "...much of problem-solving work is on an unconscious basis, that is, it happens spontaneously in the empathic interaction between worker and client" (1957, p. 87).

The findings indicate that both Caribbean and non-Caribbean workers have heard clients use colloquial terms and phrases, which they did not understand. This supports the contention that many social workers are not knowledgeable of aspects of their clients' culture, even when both client and worker are of the same cultural background. (McNicol, 1993).

An essential task in the helping relationship, when working with culturally diverse populations, is to understand language characteristics, inflection, accent and the differential use of words. As a result of some of the

respondents' lack of such understanding, they have had difficulty in interacting with and treating this population. This supports the finding by Mason (1984) that the use of creolese terms by English-speaking Caribbean clients have led to misunderstandings by many social work practitioners. The significance of exploring native language or indigenous vernacular questions was suggested by Spradley (1979). This helps to determine the workers' understanding of terminology, customs and how particular terms varied according to context or culture.

About half of the respondents were aware of some of the folk beliefs prevalent among the clients and were able to identify them. Information about folk beliefs is not usually given voluntarily by clients, particularly in a mental health setting, where practitioners are often perceived as strangers. Such information, when given, may be volunteered on the basis of the clients' perception of the problem or his/her perception of the workers' ability to identify with the (client's) culture.

However, Taylor (1989) suggests that knowledge of the prevalence of traditional folk beliefs and the belief in spiritualism must be part of the repertoire of informational prerequisites, when intervening with diverse populations. The lives of many English-speaking Caribbean immigrants have been influenced by such belief systems. The belief in

indigenous healing systems such as Obeah, for instance, is prevalent "because it serves as a mode of adaptation to stress" (Woodbury, 1975). Consequently, as Rey (1993) argues, cultural knowledge should be integrated with clinical concepts which inform skills derived from professional training. Nevertheless, some respondents have expressed apprehension in discussing folk beliefs, or if they did acquire such knowledge, were concerned about how and when to use it appropriately in practice. This reflects the ambiguity and controversy on the use of knowledge of folk beliefs by social workers (Mc Nicol, 1993).

....it is felt that some mental health professionals misdiagnose spiritual problems as personality disorders...A number of therapists from the Caribbean background use (spiritualists) as resources. This method is quite controversial among traditional psychotherapists (McNicol, 1993 p. 111-112).

There was evidence of some familiarity with cultural elements such as food, music, dance and cultural celebrations. These were used as topics of discussion by respondents to develop rapport and to dismantle communication barriers. This finding is consistent with Taylor's assertion that failure to understand and utilize elements of cultural diversity including food preferences, dress and cultural celebrations, may adversely affect communication between client and worker (1989).

The findings regarding knowledge of the relationship between the stresses of immigration and mental health care, provide some preliminary answers to questions relating to adjustment experiences in the new environment including: What are the factors contributing most to the mental health problems? What changes affect the psychosocial functioning of the newly arrived immigrant? What is the relationship between presenting problems and adjustment difficulties?

Psychosocial functioning of newly arrived immigrants is intricately tied to their adjustment experiences in the new environment. The level of emotional stress is often determined by the degree to which they relinquish their traditional values and practices and adapt those of the host society. It is also determined by the immigrants' psychosocial functioning before migration i.e., level of education, age, occupation in the home country and circumstances of migration (e.g. voluntary or forced, planned or unplanned).

The principal factors which contribute to mental health problems of immigrants are those which involve family separation, sacrifices and the self-imposed pressures of educational and occupational achievement. The factors which impact upon psychosocial functioning centered around problems of identity in new environment and the experience

of racism. With regards to the issue of identity, Adams (1989) found in his study of Jamaican immigrants that,

....most subjects reported such difficulty in experiencing a sense of community akin to what they enjoyed in the larger West Indian community. Subjects argued that it was difficult to be yourself...(their native) culture also conveyed a sense that one belonged; one was a part of a group that was successful. Some subjects argued that it was especially difficult to find the psychosocial space to discover and develop their uniqueness (in the new society) (P. 238)

Experiences of racism were found by the respondents to precipitate emotional stress among some clients. With regards to such experiences, Adams (1989) noted that immigrants,

reported feeling surprised at being discriminated against, having grown up in a society where they took their positions as a first class citizen for granted or had never felt discriminated against solely on the basis of skin color (p. 239)

Adjustment difficulties were often caused by acculturation stresses and regularly mentioned in the presenting problems of the charts reviewed by the respondents in this study. This finding was consistent with those of McNicol, (1993) and Matsuoka, (1990). McNicol notes, as with "most immigrants, West Indians experience acculturation stress and culture shock.... Some factors that may either mitigate or exacerbate the stress and shock, are prior intercultural experiences, voluntariness of

migration, education, racism, and social support systems". (p. 17).

Dysfunctions in social and interpersonal roles and adjustment to the climate were prominently listed as part of the presenting problem. Matsuoka (1990) found that "the conditions that predispose individuals to mental health problems following initial contact include conflicts in identity, roles and values; drastic ecological and demographic shifts; changing levels of aspiration; and the use of coercion by the dominant group to attain its objectives". (p. 341). The findings also confirm the approach emphasized by Matsuoka (1990) that, "social workers are....advised to take an indirect approach to assessment. For example, social workers should address general issues of adjustment before addressing most obvious family problems" (p.343).

Respondents' identification of cultural factors which they felt enhanced mental health care again demonstrates their awareness of some cultural practices. The factors centered around the strengths of intra-familial relations, intra-group cooperation and positive attitude toward work. Similar characteristics were found to be critical elements for the treatment of culturally diverse groups, in Jacobs' and Bowles' (1988) analysis, where they proposed that for effective intervention, workers must have some understanding

of the value system, family interactions, and role assignments, such as those in parent-child relationship, in addition to "the impact of immigration and cultural adjustment, the extended family network, and the help seeking behaviors of ethnic groups" (p. x).

However, the respondents had little knowledge of how these factors affected mental health care. This indicates that with regards to aspects of the culture which enhanced intervention, the knowledge stage, which "expands the amount of information about culturally learned assumptions" (Pedersen, 1984) was not formalized among these social workers, in a way that could promote effective practice.

#### Sources of Cultural Knowledge

The response to the acquisition of cultural knowledge by the respondents, demonstrates that the greatest amount of cultural information was gained directly from clients. Information about the culture was acquired by discussing with clients what is of significance in their culture, in the process of getting information on the presenting problem. (d'Ardenne and Mahtani, 1990). This finding also represents one of the first steps in learning about another culture, namely, 'cognition' which defines,

...the way the culture is represented to the individual and by him; for example, the representation of objects through the use of words, or the representation of roles.

Without a considerable degree of consensus about the use of categories, communication between individuals, and ultimately all social interaction, becomes very difficult." (Taft, 1977, p. 132)

Other methods of acquiring cultural knowledge regularly among the respondents, such as family heritage, travel and the media were proposed by d'Ardenne and Mahtani.

Direct contact, through kinship, friendship or travel, is bound to be a very different experience than indirect contact with a culture, for example, through reading, second-hand accounts or the media. You can make friends with neighbors from another culture, or you can read literature that introduces you to a culture. What matters is that you seek information and experience of other cultures in all possible ways that are around you." (1990, p. 23)

Training programs in cultural sensitivity and culturally informed colleagues were the other sources of information, identified by the social workers. However, these sources, it was felt, were not sufficiently used. Participation in training seminars tended to increase cultural sensitivity, but did not increase knowledge of the culture, nor skill in its application.

#### USE OF CULTURAL KNOWLEDGE

When it occurred, the respondents' use of cultural knowledge was determined by certain identifiable culture

variables. This demonstrates another aspect of multicultural development, in which intervention or action is based on the social worker's "clarified assumptions and accurate (cultural) knowledge" (Pedersen, 1988). The social workers' use of cultural knowledge in practice was related to place of birth, socialization, or exposure to English-speaking Caribbean culture, rather than any formal training or the number of clients treated. This finding would indicate that "insiders" or those who were intimately associated with the clients' culture, was more likely to use it in practice. According to McGill, "...the insider understands, emphasizes and interacts with the (clients) on the basis of shared experiences" (1992, p. 342)

There were some feelings of frustration expressed by those respondents, who did not use cultural knowledge. Indeed, it was felt that culture-related obstacles obstructed use. This was usually found among the non-Caribbean workers. (McNicol (1993) notes that, "a therapist of a different culture may encounter difficulties in working with West Indian families..." (p. 116). Most of these workers reported that the presenting problem of their clients did not require the use of cultural knowledge. Unfortunately, such a decision would deny the clients the worker's potential for understanding many of their emotional difficulties, since the core problem may be related to cultural adjustment, as borne out in the findings.

The areas of culture mentioned by respondents, as knowledge used in their practice, namely, bereavement, discipline of children, the role of the extended family and folk beliefs, do encompass some of the essential "cultural issues" identified in Caribbean culture. McGoldrick, et al (1984), examined several of these issues which included the role of extended family members, disciplinary practices, and folk beliefs. These are viewed as important dimensions of cultural knowledge:

If we consider the extensive role played by extended family members in the rearing of children, it would be crucial to examine the history of symptom across generations...In working with West Indian families, the therapist cannot get away from discussing the events that have occurred in at least three generations... Folk beliefs also extend a strong influence on West Indians. Some families in crisis will consult a practitioner of obeah (witchcraft)" (p. 13)

Using the therapeutic process as an educational tool, as did at least one respondent with regards to the discipline of children, was advocated by McNicol (1993). "In working with immigrant families, much of the therapy may be educational in nature, since many adjustment difficulties may be the results of cultural differences or lack of knowledge about the U.S. educational, social, legal and political systems". (1993 p. 134)

The ambivalence relating to integrating knowledge of folk beliefs into the respondents' practice, however, is not uncommon among mental health practitioners, as Lefley (1988) notes:

The culturally sensitive (and non-defensive) professional may adopt various stances with respect to native healers. Many reject their science out of hand, viewing them as charlatans, perpetuators of superstition, or workers of malevolent evil. Others consider them valuable assets for learning and referral purposes. Much depend on the belief system as well as on the presenting problem." (pp. 8-9).

Although bereavement was not discussed as one of the essential cultural issues in previous studies, the fact that it was mentioned by respondents, suggests its relevance to working with this population. As with the other identified customs, it is important to examine the cultural patterns expressed in bereavement rituals. The worker should be able to discuss ethnic, cultural and religious traditions related to death, as a means of highlighting differences and commonalties among clients of variant backgrounds.

The respondents, who used cultural knowledge, cited significant improvement in the clients' functioning. For example, clients were able to resolve issues around bereavement and the disciplining of children, through the workers' ability to utilize their knowledge of the culture in practice. In his discussion of evaluating outcomes in a

community mental health program, Patton, (1989) states that staff should document,

the unique meaning of the outcomes for each client... about how clients' lives change over the period of treatment and following treatment. It is possible to construct an overview of the pattern of outcomes for a particular treatment modality (p. 63-64).

Although the researcher found few cases with documentation of treatment and outcome, following knowledge use, some social workers did report success with clients, when they used cultural knowledge.

#### Treatment Approaches

The findings indicate that respondents used supportive therapy most frequently with this population. Compared to other approaches, it was felt that supportive therapy would be more appealing and less threatening to the client. This approximates the conclusion drawn by McNicol (1993), regarding the therapeutic alliance,

In general, West Indians want a psychotherapist to be active and directive, yet personal, warm, sympathetic (p. 117)

The respondents, who used supportive therapy, felt that in trying to help clients resolve problems, it was important to provide a sense of warmth and acceptance of cultural difference.

Those respondents who found family therapy useful in their intervention, focused on involving members of the extended family, who were viewed as instrumental in concretizing the therapeutic alliance and in achieving therapeutic goals. Indeed, McGoldrick, et. al. (1982) found that in working with English-speaking Caribbean clients, "...the multigenerational perspective could serve to lower anxiety by taking the focus away from the 'identified patient' and by putting some distance between the symptom and the nuclear family" (p. 131)

However, "input from the extended family", reported as essential by respondents, is not usually attained without difficulty or resistance, as McGoldrick (1982) further states,

"The West Indian family finds it difficult to admit that there is a problem it cannot handle. Family members tend to be quite stoical and have a covert agreement among themselves not to reveal feelings. The therapist's efforts to amplify feelings could be threatened" (pp. 130-131).

Although none of the respondents used a "multicultural approach", as recommended by Sue and Zane (1987) and Pedersen (1985), their intervention indicate that they have, to some extent struggled to integrate what cultural knowledge they had, with learned psychotherapeutic

approaches. The multicultural approach emphasizes the importance of cultural diversity among clients and the practitioners' capacity to understand and use the elements of that diversity in practice. In particular, Sue and Zane suggest that, not only should the treatment modality "fit" the experiences of the client, but cultural knowledge, strategically used in intervention, would increase worker credibility. There was no consistent pattern of acquiring and using aspects of cultural knowledge among the respondents.

#### Obstacles to the Acquisition and use of Cultural Knowledge

Alternate research questions in this study, for those social workers who did not use cultural knowledge are: (a) what were the reasons for non-utilization of cultural knowledge? (b) what did those workers do about it? It was found that the use of cultural knowledge was significantly influenced by the cultural background of the respondents. But other variables in the form of obstacles, impacted upon the acquisition and use of cultural knowledge.

Several professional relationship obstacles which created some interactional distance between worker and client were identified. The client's negative associations and conceptualization of mental illness, reported by the respondents appear to be a typical finding among immigrant

populations. Those findings include the "somatization" of emotional problems and "cultural fatalism". Comitas-Diaz describes these immigrant help-seeking behaviors as having a muzzling effect on clinicians' use of cultural knowledge and therapeutic outcome. There is no differentiation,

"between physical and emotional concerns in the same way the Anglo culture does...They see the mental state affecting the physical condition and vice versa...A related concept is cultural fatalism or the belief that some things are meant to happen regardless of the individual's intervention (1989, pp. 41, 42).

The impact of a cultural incongruent conceptualization of mental illness and psychotherapy was emphasized by McNicol, (1993), and supports the findings related to such obstacles.

"Another impediment to accepting psychotherapy is the social stigma attached to it. The average West Indian believes that a person is either 'normal or crazy', and only 'crazy' people seek psychotherapeutic help. Also for West Indians, the causes of 'craziness' may be traced to the family, and this may cause a loss of status for the family - something that is extremely important in the West Indian community" (p. 103).

By including the clients' use of traditional remedies, such as those provided by family, friends and folk healers, in the repertoire of obstacles, respondents were identifying "alternative resources" to mental health care (Rogler, et. al. 1988). Similarly, "institutional barriers", including

the presence of workers, who were unfamiliar with the clients' culture, either disrupted the therapeutic alliance, or delayed its development.

Another reported obstacle faced by respondents in their attempts to acquire cultural knowledge and use it in therapy was the clients' strong preference toward maintaining and guarding family secrets. This tendency was indeed portrayed as a characteristic, which has potential for jeopardizing the therapeutic relationship. This may be accounted for because,

...although West Indians may appear to be engaging socially, sharing real family secrets is a difficult issue. Secrets are to be kept within the family unit. West Indians also tend to deny family problems because they believe there is nothing that they cannot solve themselves within the family." (McNicol, 1993, p. 120)

Despite the fact that many of the respondents have had cross-cultural experience i.e., working with clients from cultures other than their own, there were obstacles, which approximated the extent of that experience. In this regard, d'Ardenne and Mahtani (1989), confirm that,

...we have found that our psychological training has not always provided an adequate means of dealing with cultural differences. It is these very differences that will form a barrier within the therapeutic relationship with transcultural clients (p. 74).

A number of shortcomings in the agency's ability to develop and maintain culturally relevant programs, were also cited as serious obstacles. Such deficiencies represent a dimension of cross-cultural social work, which requires an exploration of knowledge and strategies of intervention.

Nevertheless, in their attempts to manage those obstacles to the acquisition and use of cultural knowledge, some respondents have focused on their own attitude and disposition within the therapeutic alliance. In doing so, they are addressing the issue of worker "credibility" as outlined by Sue and Zane, (1987).

Credibility refers to the client's perception of the therapist as an effective and trustworthy helper. The role of cultural knowledge is to alert therapists to possible problems of credibility. Without knowing the cultural values of an ethnic minority group, therapists would have to assess their credibility on a case-by-case basis. They would be unprepared to deal with possible cultural discrepancies in conceptualizing the problem, finding means to resolve problems of the client and setting goals for treatment (p. 41).

The social worker's role as "culture mediator" becomes central to this process, especially in working with English-speaking Caribbean clients because of "...the importance in West Indian culture of seeking advice from experts" (Fandeti and Goldmeier, 1988, p. 174)

SUMMARY

The social workers support the view that understanding culture is important and the need to be aware of cultural knowledge of culturally diverse populations. However, the workers demonstrated a minimum amount of knowledge about the culture of English-speaking Caribbean clients and have done very little to learn more. They have not developed a cultural consciousness for the special needs of the clientele, nor do they have any systematic means of providing culturally relevant mental health care to English-speaking Caribbean clients. As a result, these workers apply very little cultural knowledge in their intervention. Some of them fail to see the relevance of using cultural knowledge in assessment and treatment, while others just do not know how to formalize and use such knowledge in practice. Nevertheless, those who did attempt to use cultural knowledge, reported some positive treatment outcomes.

The Caribbean-born social workers, although expected to have a cultural advantage, do not have much knowledge about Caribbean culture, beyond their respective Caribbean country of origin. The non-Caribbean social workers, by virtue of their socialization, are unfamiliar with the customs of the clients.

The acquisition and application of cultural knowledge were stymied by several obstacles: (1) clients' resistance (2) linguistic differences (3) insufficient cross-cultural training and (4) inadequate program planning to include cultural diversity issues. These problems occur within a mental health system that has acknowledged the necessity of responding to changing demographics (i.e. multicultural clientele), but is neither empathetic to client needs nor structurally designed to deal with the change adequately.

The potential consequences of these inadequacies may be placed into three categories: (1) positive for the system. Here the mental health system does very little to accommodate the cultural needs of the client and does not have to invest funding in training and restructuring. The client, regardless of cultural background, is expected to conform to a homogeneous approach to treatment. (2) negative for the system. By not developing culturally relevant intervention, resources will be wasted on ineffective programs. (3) negative for the consumer (client). The clients' needs are not being met and this creates frustration and a desire not to seek professional mental health services. Yet simultaneously, there has been a noticeable increase in referrals of diverse populations, including English-speaking Caribbeans. What then can be done to circumvent these problems and construct a culturally

adequate system of mental health care, (i.e. knowledgeable and skillful)?

The findings reveal that social workers and mental health professionals in particular, have both a challenge and responsibility to carefully address the needs of immigrant groups they serve. The success of this task hinges upon two major factors: (I) the willingness of workers to acknowledge and accept the client's cultural heritage and to fully understand its role in promoting good mental health and (ii) the courage and capacity of mental health providers and policy makers to transpose their services into "culturally competent" systems. The social workers expressed an awareness of the clients' culture and of its importance, but in general, lack the knowledge, guidance and skills needed to convert what they know about the culture, into effective practice.

The findings indicate that the respondents also recognized the importance and relevance of knowing the culture of their clients. However, there were variations by social worker characteristics, in the extent of their cultural knowledge. The respondents tended to agree that there are several distinguishing features of English-speaking Caribbean culture, the identification and understanding of which could enhance intervention. They were generally not trained to work with culturally diverse

groups, including Caribbean immigrants and felt that there were several factors which precluded the acquisition and effective utilization of cultural knowledge in practice.

These findings seem to support those who found that clinicians working with immigrant populations, lack the knowledge of the clients' culture. (Jones and Korchin, 1982; Mason, 1984; McNicol, 1993). In fact, most of the respondents appear to be in the awareness stage of multicultural development. The skills required for adequate intervention and the knowledge, which informs those skills, were less well developed among the workers.

## CHAPTER VII

### IMPLICATIONS FOR SOCIAL WORK

Based on the findings presented in this study, psychiatric social workers must increase their knowledge of the clients' culture. If this is to be accomplished by a broad cross-section of social workers and the social work profession, then schools of social work, state and city departments of mental health and service providers will have to escalate systematic recruitment, training and education.

The findings suggest that the mental health clinic (Bedford Stuyvesant Community Mental Health Center) needs to develop a system of culturally competent holistic practice, which would help remove obstacles to the acquisition and use of cultural knowledge by social workers. These obstacles include failure to prepare direct service workers with the necessary cultural resources and tools i.e., knowledge and skills for effective intervention. A coordinated system of training, facilitated by the utilization of indigenous and institutional resources, can help in the accumulation of cultural knowledge, sensitivity and skill.

The transformation of cultural sensitivity into meaningful practice in mental health, must be preceded by the workers' attachment of significant value to the need for

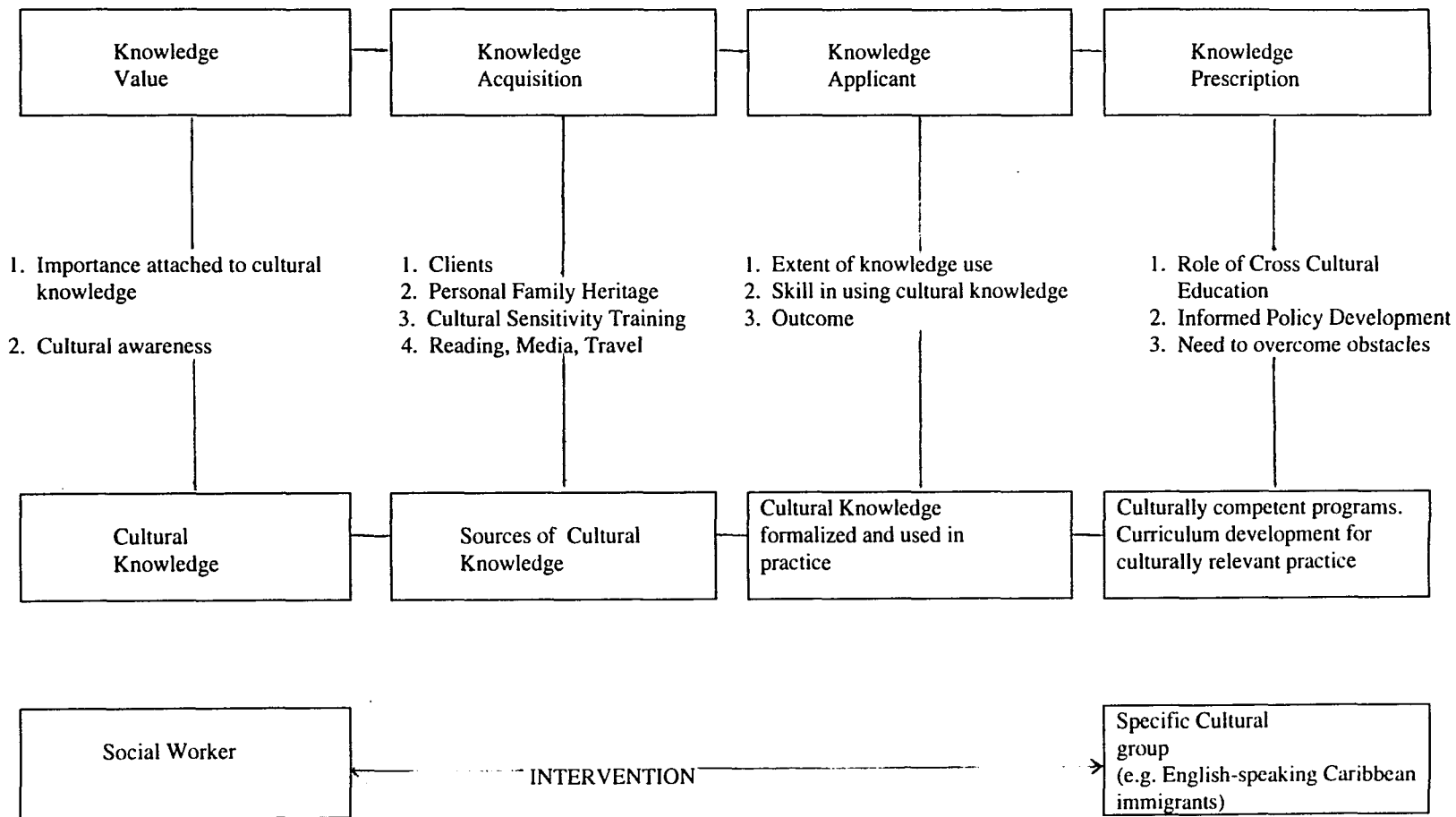
cultural knowledge. The acquisition of cultural knowledge from reliable sources, such as clients and their families, should be followed by carefully guided application of that knowledge in mental health care. This sequential process i.e., knowledge value, knowledge acquisition, and knowledge application, provides the conceptual framework for training and policy development (see figure 2). This in turn must be informed by an empirical foundation for cross-cultural social work practice, as presented in this study.

#### Training and Education

A coordinated network of training and education, for social workers who treat diverse populations, will contribute toward a data base on multicultural resources. The study revealed that a significant number of social workers are more culturally aware than culturally knowledgeable therefore, a data base would be instrumental in providing culturally relevant information. In addition, there will be less frustration and ambivalence by those mental health professionals who work with diverse populations, including English-speaking Caribbean immigrants. This will be an appropriate response to the stated deficiency which holds that,

sensitivity to the cultural varieties of self-expressions, problem-solving and language is generally a neglected area in the education, training and professional

Figure 2



supervision of mental health workers.  
(Brislin and Patterson, 1976, p. 96)

Unlike two decades ago, when most social workers were not only middle-class, but largely culturally and ethnically different from their clients, similarity in cultural background characteristics is more common in the profession today. Among the psychiatric social workers conventionally working with English-speaking Caribbean clients, are those who are themselves from the Caribbean. Many of these workers can be a source of cultural knowledge for their peers. They can also become valuable consulting contributors to in-service training and in the designing of culturally competent mental health programs, especially on cultural data from their respective Caribbean countries. However, opportunities for sharing of cultural information must be created through restructuring education programs, peer supervision, agency-sponsored staff development and re-framing of policy.

A number of cross-cultural training models have been developed by some authors as part of continuing education programs for mental health professionals (Baker, 1989; Green, 1982; McNicol, 1993; Thrasher, 1988). Schools of social work need to integrate such models into their curriculum, which should include, not only cultural sensitivity training, but course content around the effective application of cultural knowledge in practice. If

one of the goals of social work is social reform, then education and training must seriously make the sociocultural approach a major part of the basic framework of intervention (De Hoyas, et. al. 1986; McGoldrick, et. al. 1982).

More specifically, social work educators must begin to review the content of their curriculum, in both theory and practice. If indeed educators recognize the intimate relatedness of culture to the helping process, then it is incumbent upon them to re-examine their knowledge of other cultures. The objective is for them to mobilize and educate social work students to a level at which they are knowledgeable and skilled in providing culturally relevant services. Are these purveyors of social work education culturally sensitive and familiar with the values and customs of the clients their students will treat? If not, what have they been doing to ensure this? Just as providers of mental hygiene services are summoned to be culturally competent, so too should schools of social work and other training institutions be expected to develop culturally relevant curricula. The findings of this study do not demonstrate effective cultural education. The adoption of a culturally competent model, as part of the core course content, could enhance social workers' cross-cultural skills.

Similarly, social work supervisors and field instructors play a key role in training. Their effectiveness as mentors and professional role models depend on their abilities in promoting and harnessing of cultural knowledge and resources of the clientele. The findings can help supervisors to identify a practice niche, for mental health professionals and other social work practitioners, that incorporate cultural knowledge into social work conceptualization and practice.

The multicultural development model, which focuses on awareness, knowledge and skills, can be employed to legitimize the role and need for cross-cultural training for social workers. As the findings demonstrate, although the workers were familiar with general assumptions of English-speaking Caribbean culture, the development of cultural knowledge is lacking, but essential. Green (1982) asserts that:

There are several reasons for the need to acquire cross-cultural knowledge and capabilities in social work. Many workers know little of the cultural characteristics of their clients. This is not surprising, since it is only recently that minority concerns have appeared in the curriculum of social work programs. Yet, unfortunately, much that passes for 'cultural sensitivity' training, be it formal education or on-the-job workshops, is trivial at best and tokenism at worst. It is necessary, therefore, to propose ways of acquiring information and utilizing it in a systematic way. the anecdotal approach to acquiring knowledge about values, preferences and expectations of culturally distinctive clients, is simply inadequate. (pp. 49, 50).

The findings reveal that there is an urgent need to reformulate the education of those who provide direct mental health care and who exhibit some awareness of the culture, but are confronted with a number of resource and culture-related obstacles. There has not been any critical thinking about the role of culture in the delivery of mental health services and overt application of cultural knowledge has been sporadic. Perhaps there should be more training of social workers from the Caribbean, since they are more likely to use cultural knowledge in practice. Non-Caribbean workers need to recognize the areas of potential difficulties in working with English-speaking Caribbean clients, some of which were presented in this study.

Some of the crucial areas of English-speaking Caribbean cultural knowledge were identified. Cultural knowledge, when applied, was used primarily to gather information relevant to the presenting problem or to help develop treatment plans. However, we need to determine, through further research, which intervention strategies or techniques have been helpful to other culturally different clients and their families and the extent to which those approaches were influenced by cultural knowledge. Empirically supported cross-cultural studies in mental health care are necessary, in light of the fact that the

number of immigrants entering the United States from a variety of cultures is on the increase.

The findings from the study can also have an impact on mental health policy affecting newly arrived immigrants. The need to address the mental hygiene problems of culturally diverse groups have been acknowledged and expressed by policy makers. However, the values that drive such expressions must be guided by accurate facts about the cultural groups for which change is planned. The establishment and maintenance of culturally competent policies and programs hinge upon the continued accumulation of relevant cultural information. Careful assessment of the sources of such information must be made. These will have to include knowledge acquired from culturally diverse communities, through social workers in direct practice, based on knowledge gained from clients.

This study provides information that would be required for effective planning of mental health service delivery to English-speaking Caribbean clients and other culturally diverse groups. For instance, the identification of adjustment problems and the ways in which some social workers have attempted to use the knowledge of traditions and customs to resolve these problems, would help to increase the skills of mental health professionals. This will ultimately promote the social functioning of immigrant

clients and their families. Conversely, the difficulties raised by the respondents will help social workers avoid pitfalls in intervening with immigrant clients.

It is not enough to recognize the need for cultural awareness. If social workers, supervisors, educators and policy-makers do not understand the dynamics that shape the lives of Caribbean immigrants, there will inevitably be gross misunderstanding and failure to develop the needed skills.

CHAPTER VIII

## CONCLUSION

The results of the study have furnished some preliminary data concerning the experiences of social workers, who provide mental health services to English-speaking Caribbean clients. It was found that there is a general lack of knowledge of the clients' culture. Further, awareness of elements of the culture, did not promote regular use of cultural knowledge in practice. This was demonstrated by the inability to recognize commonly used concepts and words of the culture and attributed to the prevalence of cross-cultural and programmatic obstacles to intervention.

Knowledge of the client's culture is in its embryonic stage. Cultural knowledge of mental health professionals is far from what it should be. Consequently, intervention with English-speaking Caribbean populations is not properly informed. How much is known depends on how practitioners are introduced to the culture. Nationality or association with immigrant through friendship or travel, tended to result in more familiarity with the culture. However, there are those who generalize from what they know of other non-immigrant 'minority' groups, such as African-Americans, and this has forged misrepresentation of the clients' culture.

Cross-cultural generalization can have a devastating impact on treatment outcome. This phenomenon needs to be further examined in future research.

The acquisition of cultural knowledge is pertinent to the process of developing cultural competence. People learn about other cultures in many different ways. The social workers' cultural knowledge came primarily from clients during direct practice. But what are some of the other ways in which culture is best learned and articulated as a basis for practice knowledge? Perhaps knowledge of another culture could be acquired more rapidly and effectively, by increased contact with the clients' community. This may include involvement in cultural celebrations and other activities, which promote experiential learning. Agency-sponsored trips/vacations to the clients' country of origin could greatly enhance cultural knowledge and sensitivity of practitioners. The timeframe for such learning and the determination of which elements of culture are the most important, require further research.

Although English-speaking Caribbean territories have many customary similarities, this study points to the necessity of developing mechanisms for the cross-fertilization of cultural knowledge.

Reciprocity in economic and recreational activities has been traditionally emphasized, but mutual exchanges about knowledge of specific customs, has generally been ignored, if not taken for granted. Further study is required to explore the need for such exchanges as a means of increasing cultural knowledge.

Human services practitioners, who use cultural knowledge in practice, are more likely to be of similar cultural background as their clients and they identify with aspects of the clients' culture. However, participation in cultural sensitivity training did not increase the use of cultural knowledge. When used, cultural knowledge increases the understanding of the clients' presenting problem and helps in the development of treatment plans.

Those who do not use cultural knowledge in practice, tend to be of a different ethnic and cultural background than the clients. Difficulties often stem from ignorance of the clients' culture and the absence of explicit cross-cultural policy and program design. Other characteristics of people who use or do not use cultural knowledge, such as gender and clinical orientation, should be explored.

A cross-cultural approach, which deliberately integrates cultural knowledge with therapeutic training to

develop skills, can offer a meaningful framework for practice. Sue and Zane (1987) note:

by using this cross-cultural model, it becomes apparent why simply imparting knowledge of different cultures was insufficient in the past. Such knowledge often involved very general and abstract concepts. More important, few training programs offered explicit guidelines for the application of these concepts to specific clinical tasks of therapy. (p. 44)

The authors further state that cultural sensitivity is a diffuse concept, which should be "transformed into a set of meaningful operational objectives for the development of skilled therapists" (p. 44).

This research is practice-related, intended to help human service practitioners, providers and policy makers understand the significance of culture. It also demonstrates how cultural knowledge is used and did identify some of the major factors that inhibit services to immigrant clients. It is hoped that the study will make a contribution to social workers' knowledge, in ways that they can respond appropriately to changing demographics and to clients' mental health needs.

APPENDIX A  
STAFF QUESTIONNAIRE A

Please provide the following information:

DEMOGRAPHIC

1. Gender:  
     Male           \_\_\_\_\_
- Female         \_\_\_\_\_
2. Age Group:  
     below 21      \_\_\_\_\_
- 21-30         \_\_\_\_\_
- 31-45         \_\_\_\_\_
- 46-55         \_\_\_\_\_
- above 55      \_\_\_\_\_
3. Place of Birth:  
     USA            \_\_\_\_\_
- Caribbean    \_\_\_\_\_
- Other          \_\_\_\_\_ (Please specify)
- \_\_\_\_\_
- \_\_\_\_\_
4. Where did you receive your formal education?
- |                   | <u>USA</u> | <u>Caribbean</u> | <u>Other</u> |
|-------------------|------------|------------------|--------------|
| Elementary School | _____      | _____            | _____        |
| High School       | _____      | _____            | _____        |
| College           | _____      | _____            | _____        |
| University        | _____      | _____            | _____        |
| Other             | _____      | _____            | _____        |
5. Ethnicity:  
     African-American    \_\_\_\_\_
- Caucasian            \_\_\_\_\_
- Hispanic/Latino     \_\_\_\_\_
- Afro-Caribbean      \_\_\_\_\_
- Indo-Caribbean     \_\_\_\_\_
- Other                \_\_\_\_\_ (please specify)

6. Area of residence:
- |               |                        |
|---------------|------------------------|
| Brooklyn      | _____                  |
| Queens        | _____                  |
| Manhattan     | _____                  |
| Bronx         | _____                  |
| Staten Island | _____                  |
| Other         | _____ (please specify) |
- 
7. Religion:
- |             |       |
|-------------|-------|
| Catholic    | _____ |
| Protestant  | _____ |
| Pentecostal | _____ |
| Judaism     | _____ |
| Islam       | _____ |
| Other       | _____ |
- 
8. Years in post MSW practice:
- |                   |       |
|-------------------|-------|
| Less than 1 year  | _____ |
| 1-2 years         | _____ |
| 2-4 years         | _____ |
| 4-6 years         | _____ |
| More than 6 years | _____ |
9. Years employed at current Mental Health Clinic:
- |                   |       |
|-------------------|-------|
| Less than 1 year  | _____ |
| 1-2 years         | _____ |
| 2-4 years         | _____ |
| More than 4 years | _____ |
10. Approximately what number of English-speaking Caribbean clients have you treated?
- |              |       |
|--------------|-------|
| Less than 10 | _____ |
| 11 to 30     | _____ |
| more than 30 | _____ |

11. What are the primary factors that contribute to mental health problems among English-speaking Caribbean clients?
12. Can you think of any factors in English-speaking Caribbean culture that would enhance mental health care with these clients?  
Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please describe them.
13. What intervention technique(s) do you find most effective in working with English-speaking Caribbean clients?
14. How comfortable do you feel working with English-speaking Caribbean clients and their families?  
not comfortable at all \_\_\_\_\_  
somewhat comfortable \_\_\_\_\_  
very comfortable \_\_\_\_\_  
Explain

15. How would you define the role of culture in mental health?

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16. Any other observations:

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CULTURE AND INTERVENTION

For the purpose of this questionnaire culture is defined as the values, beliefs, customs and lifestyle of an identified group.

1. Would you say that you have a good knowledge of English-speaking Caribbean culture?  
Yes\_\_\_\_\_ No\_\_\_\_\_
  
2. Do you think that there is a difference between English-speaking Caribbean culture and African-American culture?  
 much difference \_\_\_\_\_  
 some difference \_\_\_\_\_  
 very little difference \_\_\_\_\_  
 in what ways? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 no difference \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
  
3. Have you ever attended or participated in a conference/workshop/seminar dealing with Caribbean culture?  
 Yes\_\_\_\_\_ No\_\_\_\_\_  
 If so, how many?\_\_\_\_\_. When?\_\_\_\_\_.
  
4. If the answer to question 3 is yes, was your involvement in that activity helpful in your intervention with Caribbean clients?  
 Yes\_\_\_\_\_ No\_\_\_\_\_  
 If yes, in what way?
  
5. Have you ever heard people from the English-speaking Caribbean use words you did not understand?  
 Yes\_\_\_\_\_ No\_\_\_\_\_  
 If so, give examples

6. Are you familiar with the music and dances, that are common among English-speaking Caribbean clients?  
Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please describe
7. Do you know what foods are typical of English-speaking Caribbean immigrants?  
Yes \_\_\_\_\_ No \_\_\_\_\_  
If so, please name them.
8. Are you aware of any cultural celebrations observed by this population?  
Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please discuss, include the purpose of the celebration, if known.
9. Do you know of any traditional, folk beliefs prevalent among English-speaking Caribbean immigrants?  
Yes \_\_\_\_\_ No \_\_\_\_\_  
If so, please name them.

## APPENDIX B

STAFF QUESTIONNAIRE B

Please answer the following questions, based on your work with the client.

1. To what extent was/is the presenting problem related to cultural difference or adjustment difficulties experienced by the client?

very much related \_\_\_\_\_  
 somewhat related \_\_\_\_\_  
 not related \_\_\_\_\_

Please explain:

2. In what ways, if any, did the information about the client's cultural background have an impact on your clinical assessment?

3. Were there any cultural factors which you considered important in your attempts to attain treatment goals?  
 Yes\_\_\_\_\_ No\_\_\_\_\_.

If yes, (a) what were they?

(b) how were they important?

If no, please explain:

4. How did your knowledge of Caribbean culture or lack of it affect your providing mental health care for the client?

5. Did you have any difficulties, related to cultural differences, in your work with the client? Yes\_\_\_\_\_ No\_\_\_\_\_.

If yes (i) what were they?

(ii) how did you attempt to resolve them?

If no, why not?

6. Does the client believe in a traditional/"West Indian" healing system? Yes\_\_\_\_\_ No\_\_\_\_\_ Unknown\_\_\_\_\_

If yes, how did this belief affect your intervention?

7. What intervention techniques did you use with the client?

Discuss briefly why the technique(s) were or were not effective with the client.

8. Are there any cultural factors which you believe limited your ability to help the client? Yes\_\_\_\_\_ No\_\_\_\_\_.

Please explain:

How have you dealt with these limitations?

9. What cultural resources, if any, did you use to enhance treatment?

(a) If you did, please describe how they were used.

(b) If you did not, why?

APPENDIX C  
FOCUS GROUP QUESTIONS

All participants are social workers, who have completed the questionnaire.

Interviewer: These are follow-up questions to the questionnaire you were asked to complete.

1. What does it mean to be a Caribbean or non-Caribbean working with Caribbean clients?
2. Could you give a case example of your work with a Caribbean client?
3. What were some of the specific presenting problems of Caribbean clients? Was there anything unique about those problems?
4. Where did you get most of your information (knowledge) of Caribbean culture? What resources? e.g. the media, talking to Caribbean immigrants, reading books or magazines, clients, friends or colleagues.

5. List a few treatment goals you have established for Caribbean clients and say specifically how they were related to cultural factors.
  
6. One of the customs mentioned as an important cultural factor in establishing treatment goals is the way Caribbean people discipline their children. What do you think of this issue within the context of child abuse laws in the United States?  
What is your experience in treating this problem?
  
7. What about Caribbean culture, do you think you would need to be more helpful to this clientele?
  
8. In your assessment how is the Caribbean client's perception and understanding of mental illness different from those of non-Caribbean clients?
  
9. Resistance to therapy appears to be common among Caribbean clients. How(specifically) have you dealt with resistance?

10. Give a specific example of when you were "lost" in your intervention with a Caribbean client.
  
11. Have you ever attempted to integrate the client's traditional beliefs with the techniques you have learned in psychotherapy?
  
12. English-speaking Caribbean clients tend to be "private" with regards to personal issues. Has this been a problem for you in working with this group? Please explain.
  
13. Would you like to make any further comments about the cases you presented or about your experience in working with Caribbean clients in general?

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