

Black Caribbean Immigrants

Challenging Mental Health Concerns among Black Caribbean Immigrants

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Dissertation submitted to the faculty of the Virginia Polytechnic Institute
and State University in partial fulfillment of the requirements for the degree of

Doctor of Philosophy

in

Counselor Education

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August 25th 2015

Falls Church, VA

Keywords: mental health, counseling, Black Caribbean immigrants, racial and ethnic identity

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Abstract

The racial and ethnic diversity of the United States continues to evolve due to increases in immigration from nearly all parts of the globe, including the Caribbean region. Like the U.S., this region can also be considered a melting pot of cultures, with the Afro-Caribbean population widely scattered across these island nations. Important to this investigation is the large diaspora population of Black Caribbean immigrants (BCs) in the U.S. who are often viewed as African American simply by virtue of their skin tone and facial features. As such, this racial consolidation does not take into account their distinct history, immigrant experiences, and cultural “separateness,” particularly with respect to mental health counseling. Current research is limited as to how the racial and ethnic identities of various generations of Black Caribbean immigrants in the U.S have shaped their experiences—and especially how racism in American may be impacting their lives. Moreover, their already limited experience with the counseling process may be undermined by culturally-inappropriate services that do not consider their distinct cultural beliefs and needs.

Guided by known and respected clinical standards for multicultural counseling and training for culturally-competent counseling, this qualitative study explored the counseling experiences of eight English-speaking BCs. Themes related to if and how mental health clinicians are actually addressing their racial distinctiveness, ethnic identity, and immigrant experiences were highlighted. Implications for counselors, counselor educators, and Black Caribbean immigrants were summarized.

Acknowledgements

First and foremost I acknowledge my Lord Jesus Christ for His faithfulness and His promise that I can do all things through Him strengthening me.

It is a pleasure and an honor to express my gratitude to my committee chair, Dr Laura Welfare, for her unwavering commitment to see me through the completion of this dissertation. Dr. Welfare: God answered my prayer when he blessed me with you as my Chair. I would like to thank my other committee members: Dr. Hannah Bayne for her support and knowledge of all things counseling, which truly strengthened me along the way; Dr. Nancy Bodenhorn for the inspiration to write this dissertation, and Dr. Peggy Pimentel for her constant listening ear and guidance throughout the writing process. I truly enjoyed working with each of you.

I must express my gratitude to my family for their unwavering support and prayers in my life throughout this entire journey—especially my big sister, Jackie, who continues to be one of my biggest cheerleaders. I am honored to have such a wonderful family. Without your love and support this dissertation would never have been dreamt of...let alone achievable!

I would also like to thank my friends and colleagues who understood that my school commitments did not replace them, but for a short time had to take precedence. For their understanding and their technical support when I had nothing left to give—I thank each and every one of them. I also want to thank my former doctoral colleagues for their support and encouragement throughout the entire graduate process. I must also acknowledge Laurie G., for without her encouragement and editing assistance this dissertation would have taken much longer to complete.

Last but certainly not least, I would like to recognize and thank the brave participants of

this study who trusted me to tell their story, and the story of our people that needed to be told.

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CHAPTER ONE

INTRODUCTION

Culture is an essential part of human identity. It influences how one behaves; it affects one's values, norms, and beliefs; and to a significant extent it shapes how one adapts to one's circumstances in order to thrive (McAuliffe, 2008). Patterson (2008) defined culture as “a repertoire of socially transmitted and intra-generationally generated ideas about how to live and make judgments, both in general terms and in regard to specific domains of life” (p. 208). Humans assimilate these cultural norms and expectations over the course of years, beginning from birth. While it used to be that cultures rarely collided, advances in transportation, economic incentives, human curiosity, and widespread migration have made the world a much smaller place. Now, the notion of “multiculturalism” is a feature of most societies and places.

Immigrants to a foreign locale bring new ideas about how to live, and in so doing they contribute to ongoing, dynamic cultural shifts. According to Barzun (n.d.), “A culture may be conceived as a network of beliefs and purposes in which any string in the net pulls and is pulled by the others, thus perpetually changing the configuration of the whole.” In the U.S., this is a very large net with more varied cultural strings than perhaps any other place on earth. In other words, cultural change in the U.S. has been fluid with many contributors to that evolution. However, important to this investigation is that not all of those cultural contributors are viewed as distinct from others who may physically look somewhat similar. Such is the case of the Black Caribbean (BC) immigrant.

BC immigrants—namely those who emigrate from Jamaica, Saint Lucia, Barbados, Grenada, Trinidad and Tobago, Antigua-Barbuda, Saint Vincent and the Bahamas—are

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sometimes included in the larger population of African Americans simply based on the color of their skin. Making this assumption fails to recognize that BC history and culture are significantly different from African American (AA) history and culture (Gopaul-McNicol, 1998; Rogers, 2006; Waters, 1999). While this cultural consolidation is largely inconsequential for providers of many services (e.g., doctors and dentists), this is not the case for mental health professionals who may lack insight into the culturally distinct needs of BC immigrants. In fact, BC immigrants might not seek counseling at all—or if they do leave counseling early—because of this lack of culturally-appropriate care (Baptiste, Hardy & Lewis, 1997).

The unique cultural values of BC immigrants that impact their mental health are rooted in religion, philosophy, medicine, social interactions, education, and criminal justice traditions (Gopaul-McNicol, 1998). The age at which one migrates, the length of time in the U.S., and generational status are all factors that impact one's mental health status (Jackson, Forsythe-Brown, & Govia, 2007). Unfortunately, the fact that African Americans and Black Caribbean islanders tend to be viewed as one racial group in the U.S. means that very little attention has been given to actual differences in AA and BC health. As such, it is important for counselors to better understand the experiences of BCs who seek counseling in the United States.

Black Caribbean Immigrants Identified

Within the last decade an estimated 1.7 million BC immigrants have entered the United States (Thomas, 2012), primarily for economic and educational options that are not readily offered in the Caribbean (Baptiste et al., 1997; Foner, 2001; Murphy & Mahalingam, 2004; Waters, 1994). Despite the distinctiveness of each nation, the BC immigration experience and the racial identity development of these Caribbean islanders can be considered similar because of their overarching Caribbean culture. Some of the hallmarks of Caribbean culture include their

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commitment to hard work and the importance of education and family (Rogers, 2006).

Moreover, since Black people are in the majority in the Caribbean, they are not the recipients of racism and are able to live their lives without the detrimental effects of racism. English is the primary language spoken, but each island has some variation of a dialect that was adopted during periods of colonialism (Matthews & Mahoney, 2005).

Similar to most immigrants, those from the Caribbean may choose to retain their important cultural traditions and beliefs while assimilating into the U.S. culture in order to function effectively (Baptiste et al., 1997; Murphy & Mahalingam, 2004). Depending on the unique BC immigrant experience of each, functioning in both cultures can be stressful. For example, migrating from a majority culture to a place where Blacks are the minority could create adjustment problems that are manifested as feelings of anger or frustration. Some BCs may also feel devalued when confronted with the reality that, unlike their native Caribbean experiences, they now may be perceived negatively because of their skin color and/or immigrant status (Murphy & Mahalingam, 2004).

Generational Differences

In addition to differences between AAs and BCs, there are also differences across generations of BC immigrants, which can have a tremendous impact on the immigrant family as a whole (Harker, 2001). This notion of “generation” is defined by the point at which the parents arrived or the age of the children when they migrated to the U.S. (Rumbaut, 2004). First-generation immigrants are those who migrated to the U.S. as adults; any children they brought with them aged 12 or older would be considered the 1.5-generation immigrant. Second-generation immigrants are born U.S. citizens to at least one immigrant parent. Third-generation immigrants are the children born in the U.S. to native-born U.S. citizens, and have ancestral ties

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to the Caribbean (Rumbaut, 2004; Zhou, 1997). The first- and 1.5-generation immigrants must seek U.S. citizenship; in contrast, second- and third-generation children are U.S. citizens by virtue of the fact that they were born in this country.

“In addition to intergenerational factors, there may also be a differential rate of acculturation based on one’s role in the family system and varying degrees of contact with the dominant culture” (Gushue, 1993, p. 491). Thus, it should not be assumed that everyone in an immigrant family shares the same cultural traits, values, and beliefs. This fact highlights the importance of evaluating the children’s cultural identity separately from the parents. For instance, the first-generation immigrant is more likely to enter the workforce (perhaps working several shifts or multiple jobs to support the family), while the second and 1.5-generation will enter school (Mitchell & Bryan, 2007). These “mainstreaming experiences” cannot be equated in terms of the rate of acculturation since a worker’s ways of interacting with the U.S. culture will be different from a younger student’s experiences with the new culture. While one or both first-generation parents are working and focusing on how to survive in the new culture, the 1.5- and second-generation children will be primarily focusing on how to fit into their new school dynamic. Not only must they learn how to fit into the new school system just in terms of personal happiness, they have to perform academically because education is one of the primary reasons for migrating and is viewed as the path for achieving their American dreams (Baptiste et al., 1997; Mitchell & Bryan, 2007; Morrison & Bryan, 2014).

As such, school counselors need to examine the impact of school, the classroom, their peers, as well as other American and social media influences on the 1.5- and second- generation (Mitchell & Bryan, 2007; Zhou, 1997). This formal and informal acculturation may allow the 1.5-generation to mainstream into U.S. culture at a more rapid rate than the first generation.

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Gushue (1993) asserted that immigrant children who are closer to identifying with the counselor's worldviews—namely, who are further along in their acculturation—might have a greater alliance than those who have not acculturated as much. Studies also show that second-generation BCs (i.e., American-born citizens) may identify more with AA culture than their parents (Goebert, 2009; Hall & Carter, 2006; Waters, 1994). Such information will help the counselor better understand family dynamics—namely, that even though they all belong to the same family, generationally they are different. Knowing how the different generations identify themselves would also help the counselor to better understand their identity development.

The Counselor's Challenge

“History and current power relations create and shape the opportunities people face in their day-to-day lives, giving some people ‘ethnic options’ and others ‘racial labels’” (Waters, 1999 p. 47). In short, BC immigrants face many labels on the path to acculturation that affect their identity. Some counselors focus on racial identity when dealing with persons of African descent. Waters (1999) discussed that while this is an important factor in the counseling setting, it does not exist in a vacuum. Rather, the skilled counselor will first understand that there may be a difference in the process by which racial identity is developed in a client. Toward that goal, research is needed as to the ways that cultural and racial identity is formed for a BC immigrant as opposed to for an African American. Without question, it should include their history and identity prior to immigrating.

Many people migrate to the U.S. with their identity already formed, and this cultural heritage is fostered through ongoing connections to their homeland (Foner, 2001). While their identity development in the United States cannot be separated from their previous identity, it must be inclusive of it. However, approaches that counselors use with their AA clients may not

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be inclusive of all the generation-specific differences among first generation BCs (native Caribbeans), 1.5-generation BCs (those who came to the U.S. as children), and second-generation BCs (the U.S.-born children of Caribbean-born parents) and third generation BCs (the U.S.-born children of U.S.-born parents of Caribbean ancestry (Butterfield, 2004; Waters, 1999). There has been some research on different generations in the Hispanic and Asian populations, but very little attention have been given to these issues in Black immigrant communities (Jackson et al., 2007). In the counseling setting, the reality is “in such families, the counselor is no longer dealing with one culture but two or more” (Gushue, 1993, p. 491). Therefore, in order to truly understand counseling dynamics, it is necessary to consider not only the adult immigrant who chose to move to the U.S., but also the children they took with them, as well as any children born in the U.S.

Harker (2001) wrote “that post-1965 immigrants indicate that the straight-line theory of assimilation, which assumes that immigrant social outcomes will improve over time, eventually reaching parity with better native outcomes, may not apply to all, or even most, of today’s immigrants” (p. 971). Thus, the assumption that with longevity in the U.S. the BC immigrant will become more acculturated into mainstream American society, as well as become more ethnically and racially identified as AAs, may not necessarily be true. According to the Migration Policy Institute, six million BC immigrants in the United States self-identified as being from the Caribbean in 2009 (McCabe, 2011). This reality reflects the fact that a sizable proportion of Blacks in the U.S.—including a little more than half of all Black immigrants (Thomas, 2012)—still have ties to their homeland.

Harker (2001) also asserted that “the migration experience is often a stressful life event” (p. 974), and without social support, it can cause some to become mentally unstable. Hall and

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Carter (2006) documented that immigrants who were grouped into a minority population, and experienced racial discrimination because of it, displayed behavioral dysfunctions and psychological problems. This fact is significant for 1.5- and second-generation BC school children. Schools in the U.S. collect data about students' race and ethnicity but often use the standard US Census racial categories, which do not separate BCs from AAs. Therefore, BC students are nearly always grouped with the AA population. Rather than helping them to maintain their distinct cultural identity, research shows that this cultural consolidation can be perplexing to students (Morrison & Bryan, 2014). Add the compounding effects of acculturative stress, adjusting to a new school system, family pressure to do well, and generational differences—and you have a recipe for psychological stress and the possibility of the BC immigrant student failing at school (Mitchell & Bryan, 2007; Morrison & Bryan, 2014). As a result, it is particularly important for school and community counselors to support this distinct population, advocate for appropriate resources, as well as make other professionals (e.g., teachers and psychologists) aware of the issues facing BC immigrants (Morrison & Bryan, 2014). Given the challenges of assimilating into a new culture—and especially one where (a) American Blacks represent the minority, and (b) they are unlikely to share the cultural traits and expectations Black Caribbeans—it is particularly important for counselors to be ready to and capable of supporting BCs who seek treatment.

Mental Health Risks for Caribbean Immigrants

Little attention has been paid to the mental health of BC immigrants. Moreover, much of the available research in the mental health area lumps them together with the African American population (Broman et al., 2008), which as discussed earlier is problematic. Research on BC immigrants and mental health treatment has been limited to the National Survey of American

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Life (NSAL) (Jackson et al., 2004). As stated on the Inter-University Consortium for Political and Social Research website (ICPSR, 2015), the NSAL was designed to . . .

. . . explore racial and ethnic differences in mental disorders, psychological distress, and informal and formal service use from within the context of a variety of presumed risk and protective factors in the African-American and Afro-Caribbean populations of the United States as compared with White respondents living in the same communities. (para 1)

Jackson and colleagues were the first to examine physical and mental health data of BC individuals separately from analogous data for African Americans. The NSAL was initiated just after the 9/11 terrorist strikes in the United States. BC immigrants were no different from other immigrant groups in that they had fears about their immigrant status; as a result, they were no longer willing to participate in the NSAL survey due to fear of possible deportation. Their reluctance to be officially “documented” in this way decreased their already limited representation in the survey in comparison to the much larger AA sample. Additionally, although a cash incentive was used to increase participation, any survey that requests sensitive information on “mental disorders, psychological distress, and informal and formal service use” is certain to have some inherent limitations. Specifically, the NSAL data was limited by (a) those who chose to participate, (b) how accurately participants identified themselves, and (c) how truthfully participants reported their symptoms. Despite these drawbacks, The NSAL is important in that it was the first to attempt to determine the contribution of the immigration experience on BC individual’s mental health (Williams et al., 2007). It should also be noted that later studies that used NSAL data to describe Blacks people in America often grouped people of Caribbean descent with AAs. A number of these investigations examined the intra-group differences between African Americans and BC immigrants, several of which are described below.

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Williams and colleagues (2007) used the NSAL to compare BC mental health data with that of AAs. The study took into account the BC immigrant length of residency in the U.S., age of migration, ethnic origin, gender differences, and generational status. When compared to AA women, BC women reported lower levels of depression and anxiety disorders. The research also showed that BC immigrants who had recently come to the U.S., as well as other BC immigrants who had lived in the U.S. fewer than 20 years, consumed less alcohol and were less likely to use illegal drugs when compared to AAs. In contrast, BC men were diagnosed with higher levels of mood disorders than AA men. Finally, there were no differences in disorders between AA and BC people residing in the U.S. longer than 21 years. This similarity may be due in part to being in the U.S. less than 20 years—in other words, their place of birth and more recent ties to their homeland may have provided some protective effect against disorders. A limitation of this study was that the mental diagnosis was self-reported from each participant, which could impact validity. Also, the BC sample had to identify as Black to be included in the study; accordingly, this could have affected the sample size and external generalizability of the findings in that some Caribbean immigrants do not self identify as Black.

Himle et al. (2009) used the NSAL data to examine the prevalence and severity of anxiety disorders among AAs, Blacks of Caribbean descent, and Whites. Overall, Blacks of Caribbean descent had lower rates of anxiety disorders than African Americans and Whites. However, Black men of Caribbean descent had the highest rates of PTSD of all the groups studied. The researchers concluded that BC men had a more difficult time acculturating in the U.S. because they were used to a more patriarchal society where they were the main breadwinners (Baptiste et al., 1997; Mitchell & Bryan, 2007). In comparison, BC women who were primarily homemakers, had increased opportunities for employment and adjusted more

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easily to the immigration process and had lower rates of PTSD. One of the limitations of this study was that while the few AA and BC participants who met the criteria for anxiety disorders could indeed have provided an accurate representation of the low prevalence, that data could also have emerged from inaccurate self-reporting. Thus, this study cannot conclusively determine the effects of race and ethnicity as risk factors for anxiety disorders (Himle et al., 2009).

Broman et al. (2008) also used the NSAL data to examine the prevalence of substance disorders among African American and BC immigrants. The authors noted that both BC and AA men and women who had lower levels of education had the highest rates of substance abuse within their racial subgroups. Significantly, BC individuals who were not born in the U.S. (first-generation immigrants) had a lower prevalence rate in comparison to BCs born in the U.S. (third-generation immigrants). Also significant was that second-generation BC immigrants were two times as likely as AAs to meet the criteria for substance abuse disorders. When looking at gender and the 12-month prevalence rate for substance abuse disorders, BC women were significantly lower in comparison to AA women. This was not the case, however, for BC men and AA men who prevalence rates were similar. One of the limitations of this study is that the BC sample was relatively small when compared to the larger and more diverse AA population sample. Thus, the results may have reflected fewer differences than actually occurred (Broman et al., 2008). Nonetheless, the data from this study is important because as the BC population escalates it will become increasingly important to look at differences within the Black population so that mental health treatment protocols can be designed and carried out with cultural sensitivity.

Other studies also support the NSAL data, which concluded that, overall, BC immigrants are at increased risk for aggression and psychiatric disorders, such as depression, in comparison to African Americans. For example, researchers have linked this elevated risk to the stress

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associated with being in the minority and adjusting to the unexpected realities of racial discrimination, economic hardship, and the family reunification process (Murphy & Mahalingam, 2006). Moreover, self-reported feelings of being devalued and invisible as an immigrant can lead to frustration, depression and anger, which can further complicate their sense of belonging in the U.S. (Baptiste et al., 1997; Murphy & Mahalingam, 2006). However, the younger the age at migration, the lower the risk for all mood disorders, which also reduces their risk for suicide attempts (Joe, Base, Breeden, Neighbors, & Jackson, 2006). It should also be noted that there were no differences in the risk for disorders between AA and BC immigrants who had resided in the U.S. for 21 years or longer (Williams et al., 2007). The impact of years in the U.S. and generational status (as well as other cultural factors) represent significant considerations for counselors who work with BCs because it can influence risk factors and what type of mental health options and resources that will be available (Williams et al., 2007).

Also important for this study is that cultural norms may directly impact if and how BC immigrants report mental health symptoms. For example, they may describe their mental health illness with psychosomatic symptoms such as upset stomach, or aches and pains throughout their body. These symptoms are more culturally acceptable and can be discussed without the individual feeling a sense of failure (Gopaul-McNicol, 1998). Moreover, Joe et al. (2006) reported that BCs are more likely to seek help for their emotional problems from religious and non-mental health professionals. Thus, the researchers concluded that it might be important to examine the role of their ethnicity more so than their nativity, race, and the assimilation process.

Mental Illness and Crime

Individuals who do address their mental illnesses are also vulnerable to becoming involved in crime and the criminal justice system. This reality is significant because untreated

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mental health conditions may increase the likelihood of criminal activity, which in this country is more likely to lead to incarceration than to viable ongoing treatment options. The current research within the penal system does not differentiate between BC immigrants and AAs. However, in 2010 the incarceration rate for Blacks males in the U.S. was approximately 1 in every 15—in comparison to 1 in every 106 White males—which is six times higher than the national average across all races (Drake, 2013). Those statistics, combined with a Bureau of Justice Statistics report from 2005 showing that more than half of the jail/prison population had a mental health problem, is particularly alarming (James & Glaze, 2006). Even though this report does not separate BCs from AAs, a separate study showed that between 1997 – 2007, BC immigrants in the penal system were primarily incarcerated for nonviolent crimes such as traffic offenses, simple assault, drugs and larceny (Roberts, 2009). Since it was not documented if these crimes were committed because of prior mental illnesses, further study needs to examine the impact of mental health and incarceration of Black Caribbean immigrants.

Suicide

Suicide is rarely mentioned, let alone fully discussed, within Black communities. Joe et al. (2006) studied AA populations (included BC individuals) using self-reported NSAL data and found that there was an 11.7% for suicide ideation rate, and a 4.1% rate for suicide attempts. Of greatest concern was the high rate of suicide attempts among BC men (7.5%), whereas BC women had the lowest suicide attempts at 2.7%. These statistics are noteworthy because when compared with the general population, women usually have higher rates of suicide attempts than men; yet BC males had a 4.9% prevalence of attempted suicide. Although Barnes (2010) noted that the suicide rate for AAs increased as they moved into more urban areas, she did not mention if this was inclusive of BC individuals. The prevalence of suicide attempts also has a

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regional component. BC immigrants living in the southern part of the U.S. had fewer suicide attempts and ideations than those living in the Midwest. There is no data, however, that reports if the suicide rate among BC immigrants increased with migration to the U.S.

In terms of trends, the NSAL survey reported an increase in suicide rates during the 1980s and 1990s, and in recent years it has become a mental health concern as the rate of suicide and suicide attempts increased among young Blacks (Barnes, 2010; Joe et al., 2006). Contributing factors for the suicide increase among BC immigrants in the U.S. include disrupted families, loss of relationships, and lack of spiritual connectedness (Gopaul-McNicol, 1998). These connections are supported by the work of Murphy and Mahalingam (2004), who emphasized the sizable role of the family in the Caribbean as a source of social support, and how these ties help the BC immigrant through psychological stresses as they try to maintain their racial and ethnic identity while acculturating in the U.S. Although much of this research is inconclusive due to inherent limitations in self-reported data, it is clear that BCs have unique mental health needs, such as devalued minority status, unmet pre-migratory expectations, and stresses associated with the reunification of family and changing gender roles (Baptiste et al., 1997)—all of which have negative outcomes such as incarceration or suicide risk if mental health treatment is not accessible and effective.

Counseling Black Caribbeans

In addition to the mental health risks described above, BCs are also challenged in seeking and receiving skilled counseling in the United States. Mental health treatment for this population needs to be flexible and have few barriers to treatment due to the persistent nature of mental illness and the likelihood that BC clients will exit formal systems of mental health care and instead rely on informal systems of treatment, such as spiritual or religious resources

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(Woodward, Taylor, Bullard, Neighbors, Chatters, Jackson, 2008). One barrier to effective treatment is the false assumption that all people who have dark skin color, a distinctive hair quality, and certain facial characteristics share the same cultural identity (Rogers, 2006; Waters, 2001). Community mental health and school counselors who make that mistake and equate the issues facing BCs and AAs—not to mention treatment approaches—can negatively impact the counseling relationship in serious ways (Sue & Sue, 2013). School counselors in particular need to recognize that failure to adequately address some of their cultural issues can lead to poor academic achievement and higher dropout rates among this student population (Mitchell & Bryan, 2007). Clinicians also need to be aware that, culturally, BC immigrants and AAs describe their identity differently (U.S. Department of Health and Human Services, 2002). For example, BC immigrants very rarely describe themselves in terms of being “Black,” but rather identify closely with their native country. It is not that they deny their dark skin; instead, they identify more with their island-specific cultural experiences and do not view being Black as the same as being AA. Research shows that the stereotypical negative views associated with racism (i.e., being viewed as inherently inferior) and the various labels that are suddenly forced upon them represent two of the biggest hurdles that BC immigrants have to overcome as they acculturate in the U.S. (Gushue, 1993; Murphy & Mahalingam, 2004). Similarly, school counselors need to be aware of how these hurdles also affect students and families—that this notion of racism and discrimination is new to them and it can have adverse effects on the children’s mental health status (Morrison & Bryan, 2014).

Indeed, the Surgeon General reports that the mental health needs of this population are not being met (U.S. Department of Health and Human Services, 2001)—in part because BC immigrants in need of care are reluctant to seek treatment due to the negative perceptions and

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stigma associated with mental health care (Bailey et al., 2010). Compounding the problem is that mental illness is viewed as being heredity, which in their minds puts the entire family at risk for negative stereotyping (Baptiste et al., 1997). Another association that can prevent the BC from seeking mental health treatment has to do with being viewed according to the AA stereotype—that BC immigrants are sometimes perceived as dangerous (Anglin et al., 2006), which would hinder their full acceptance into society. When that occurs it prevents BC immigrants from achieving their dream of a better life in the U.S. The outcome that they envision from seeking treatment to address this frustration, anger or disappointment is a punitive response, rather than supportive counseling (Hutchinson, Neehall, Simeon, & Littlewood, 1999). This can lead to shame, feelings of being viewed as inferior by society, embarrassment, and believing that he or she was not able to “make it” in the U.S. (Thompson, Bazile, & Akbar, 2004).

Another factor contributing to BC immigrants not seeking treatment is purely economic. With or without health insurance, treatment options can be expensive if one includes the cost of doctor visits, lost wages from having to take time off work, and the cost of any medications. Additionally, their lack of information about how much treatment really costs can also be a barrier to treatment (Thompson et al., 2004). BC immigrants may visit their primary doctor because they believe (a) it is less expensive than seeing a counselor, and (b) they believe that the symptoms they are experiencing are physical rather than psychological. They may also believe that their primary doctor knows them the best and can better assess their life stressors.

As noted earlier, BCs are more likely to seek help for emotional problems from religious/spiritual leaders (Joe et al., 2006), as well as groups that have roots in the Caribbean (Bailey et al., 2010). For example, Haitians tend to continue to rely on traditional forms of healing (i.e., “voodoo”), and Caribbeans in general are reluctant to share problems beyond

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family and religious structures (Baptiste et al., 1997; Gopaul-McNicol, 1998). In fact, religion and the church are usually seen as the primary resource for mental health assistance—both from leadership and other church members who can be relied upon for supportive prayer (Gopaul-McNicol, 1998). Research confirms that BC immigrants usually seek spiritual help first and would be unlikely to seek other counseling professionals if a minister is available (Thompson et al., 2004; U.S. Department of Health and Human Services, 2001).

Thompson et al. (2004) described another barrier for individuals from minority groups who do seek counseling. Some African Americans, for example, prefer to work with an AA therapist (Thompson et al., 2004)—but AA therapists are not available in every location. Similarly, there are insufficient BC therapists to serve every BC client. Similar to AAs, BCs need to know that they and the therapist will have similar attitudes towards treatment (Asbury et al., 1994). If this psychological/emotional congruence is absent, they may believe that they will be misdiagnosed. In fact, Thompson et al. (2004) confirmed that AAs come to the counseling relationship with some degree of mistrust as to how they are viewed, which may influence their mental health diagnosis. Similarly (or perhaps even more so given the lack of trained BC clinicians), BC immigrants may relate to that mistrust, which is compounded when they are viewed generically as African Americans. Instead, Black Caribbean islanders believe that they have a unique racial/ethnic identity, and if not considered in treatment, they may feel alienated. Being misunderstood (or feeling completely misunderstood) may lead BC immigrants to leave treatment early or to seek alternative behaviors and coping mechanisms to relieve their stress and/or anxieties (Baptiste et al., 1997).

Multiculturally-Competent Counseling & Training

Multiculturalism focuses on ethnicity, race and culture; in contrast, diversity refers to one's age, gender, sexual orientation, religion, physical ability, and so on (Arredondo et al., 1996). For several years the mental health profession has provided diversity training, but only recently have counselors been trained with respect to multiculturalism. The Association for Multicultural Counseling and Development (AMCD), which is a division within ACA (American Counseling Association), recommended that counseling professionals become more culturally aware in three areas: (1) Counselor Awareness of their Cultural Values and Biases, (2) Counselor Awareness of Client's Worldview, and (3) Culturally Appropriate Intervention Strategies. The Council of Accreditation of Counseling and Related Educational Programs (CACREP) standards (2009) inform multicultural competencies and structure counselor training. The ACA Code of Ethics requires counselors to participate in multiculturalism/diversity training as part of their professional counselor development. Nowadays, academic counseling programs are encouraged to recruit a diverse student population, as well as ensure that students acquire the multicultural competencies they will need to engage effectively with an increasingly diverse clientele (American Counseling Association, 2014).

Day-Vines et al. (2007) reported that mistrust in the counseling relationship, which can lead to the early termination of that association, could emerge when a client perceives that the counselor does not understand his or her cultural experiences. To ensure that this does not occur, the counseling field has several instruments designed to assess the multicultural counseling competencies of counseling professionals. Some include the Multicultural Counseling Inventory (MCI), the Cross-Cultural Counseling Inventory-Revised (CCI-R), and the Multicultural

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Counseling Awareness Scale (MCAS-B). These instruments continue to be tested and validated for their effectiveness, but there is no current data to support if counselors who scored well on these instruments had more positive outcomes with their multicultural clients. An evolving issue in counseling continues to be how difficult conversations involving race, ethnicity and culture can best be handled in the counseling process. In order for these issues to be explored for the betterment of the counseling relationship, Day-Vines et al. (2007) suggested that broaching be employed. This strategy of addressing factors such as race, ethnicity and culture—and the impact one or more of those elements has on the client’s concerns—can enhance the safety of the counseling relationship. A safe atmosphere within which to discuss these concerns can only invite the BC immigrant to have a more positive counseling experience.

Statement of the Problem

Black Caribbean islanders who immigrate to the United States have a unique cultural identity that differs in many ways from that of African Americans. However, they are often misidentified as AAs simply because of the color of their skin and other physical similarities. One tradition they bring with them is their reluctance to engage in formal counseling relationships, preferring instead to seek help from spiritual leaders or family members. When they do seek the help of a professional counselor, BCs typically have to confront the cultural misunderstandings that accompany that misidentification. Moreover, because of the stresses they face in differentiating themselves and dealing with unaccustomed racism, BCs are at risk for increased rates of suicide attempts, PTSD, and substance abuse disorders. The problem that prompted this investigation is that counselors may not understand the cultural identity of Black Caribbeans, and therefore may be unprepared to provide effective treatment options.

Purpose of Study and Research Questions

This qualitative investigation was designed to explore the lived experiences of Black Caribbean immigrants who have sought professional mental health/counseling services in the United States. In so doing, a primary goal is to examine how the counseling field can have a better understanding of this sub-population of Black Americans by highlighting important therapeutic considerations such as the immigrant history of BCs, the role of generation, and the development of their racial and ethnic identity. By better understanding their varied experiences, counselors may be able to make treatment options more accessible and more effective. Increasingly, counselors are working to provide culturally-appropriate services to all clients; however, BCs represent a significant cultural subgroup that has not been adequately studied in the counseling research thus far (Baptiste et al., 1997; Joe et al., 2006).

The following research questions were developed to guide this investigation:

1. What are the lived experiences of BC immigrants as they access mental health treatment?
2. How, if at all, does the counselor address the cultural and ethnic heritage of BC immigrants during mental health counseling?
3. How do BC immigrants experience their culture and ethnicity in the counseling relationship?

Definition of Terms

In this section, the definitions for terminologies used are presented.

Acculturation: Individuals taking on different aspects of other cultures that they have encountered, such as mannerisms, behaviors, dress, and values; transitioning from

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one's culture of origin to a new society's culture (McAuliffe et al., 2008; Phinney, Horenczyk, Liebkind & Vedder, 2001).

African American: A person residing in the United States with ancestry from any part of the Black racial groups of Africa (U.S. Census, 2010).

Black: A word generally used to refer to people of African descent, African Americans, and Caribbean people (Butterfield, 2004).

Broaching: A counselor's ability to sensitively examine a client's racial and cultural heritage during the counseling relationship to improve the therapeutic process (Day-Vines et al., 2007).

Caribbean Immigrant: Individuals from English-speaking Caribbean countries that migrated to the United States (Thomas, 2012). A Black Caribbean immigrant refers to Caribbean immigrants of African descent who migrated to the U.S.

Culture: "A repertoire of socially-transmitted and intra-generationally generated ideas about how to live and make judgments, both in general terms and in regard to specific domains of life" (Patterson, 2008, p. 208).

Discrimination: To treat an individual or group of people differently, usually in a negative way, based on their actual or perceived membership in a certain group or social category.

Enculturation: The process whereby individuals are socialized into their own cultural group by parents, peers, and other adults (Chung, Bemak, Ortiz & Sandoval-Perez, 2008).

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Ethnicity: The norms, values, attitudes and behaviors of a particular group's culture; an individual's culture of origin is handed down through the generations and internalized (McAuliffe et al., 2008; Phinney, 1996).

Minority Status: The differentiation by the majority group of those who have less power, privilege, and control.

Multiculturalism: An ideology on the part individuals, groups, or governments that our ethnic, cultural, racial and religious diversity should be embraced and celebrated.

Race: A category that divides and identifies groups of individuals based on several physical and biological features; race distinguishes people based on phenotype categories e.g., "Black" or "White" (American Psychiatric Association, 2013; McAuliffe et al, 2008).

Stereotypes: Shared idea positive or negative held about a particular group of people.

Overview of the Method

A qualitative research design was used for this study. This was a phenomenological investigation in that it looked at the personal perceptions of the participants. Participants for the study were from various English-speaking Caribbean countries who immigrated to the U.S. either as a child or as an adult, and who at some point during their tenure in this country attempted to seek mental health treatment. Potential participants were recruited via snowball sampling—principally through the researcher's network of family, friends, and colleagues. No first-degree relatives were included given the dual relationship with the researcher. Prior to each in-person or telephone interview, each participant was informed of the purpose of the study, the procedures I would be using, and the anticipated risks and benefits. They were also assured of complete confidentiality and were given permission to withdraw at any time without penalty.

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They were not compensated for this study and were required to sign an informed consent form. All sessions were audio taped and transcribed verbatim and resulting data was coded for meaning. Additionally, field notes were interpreted and assigned meaning, and findings were organized thematically. Approval was obtained from the Virginia Tech Institutional Review Board prior to the initiation of the study.

Limitations

There were several limitations associated with this investigation that must be acknowledged. Firstly, the sample of participants was recruited from Caribbean communities primarily in the New York City and Washington DC areas. Although research shows that most BCs live in large urban areas (McCabe, 2011), the individuals selected for this investigation should not be considered to be representative of a national sample of BC immigrants. Another limitation was that those who agreed to participate may have had positive mental health treatment experiences, which could have skewed results in a positive direction. Conversely, it is equally possible that those who chose to take part in this investigation had a negative experience with mental health treatment, which could have skewed the results in a negative direction. Additionally, participant responses may have been influenced by their knowledge of mental health, how they felt at the moment, and how well they were able to recall their counseling experiences. As with any investigation that relies on self-reported data, there is a risk that participants felt compelled to respond in a socially-favorable way, or according to what they felt the researcher wanted to hear.

Document Organization

This proposal is organized into three chapters. Chapter One introduces the study and describes the context for this investigation; it also provides a statement of the problem and the

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purpose of the study, and lists the three research questions. The first chapter also contains important term definitions, a methodology overview, and a brief discussion of the limitations of the study. Chapter Two provides a review of the literature on mental health and Caribbean immigrants in the U.S. Chapter Three focuses on the methodology I used to conduct this investigation, including data collection methods and data analysis procedures. This chapter also includes a discussion of participant selection and safeguards to credibility and validity. Chapter Four details the process by which interview data was distilled into major themes for each of the research questions. Participant comments are included here to support the findings detailed herein. Finally, Chapter Five synthesizes the findings from this study, discusses some study limitations, and makes suggestions for future research.

CHAPTER TWO

REVIEW OF THE LITERATURE

The American Counseling Association Code of Ethics (2014) states that clinicians are required to be knowledgeable about multicultural and diversity issues in both their training and supervisory practices. This prerequisite has become increasingly significant since the broad terms “multiculturalism and diversity” now imply that a counseling professional must be sensitive to a client’s age, color, culture, disability status, ethnic group, gender, race, language preference, religion, spirituality, sexual orientation and socioeconomic status. While this is a long list that may appear daunting to fully understand and incorporate during diagnosis and treatment protocols, a simplified interpretation is that a skilled clinician will examine how a client’s culture impacts his or her experiences and treat accordingly. In addition, the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5; American Psychiatric Association, 2013) now includes techniques that can assist the clinician in better understanding the dominant cultural context that impacts specific cultural groups and how they express their symptoms and experiences.

This chapter addresses the acculturation process of Black Caribbean (BC) immigrants, who may be mistakenly identified by mental health providers as African Americans (AAs). This literature review also details the previous research of mental health treatment of BC immigrants, and the significant impact of their cultural values and ethnic identity on treatment options and outcomes. Focusing on the BC immigrants’ lived experiences, national cultures and distinct ethnic identities will better frame how they adapt to the notion of not only being an American, but also how they cope with their mistaken identity as African Americans in the context of mental health treatment options.

The Migration of Black Caribbeans to the United States

During the mid 20th century the influx in migration from the Caribbean to the United States was almost as significant in terms of numbers as the migration of immigrants from Mexico and Canada (Thomas, 2012). For the purposes of this study, the Black Caribbean immigrants under consideration are primarily from what is now known as the Commonwealth Caribbean or the Anglophone Caribbean—countries formerly under control of the United Kingdom, and thus English-speaking (Butterfield, 2004). This includes people from Jamaica, Saint Lucia, Barbados, Trinidad and Tobago, Bahamas, Antigua-Barbuda, Saint Vincent and Grenada. They sometimes identify as West Indians, or represent their dual identity with a hyphenated ethnic identity such as Jamaican-Americans or Trinidadian-Americans (Butterfield, 2004; Waters, 1999). Despite their cultural and geographic differences, these islands are similar in that the majority of their migrant populations are comprised of Black individuals who identify as Black on the U.S. Census (Waters, 1999). Using U.S. Census reports from 2008-09, Thomas (2012) reported that there were 1.7 million BC immigrants in the United States, and that one in every two Black immigrants was of Caribbean descent. It is estimated that BC immigrants make up 4.4% of the Black population in the U.S. and represent 60% of the Black immigrant population (Thomas, 2012; Williams et al., 2007). Despite the fact that they have come from different islands with diverse customs and beliefs, BC immigrants share an overarching identity and culture that is all their own, and which is deeply ingrained in their past history and experiences in the Caribbean (Rogers, 2006; Waters, 1999). As such, this Caribbean cultural identity causes them to identify with each other and impacts how they have, and continue to, assimilate into the melting pot that is America (Murphy & Mahalingam, 2006).

Becoming American

A better understanding of the BC immigrant experience can help to explain the acculturation issues of this population, as well as elucidate some of the factors that may contribute to the mental health challenges they face (Jackson et al., 2007). Although the following demographic statistics apply to all Caribbean immigrants (i.e., including those who self-identify as Hispanic-Caribbean—for example from Cuba), it is important to provide some basic demographic information. In 2009, there were over 6 million individuals of Caribbean descent residing in the U.S.; approximately 41% of those were native born (i.e., U.S. citizens), and the rest were born in the Caribbean. The majority of these individuals (approximately 65% according to McCabe (2011) reside in the greater New York-New Jersey-Pennsylvania metro area or in Florida. Caribbean immigrants share certain population-specific attributes as well:

Compared to other immigrant groups, the foreign born from the Caribbean are less likely to be new arrivals, tend to have higher levels of English-language proficiency, and become naturalized U.S. citizens at higher rates. At the same time, Caribbean immigrants are more likely to be older than other immigrant groups and Caribbean men have lower rates of civilian labor force participation. (McCabe, 2011, para 3)

In comparison to many other immigrant groups (e.g., Black Africans and Hispanics), a Black Caribbean immigrant usually enters the U.S. legally (Thomas, 2012). Moreover, they typically enter the U.S. voluntarily—as opposed to coming to this country as a refugee or a seeker of political asylum. It should be noted that after the Haitian earthquake in 2010, many Haitians entered the U.S. under Temporary Protected Status (TPS), which allowed them to remain the U.S. legally; however, they were ineligible for public assistance benefits (Thomas, 2012). Some BC immigrants enter this country legally with a permanent resident card, which they obtain

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through the Diversity Visa program. This program is offered on an annual basis through an application process.

As noted above, most BC immigrants choose to go through the process of becoming a naturalized U.S. citizen (Thomas, 2012), which first requires that they become a permanent resident. In some cases, BC immigrants (e.g., those with certain educational or specialized job skills) enter the U.S. with jobs—but this is not the norm. In fact, less than a third (29.2%) of Caribbean immigrants have a high school diploma or GED as their highest educational credential, and just 18.6% came to the U.S. in 2009 with a college degree (McCabe, 2011). In terms of stresses to this population (and indeed, to any immigrant population), leaving family members behind in the care of relatives can be very stressful, and once reunited presents a different set of stressors and apprehension among family members. However, unlike many other immigrant groups, BC immigrants are extremely reluctant to seek psychological services (Gopaul-McNicol, 1998). Also important to note is that the process of becoming a legal resident, being sponsored, or securing steady employment involves a criminal background check; thus, some live in fear of being arrested until they become legal residents of the U.S. Moreover, even with their education levels and skills, most end up working in low-paying menial jobs with few benefits. One must also consider those who are working illegally (e.g., on expired visas), and with immigration laws constantly in flux there is fear and anxiety associated with possible deportation (Baptiste et al., 1997).

In summary, their low-wage jobs and reduced access to public benefits, the negative stereotypes associated with certain immigrant groups, and the long road to citizenship all present challenges to the BC immigrant population. The fact that they are reluctant to seek services

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makes it challenging to study this population (Jackson et al., 2007). The following section discusses the acculturation process and problems that this cohort is likely to experience.

Acculturation Process and Problems

Acculturation has been defined as the process of change from one's cultural identity to that of an adopted society or country (Alba & Nee, 1997). Berry (2003), however, described it as more than a culture change—but rather an exchange of cultures. Similarly, Rogers (2006) asserted that adjusting to life in the U.S. does not imply that immigrants should minimize or even renounce their immigrant identities; instead, acculturation implies an amalgamation of both the home and adopted cultures. In the case of Black Caribbeans, however, research indicates that their individual countries of origin tend to be marginalized in discussions of racial and ethnic amalgamation—the end result being that they are lumped into one category based on phenotype (Waters, 1991; Rogers, 2006). Minimizing their immigrant ties to the Caribbean often leads the BC to negotiate strategies on how best to integrate and adapt into both societies, because their racial and ethnic identities are fluid and not simply a matter of choice (Berry, 2005; Butterfield, 2004).

Another issue that faces Caribbean islanders While acknowledging that racism is a daily reality, BC immigrants choose not to allow the negativity and the detrimental effects of racism dictate their daily lives (Murphy & Mahalingam, 2004; Waters, 1999). They know racism exists, but it does not determine their behaviors. Unlike America's African-American population—who in most cases have thin, or more likely unknowable, ties to their African roots that go back multiple generations—the significant growth of the Black Caribbean population in the U.S. took place at the turn of the twentieth century when most came to this country for better wages and growing employment opportunities (Thomas, 2012). Thus, the behaviors, beliefs, and

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cultural practices of BCs tend to be guided by their more immediate Caribbean heritage and identity. Indeed, they find support from other Caribbean immigrants like themselves (Butterfield, 2004; Rogers, 2006; Waters, 1999).

Lorick-Wilmont (2010) examined the role of a community-based organization that serves first-generation BC immigrant clients. She asserted that their strong ties to their Caribbean ancestry, customs, language helps to maintain their Caribbean ethnicity and slows the rate of acculturation. In fact, it is this commonality that many BC immigrants seek in order to support them during the often-stressful migration process. Moreover, there tends to be stronger language accents and more overt displays of their ethnic culture among first-generation BC immigrant groups, which disputes an implied congruent identity based on the “Black” label imposed on all people showing with the same dark-skinned complexion, and physical features (Shaw-Taylor, 2007).

Generations of Immigrants

An immigrant is tasked to create a new identity that represents an amalgamation of valued cultural behaviors from home with new cultural norms and expectations. As such, post-immigration cultural attributes cannot be directly equated with an immigrant’s homeland culture because each individual selectively decides what cultural behaviors to keep and exhibit once they have established themselves in the U.S. (Zhou, 1997; Waters, 1999). Similarly, later studies have supported the concept of acculturation as a process that is adapted and negotiated over time (Butterfield, 2004; Rogers, 2006).

Generational differences between first-, 1.5-, second-, and third-generation immigrants have been examined from a number of perspectives. For example, Zhou (1997) discussed the significant impact the “generation factor” has for immigrant children. She reported that second-

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and third-generation children who live in better socioeconomic communities are more likely to thrive. They will have less difficulty balancing cultures, they will attend better schools in safer neighborhoods, and more likely to receive supportive resources—which in turn produces better students. In contrast, immigrant children from lower socioeconomic status (SES) are more likely to attend public schools in which (a) they are the dominant culture in that area, or (b) they may be mixed with other immigrant nationalities—both of which could mean that they would have a more difficult time assimilating onto the broader “American” culture. Moreover, immigrant children of lower socioeconomic status may also have a harder time retaining the cultural attributes and behaviors of their native country (Mitchell & Bryan, 2007; Morrison & Bryan, 2014). For example, they may not be able to afford to attend cultural events that are important part of their home culture, buy the traditional foods that they are accustomed with eating, or visit family member in their family’s country of origin, which serves to bolster those cultural ties.

It is also important to note that these children—some for the first time—are being exposed to different cultures, some inherently associated with a higher standard of living, such as Europeans and Asians. As such, BC immigrant children might view their cultural heritage as being associated with an “inferior” third world country and might not want to be associated with it. This struggle can lead to family conflicts, especially since younger immigrants generally tend to assimilate more quickly than adult family members (Zhou, 1997). According to Harker (2001), “Conflict tends to increase as family stability decreases. Among immigrants, these trends tend to occur over time and across generations spent living within the U.S” (p. 974).

Morrison and Bryan (2014) recently discussed some of the issues and dilemmas facing BC immigrant school children. BC parents traditionally have a high regard for teachers and trust their children’s education and training to them. They view their roles as getting their children to

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school on time and ensuring that they complete their homework. In contrast to most native-born American parents, BC immigrants tend not to be as involved in what is going on in their child's school. Although culturally appropriate and expected in their country of origin, this can be perceived in an American school as being an uninvolved parent. This perception can then put a strain on the teacher-parent relationship, which in turn can affect the students because in comparison to other children with more engaged parents, BC school children may end up feeling devalued by their parents, causing conflict between them. As a consequence, school counselors need to establish training opportunities for teachers and others working with BC students about their immigrant experiences and culture. They also need to devise effective strategies for those working with BC students to improve their American Standard English language skills—while at the same time honoring their language differences. Promoting the BC immigrant experiences in a positive light can help facilitate a smoother transition for the several different generations of immigrants that will enter the school system.

Changes, both good and bad, have been well documented among generations of immigrants in this country; however, generalizations are risky and differ among different ethnic groups. Twenty years ago, Waters (1994) asserted that subsequent generations of immigrants “basically reject the immigrant dream of their parents toward individual social mobility and accept their peers’ analysis of the United States as a place with blocked social mobility where they will not be able to move very far” (p. 10). Even today, immigration scholars do question the extent to which today’s immigrants and their children will be able to attain the “high levels of intergenerational upward mobility experienced by much of the immigrant stock of the 19th and early 20th centuries” (Pew Research Center, para. 26). The skeptics list important factors for this assertion:

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Most modern immigrants are non-white and thus face deeply ingrained social and cultural barriers; about a quarter of today's immigrants (the vast majority of whom are Hispanic) have arrived illegally and thus must navigate their lives in the shadows of the law; globalization and technology may have eliminated many of the jobs that provided pathways to the middle class for earlier generations of hard-working but low-skilled immigrants; the relative ease of travel and communication have enabled today's immigrants to retain their ties to their countries of origin and may have reduced incentives to adapt to American customs and mores. (Pew Research Center, para. 27)

In *Islands in the City*, Basch (2001) stated that immigrant identities are influenced by their everyday experiences in the American multicultural society that both “ethnicizes” and “racializes.” The experiences BC immigrants bring to the U.S. and their continued connections to their homeland (facilitated, as noted above, by the Caribbean's relatively close proximity to the U.S.) helps to shape their identities (Basch, 2001; Murphy & Mahalingam, 2006; Waters, 1999). McAdoo et al. (2007) asserted that this is how BC immigrants and their children are able to circumvent the negative effects of racism—they hold on to their ethnic experiences and cultural behaviors, which they view as positive. In so doing, they may be more successful in avoiding the adverse effects of racism in comparison to the African American community as a whole (Gordon, 2007; Mitchell, 2007).

Mental Illness and Crime

The number of incarcerated men and women in the United States has increased dramatically over the past few decades. At the end of 2011 there were 6.98 million offenders under the care of the adult correctional system (Glaze & Parks, 2012). In fact, “no other country incarcerates a higher percentage of its population than the United States. At 716 per 100,000

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capital, according to the International Centre for Prison studies, the U.S. tops every other nation in the world” (Wing, 2013, p. 1). Significant for this study is that increasing numbers of mentally ill are entering the correctional system (oftentimes for minor offenses) due to reduced community and medical services, which lead many into homelessness, increased alcohol/substance abuse, displays of aggressive behavior, and ultimately criminal acts (Hartwell, 2004). The end result is that America’s prison system has now become the new “gatekeepers” and de facto treatment center for the mentally ill (Skeem, Manchak, & Peterson, 2011).

Although the Bureau of Justice System (BJS) does not capture statistics by immigration status or by place of birth, they do report capture data by race and gender. The BJS reported that in 2008 there were 4,834 Black male prisoners per 100,000 Black males in the U.S. Some of these Black inmates were BC immigrants and inevitably faced deportation proceedings. In fact, in 2012, 6,510 were deported back to the Caribbean region—4,898 for criminal activity and 1,612 were for non-criminal activities (Guyanese Report, 2012). The Department of Homeland Security (DHS) indicated that about 15% of the deportation population could be labeled mentally disabled. Incarcerated women have a higher prevalence of mental illness at 73% as compared to 55% for men. Sadly, people with mental illnesses are particularly vulnerable to recidivism since they are likely to become trapped between the revolving door of inadequate treatment options while in prison and minimal treatment options and support in the community (Cloyes, Wong, Latimer, & Abarca, 2010).

Religious and Spiritual Beliefs

For such a relatively small area in terms of population size and geographic area, the Caribbean region features an incredibly diverse religious history, including practitioners of Christianity, Hinduism, Islam, Obeah, Rastafarianism, Buddhism, and Judaism (McAdoo et al.,

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2007). Black Caribbeans have strong ties to their religious and spiritual beliefs. In fact, first-generation BC immigrants are likely to rely on religion to meet their emotional needs (Gopaul-McNicol, 1998). Additionally, “Religion and its institutions serve as ethnic repositories that provide the means by which immigrants attempt to retain their ethnic identity, while simultaneously adapting their culture to new circumstances” (Yang & Ebaugh, 2001, p. 368). The supportive role of spiritual beliefs is also a resource that can also serve as a buffer to the impact of stressors and constraints faced by many newly arrived immigrants (Woodward et al., 2008).

Regardless of faith, religion and spirituality (and its institutions) offer the BC immigrant a variety of community resources that assist with immigrant issues, not to mention resources that promote overall health and reinforce their Caribbean identity and cultural heritage (Bashi, 2007; Taylor & Chatters, 2010; Waters, 1999). Often in partnership with schools, faith-based organizations also provide financial assistance and mentors to the BC students in the community (Mitchell & Bryan, 2007). Important to this study is that faith-based resources provide psychological help by providing links to cultural groups and networks that offer resources for optimal functioning, while at the same time reinforcing ties to their Caribbean culture (Yang & Ebaugh, 2001). Mitchell and Bryan (2007) discussed that these faith-based organizations also can be helpful in working with and supporting BC parents to become more involved in their children’s school events—even offering meeting places for various activities and programs. The strength of their religious beliefs, which should be stressed vary from country-to-country and by gender, also serves as a coping strategy that insulates them from the negativity associated with racism, as well as helps them maintain a positive self-identity that the BC immigrant is accustomed to in his or her home country (Bashi, 2007).

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Studies show that the BC immigrant will seek treatment from religious and spiritual leaders for both medical and culturally-competent psychological treatment options (Gopaul-McNicol, 1998; Taylor & Chatters, 2010). They tend to believe that psychological problems are internal and that people other than family or religious/spiritual leaders should not be involved in resolving them (Gopaul-McNicol, 1998). Similar to African Americans, if a BC does contact a spiritual leader for help and guidance, he or she is then unlikely to pursue any other treatment options—particularly the care of a licensed clinician (Thompson et al., 2004). Given this important and longstanding tie, Taylor and Chatters (2010) asserted that schools, health providers, and counseling professionals need to recognize the history and role of religion and spirituality in the lives of BC immigrants, and—if and when appropriate in a clinical setting—broach that as an issue in counseling. It is also important to note that clinicians need to recognize that some of their clients may fear being humiliated as they describe some of the religious rituals they currently use or have used in handling life's problems; they should also be open to the possibility of collaborating with their client's religious leader(s) (Taylor & Chatters, 2010).

Mental Health of Black Caribbeans

Williams et al. (2007), reporting on the mental health status of Black Caribbean immigrants, revealed some troubling statistics. The researchers indicated that only 22% of BCs were likely to seek mental health services, which is less than half the rate of AAs at 48% (Neighbors et al., 2007; Woodward et al., 2008). Gender differences have also been reported. Compared with African American men, Black Caribbean males had higher risks for 12-month rates of psychiatric disorders. In contrast, Black Caribbean females were at lower risk for 12-month and lifetime psychiatric disorders compared with African American women. This

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discrepancy is believed to be due, in part, to more employment options for women in the U.S., as well as having the economic freedom to provide for themselves and their families outside the traditional roles of household work—which may increase life satisfaction (Butterfield, 2004; McAdoo et al., 2007). Moreover, similar to AA females, Black Caribbean women tend to be very resilient and have a strong reliance on their faith, which research shows supports them and prevents them from becoming discouraged about life stressors (Barnes, 2010).

Recent scholarship has detailed the mental health risks among the BC population according to ethnicity, immigration history, and generation status. The first-generation BC immigrants exhibited lower rates of psychiatric disorders when compared with second- or third-generation BC immigrants (William et al., 2007). Additionally, when compared with first-generation BC immigrants, the third-generation BC immigrants had much higher rates of psychiatric disorders (Williams et al., 2007). These findings are consistent with Hall and Carter (2006), who indicated that an immigrant's mental health status is dependent on several factors, including age of migration, place of birth, and length of time in the U.S.

Woodward et al. (2008) examined the factors that would lead AAs and BCs with substance abuse, anxiety, and lifetime mood disorders to seek professional mental health and/or informal support through the church, family, or friends. The authors looked at educational levels, income, and severity of mental illness, all of which were determining factors in whether a participant sought professional mental health services and or used informal supports. For example, those with more education were more likely to seek both formal and informal sources of support. Individuals in low-income brackets were unlikely to seek help of any kind. Noteworthy was that those with substance abuse disorders very rarely sought mental health treatment, and only received it if they received treatment for another co-occurring disorder. This

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reluctance is probably due to the fact that BC immigrants as a whole generally do not view substance abuse as a mental health disorder. Woodward and colleagues (2008) also stated that the willingness of participants to seek help from various resources increased with the severity of the disorder. Importantly, this study as identified informal support as a powerful deterrent against some of these disorders. This is due in part to having trusted support in stressful situations, as well as the assurance that help would be there when needed.

When gender is considered, men more than women tended to use informal support networks, probably due to it being readily accessible and free of charge. Woodward et al. (2008) also noted that there were significant differences between AAs and BCs in the use of informal support, with BCs relying on their informal support system much more readily. The authors attributed this difference, in part, to BCs only having access to informal support networks in their homeland. When looking at age differences, the researchers pointed out that older Blacks (both AAs and BCs) rarely used informal supports. Certainly with the BC immigrant population, this likely can be attributed to older folks being viewed as knowledgeable authority figures who rarely communicate their problems with others.

Counseling Black Caribbeans

Counseling and therapy occur in a specific cultural context. By cultural context, we mean to suggest that individual behavior should not be assessed and cannot be understood outside of an analysis of the personal and collective realities each person confronts on a daily basis. (Parham & Brown, 2003, p. 82)

As counselors, we need to look at the Caribbean immigrant's reality, not what's assumed of a person of distant African decent and Black skin color. Lorick-Wilmot (2010) in her book, *Creating Black Caribbean Ethnic Identity*, discussed how Caribbean immigrants are reluctant to

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enter into a counseling relationship with someone who they felt would not understand both their racial and ethnic identities; nor are they likely to seek a clinician who claimed to be “color blind.” She maintained that this preference stems from a long history of racial discrimination in the U.S. and how they saw society treat other dark-skinned people.

African American counseling incorporates an understanding of the role and effect of racism on its people. When BC immigrants engage in counseling they are typically generalized as African Americans. When this occurs, their within-race differences are dismissed—including a long history where BC immigrants have represented the dominant culture in their respective countries. Thus, they are less likely to identify with the racial discrimination that AAs encounter on a daily basis (Murphy & Mahalingam, 2004; Waters, 1999). These differences pose a dilemma for the BC immigrant when he or she is identified as being a member of a group which they do not belong, and have no real understanding of the African American cultural or social context. Similarly, African Americans do not understand the diverse cultural backgrounds and ethnic options of BCs.

Patterson (2000) stated that “culture helps explain behavior but does not determine it” (p. 208), indicating that even though Black Caribbeans are associated with the African American culture, one cannot and should not assume that their behaviors will be similar. For example, BC immigrants do not express their racial solidarity as overtly as AAs do in dealing with the negativity associated with racism and discrimination (Rogers, 2006). In her book, “*Black Identities*,” Walters (1999) borrowed the following definition of ethnic and racial identity as it relates to social identity:

An identity is a conception of the self, a selection of physical, psychological, emotional or social attributes of particular individuals; it is not an individual as a concrete thing. It

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is only in the act of naming an identity, defining an identity or stereotyping an identity that identity emerges as a concrete reality. (p. 44)

Black Caribbean immigrants struggle not only to acculturate to a new country, but also to establish a new cultural identity, which is a challenge for any new minority immigrant. The added layer of complexity is that BCs are identified *de facto* with a group of people whose distinctly American prejudicial experiences and history (e.g., lynching and Jim Crow laws) do not pertain to them (Gopaul-McNicol, 1998; Waters, 1999).

Multicultural Counseling Significance

The term “multiculturalism” became entrenched in the American lexicon with the increase in diverse groups of immigrants. For this study, multiculturalism refers to an ideology on the part individuals, groups, or governments that our ethnic, cultural, racial and religious diversity should be embraced and celebrated. This term differs in meaning from “diversity,” which has more to do with the racial, gender, sexual orientation, religious, cultural (and other) differences between people. In the counseling setting, diversity is linked to a set of policies or approaches to meet compliance standards (Robinson & Morris, 2000). The accreditation and training standards around multiculturalism and diversity training for clinicians continue to be an evolving process.

For example, throughout the ACA Code of Ethics, there is an increased awareness of the need to recognize that multicultural and diversity issues are deeply embedded in all facets of the therapeutic relationship (2014). Several sections of the code are relevant to the therapeutic relationship with the BC immigrant. Section A.2.c discusses cultural sensitivity and that the counselor has to recognize the client’s perception of informed consent and the impact it can have on the client’s lives. The counselor should provide the necessary accommodations for the client

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to ensure that the individual fully understands what it means. For the BC immigrant who views his or her clinician as an expert, it is important that the clinician takes the time to explain each process within the counseling relationship (Gopaul-McNicol, 1998).

Another relevant section is Section B.1.a, which asserts that the counselor has to recognize and acknowledge that clients have different views towards confidentiality; as such, the counselor must be clear about how much information can be shared and with whom. Even though BC immigrants may have very strong family ties, due to fear that they may not be in alliance with some of their family traditions, they may be reluctant to express or share their true feelings (Gopaul-McNicol, 1998). Additionally, Section E.5.b states that the clinician should be aware that a client's expression and description of symptoms may be culturally based, as well as differ according to his or her stage in the acculturation process. Thus, caution should be used when making a diagnosis (Gopaul-McNicol, 1998).

In order to continue to advance multicultural and diversity awareness in therapeutic alliances, the Council for Accreditation of Counseling and Related Educational Programs (CACREP) recommends that students and mental health professionals have access to accredited programs that are relevant to the diverse needs and services of society. Indeed, CACREP (2009) stresses the importance of assisting professional clinicians in developing their competencies, which includes well-defined standards for diversity training and development. Similarly, the Association for Multicultural Counseling and Development (AMCD) recommends increasing a clinician's multicultural competence in three areas: attitudes and beliefs, knowledge, and skills. By focusing on these areas, the clinician will be able to develop techniques that will strengthen the counseling relationship (Arredondo, Brown, Locke, Sanchez & Stadler, 1996).

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The counselor's awareness of his or her own cultural values and biases is very important when working with BC immigrants. Within limits, a clinician should be willing to share appropriate aspects of his or her personal story for two reasons: (a) to give the client some insight into who the clinician is, and (2) to form a more trusting therapeutic relationship (Gopaul-McNicol, 1998). In order to enhance a clinician's cultural awareness and therapeutic responses, the AMCD recommends that the clinician becomes familiar with the worldview of the client (Arredondo et al., 1996); only then can the counselor recommend culturally-appropriate intervention strategies. One interesting recommendation involves simply being aware that time is a more fluid concept for BC immigrants. Thus, a clinician working with this population should allow for some flexibility with appointment times, as there is a lack of adherence to scheduled appointments (Gopaul-McNicol, 1998).

Lastly, Arredondo et al. (1996) described the importance of culturally-appropriate intervention strategies that are respectful of all clients' cultural needs and coping styles. This is a key factor in working with BC immigrants of different generations. Gopaul-McNicol (1998), for example, noted that BC immigrant children tend to be quieter and more passive in the school setting, which may be viewed by an American-born counselor (or teacher) as the child being withdrawn. In this setting, clinicians should work with students in dealing with any anxieties and give them some strategies for coping with their new lives in the U.S.—while ensuring that any suggested recommendations do not contradict cultural beliefs or behaviors.

Empirical Research Related to Counseling Black Caribbeans

There is a lack of empirical research related to BC immigrants and mental health treatment. As a result, the mental health of BC immigrants can only be presumed—the end result being that their needs are often overlooked (Murphy & Mahalingam, 2006). As discussed earlier,

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the NSAL (2004) was the first to publish a mental health study that identified this sub-population of African-American. This literature review will focus on studies where the participants were specifically identified as being of Black Caribbean descent. Two qualitative studies and four quantitative studies were conducted examining BC immigrants with respect to mental health status.

Butterfield (2004)

Butterfield (2004) carried out a qualitative study of 65 second-generation people of Black West Indian descent to examine the role of race and ethnicity in their lives and experiences. Butterfield utilized snowball sampling to identify the participants from her own New York neighborhood. Sampling criteria included demographic information such as age, educational level, gender and socioeconomic status. The participants' ethnic identity was assessed using measures such as their participation in Caribbean-specific events, the frequency that they listened to Caribbean music, whether they spoke in a Caribbean dialect, or if they or their family members often returned to their home country. Using data obtained from semi-structured, open-ended interviews, Butterfield discussed two main factors that the participants identified as being important to them in talking to her about race and ethnicity. Firstly, because the researcher self-identified as Caribbean, the respondents felt more open about providing candid responses. In fact, they reported that they might have responded differently to a non-Caribbean researcher, since some reported being mistreated by others who did not understand their culture. Secondly, the terminology she used was important in determining how the participants identified themselves. This was significant because they did not feel that they had to explain every response and did not have a fear of being misunderstood, joked about, or stereotyped.

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Several themes emerged from her study. The first was the issue of having their ethnic heritage ignored (i.e., “feeling invisible”), based on the fact that they were identified as AA simply as a result of their skin color and facial features. A second theme was that they saw themselves as separate from the AA community in that they socialized with other West Indian folks, and their identity was primarily developed by through cultural traditions (e.g., preferred foods) prevalent in their majority West Indian neighborhood. Interestingly, they viewed African Americans as an ethnic group versus a racial group in that they referred to AAs as having their ancestry in the South, which gave them their ethnicity and cultural traditions. A third theme that emerged was that the participants did not see themselves as just West Indian or Black, but an amalgamation of the two. They did not have an issue with reporting as Black—but they did with being identified as simply AAs. They wanted to be identified by their Caribbean identity and their unique ethnic heritage. A fourth theme that Butterfield (2004) described had to do with gender roles in America. The second-generation West Indian women in the study spoke of the freedom to be able to redefine themselves. As a BC immigrant they no longer had to play the role of a submissive woman in the patriarchal society that characterized their parents’ generation, but could become more independent.

One limitation of the study was that even though socioeconomic status was discussed, there was no discussion about class and the similarities of second-generation Caribbean immigrants to middle-class African Americans. Another limitation was that it only contained information about life in the U.S. and it lacked specific information about mental health services.

Jackson et al. (2007)

Jackson et al. (2007) examined the well-being of Black Caribbean immigrants and the role of different family generations using data from 1356 individuals, mostly from English-

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speaking countries. The study cohort represented geographic areas within the contiguous U.S. with large populations of BC immigrant families. This study also included immigrants born in Africa. Due to the deficiency of comprehensive studies on the Black Caribbean population in the U.S., their quantitative study focused on several factors including race, ethnicity, and migration on different generations within families and how those factors affected their emotional well-being. This longitudinal study lasted two years and four months; 95% of the participants were interviewed face-to-face and the other 5% were interviewed over the phone. The highest response rate of 78% was from Caribbean Blacks, with AAs and non-Hispanic Whites demonstrating lower rates. Participants were measured in areas of life-satisfaction, happiness, emotional support, negative family interactions, frequency of contact with family members, frequency of receiving help from family members, frequency of giving help to family members, closeness to family members, and social demographic factors (e.g., employment and education).

The results showed that participants in the age groups of 18-34 and 35-54 with higher education levels and more income were more likely to be employed than immigrants 55 years and older. The study looked at the younger group born in the U.S., which had higher access to more educational and employment opportunities. The middle-age group was more likely to be married, homeowners and providing for their families. The oldest group was less likely to be employed, probably due to retirement. The belief that immigrant groups support family members in their native countries was corroborated, since the study showed that immigrants gave more help than they received. The perceptions of the quality of family relationship did not differ across immigrant groups; they all felt that they had emotional support from family members. However, when the researchers assessed emotional well-being, there was a difference based on length of time in the U.S. The immigrants in the U.S. for 10 years or less expressed greater well

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being than those in this country for longer. Similarly, the older age at which one migrated also suggested that it had a negative effect on emotional well-being.

This study was limited in that it did not explore how some factors such as gender, economic status, and language were predictors for determining emotionally-healthy immigrants. Also the limited within-group dynamics of the BC generations did not identify factors leading to their emotional well-being.

Hall and Carter (2006)

Hall and Carter (2006) examined the relationship between racial identity, ethnic identity, and perceptions of racial discrimination among 82 first- and second-generation immigrants of Afro-Caribbean descent. The sample consisted of 27 males, 52 females, and 3 who did not identify their gender. They ranged in ages from 18 to 65 years ($M = 28.6$, $SD = 14.0$); 71% reported being first-generation immigrants, 27% identified as second-generation immigrants, and 2% were unidentified. The sample was recruited primarily in Brooklyn, New York, from two Seventh-day Adventist churches, an elementary school, and a hospital; the remainder represented individual contacts in the greater New York City area. Socioeconomic status was also reported: 2% lower class, 42% working class, 40% middle class, 7% upper-middle class, and 9% did not define. Educational level was also reported with 7% completing high school, 49% college educated, and 38% with graduate degrees.

This study used three scales and a demographic questionnaire. The personal data questionnaire requested information about gender, age, self-reported SES level, the respondent's educational level and that of their parents, place of birth, length of time in the U.S., racial group they identified with (i.e., White, Black, African-American, Asian, Biracial, Latino), and ethnic group (i.e. West-Indian, a "hyphenated" West Indian-American, or an American). If they did not

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think they fit into any of the specified groups, participants could write in their identity. The second instrument the researchers employed was the Black Racial Identity Attitude Scale (BRIAS) long form (Helms & Parham, 1996), which they utilized to measure how the participant identified their racial identity status. A Likert-type scale ranging from 1 (strongly disagree) to 5 (strongly agree) was used to self-report where they thought they belonged on the attitude scale. Each subscale was then measured using Cronbach's alpha internal consistency. The third instrument, the Multigroup Ethnic Identity Measure (Phinney, 1992), assessed ethnic identity on a 1-to-4 scale—specifically, how each respondent felt and behaved in a variety of cultural group orientations.

The results showed that there were no gender differences for racial and ethnic identity on their reports of racial discrimination over a year and over a lifetime. In contrast, second-generation respondents reported higher levels of discrimination in comparison to first-generation respondents. Ethnic identity did not predict discrimination for the year, but it did have an effect over the lifetime. Moreover, the higher the level of ethnic identity, the more likely it was that the individual perceived racial discrimination over his or her lifetime. There was also a direct link between racial identity and ethnic identity. Respondents who downplayed their racial identity (i.e., their “Blackness”) demonstrated lower levels of ethnic identity. Similarly, as ethnic identity rose, the individual demonstrated more pride and confidence in his or her racial identity.

This study remains relevant because it looked at ethnic differences within a single racial group, which is important because it is assumed from the outset that one's racial identity and one's ethnic identity are not the same. The study also captured generational differences, as well as the impact that birthplace has on racial and ethnic identity perception of racial discrimination.

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Despite its significance, this study was limited in that it only looked at two generations—those born in the U.S. and those born in another country. However, it must be noted that Hall and Carter (2006) also omitted including age/time of migration in their findings, which would have captured possible differences among those respondents who moved to the U.S. as children. In other words, the researchers did not take into account the length of time the first-generation immigrant had lived in the U.S., which could have been a significant factor in determining how much exposure an individual had to racial incidents. Finally, participants were only chosen from the New York City area, so it may not have been representative of the experiences of Afro-Caribbeans living in other areas of the U.S.

This study features several limitations. First, all the participants were from the New York City area; thus, their experiences are not necessarily those of other Black Caribbean immigrant populations elsewhere in the U.S. Second, the information relied solely on the memory recall of the participants and their perceptions of how often they experienced discrimination, rather than the actual number of times they experienced discrimination. The final limitation of this study is its reliance on the BRIAS as an accurate measure of how high levels of ethnic identity actually do buffer individuals from the effects of racial discrimination.

Williams et al. (2007)

Unlike the Butterfield and Hall & Carter studies, Williams and coauthors (2007), utilizing quantitative findings from one of the largest studies of mental health status among Black individuals in the America, investigated whether Black Caribbeans were at higher risk for psychiatric disorders in comparison to African Americans. Specifically, the authors relied on NSAL findings, collected over the span of 16 months, in order to conduct a logistic regression involving the mental health risk profiles of both Black Caribbean immigrants and African

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Americans. The sample size were all 18 years of age or older and consisted of 3,570 African Americans and 1,621 Caribbean Blacks, and 891 non-Hispanic Whites. The study looked at whether there was any variance in mental health diagnosis based on length of time in the U.S., age at which they migrated, ethnic origin, gender, and generational status.

The Black Caribbean participants who self-identified as being of Caribbean descent were either born in the Caribbean or had a parent or grandparent who was born in the Caribbean. Mental health diagnoses focused on the prevalence of lifetime and 12-month rates of mood disorders, anxiety disorders, substance abuse disorders, and any combination of disorders. The BC participants were divided into three ethnic groups: people from Spanish-speaking countries, people from English-speaking countries, and Haitians. Eleven participants that spoke other languages were placed into the English-speaking group. Four measures of immigration were utilized: (1) whether they were born in the U.S. or naturalized here, (2) the age at which they migrated to the U.S., (3) the length of time they lived in the U.S., and (4) their immigrant generation status (whether they were 1st, 2nd or 3rd generation). Face-to-face interviews were conducted in English, which lasted about two and a half hours. Logistic regression analysis was used to determine if there was any association between disorders and the participants' demographic risk factors. Logistic regression models were adjusted for age, and SAS version software was used to calculate the estimates of variance.

The results showed that there was little difference in the prevalence of psychiatric disorders between African American women and Black Caribbean immigrant women who lived in the U.S. longer than twenty years. However, this finding is linked to what Whaley and Geller (2007) described as clinical stereotyping—looking only at the Black client's key symptoms and not at the full diagnosis criteria or their cultural experiences. When generations were compared,

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third-generation Caribbean immigrants had the highest rates of psychiatric disorders. The prevalence of psychiatric disorders among both African Americans and Caribbean immigrants who lived in the U.S. fewer than 20 years was significantly lower. The results also showed that even when factoring in age at migration, Caribbean immigrants had few risks and lower rates for psychiatric disorders. Controlling for age and ethnic origin, third-generation BCs had significantly higher risks for all disorders. The only exception was first-generation Caribbean immigrant men, who exhibited higher levels of anxiety disorders when compared to other generations. Caribbean immigrant women had lower risks for all psychiatric disorders across all generations.

This study points to the complexity of assessing the identity development of a Black Caribbean immigrant, since so many factors impact their experiences. Measuring for ethnicity, duration of time in the U.S., gender, and the impact that those and other factors exert on one's mental health can be very difficult. However, one factor that resonates across available studies is that an immigrant's connectedness and cultural experiences in their homeland acted as an insulator against many disorders. In contrast, the longer someone resided in the U.S.—as exemplified by the third-generation immigrants—the more likely they were to experience a psychiatric disorder. However, if they had immigrated at a younger age they had a lower chance of experiencing a psychiatric disorder. This correlation is probably due to BC immigrants having emotional support both in their home country and in the U.S.

There are several limitations associated with this study. It must be noted that Williams et al. (2007) used NSAL data, which only captured a cross-section of immigrants with mental health disorders. Another significant potential limitation is that mental health is not readily discussed in Caribbean settings, which may have impacted their willingness to disclose sensitive

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information—and thus overall findings. However, the immigrants who took part in the NSAL study had resided in the U.S. for some length of time, were more acculturated, and/or had more experience with mental health institutions, which may have reduced the possibility for data inaccuracies. Another limitation is that the reader does not know whether all those diagnosed with psychiatric disorders were receiving treatment, as well as how that information would have affected their responses on the survey. Moreover, were they appropriately diagnosed or was the clinician hampered by the fact that he/she was unaware of important cultural differences; in other words, would the diagnosis have been different if the clinician had been culturally competent? A final limitation of the study is that it was administered in English—even though there were participants from non-English speaking countries.

Although these three studies employed relatively small numbers of BC immigrants, they are significant because they examined the psychological well-being of BC immigrants within the context of the larger American Black population. Similar to the proposed investigation, these studies also looked at the BC immigrant population across generations and how critical it is to examine for within-group differences between AA and BC immigrants. Indeed, the findings from all three studies concurred that the mental health and treatment options for BC immigrants should be explicitly distinct from that of AAs. My study will add to the literature in that I will examine BC immigrant experiences in mental health treatment in the U.S.

Himle et al. (2009)

Also utilizing the NSAL (2004) data, Himle et al. (2009) looked at the prevalence of anxiety disorders among AAs, BCs and non-Hispanic Whites in the U.S by examining age of onset, severity, and functional impairment. The purpose of the study was to explore race differences among these groups in the nature and prevalence of anxiety disorders, as well as to

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provide a detailed analysis and comprehensive understanding of the onset of anxiety disorders and when anxiety disorders are at their greatest risks for these populations. Additionally, the study suggested rehabilitative and preventative interventions that target periods of high risks for these groups.

The authors gathered participant data using subgroups from both the NSAL and the National Comorbidity Survey-Replication (NCS-R) (Kessler, Chui, Demler, Merikangas, & Walter (2005), both of which conducted national surveys of households in the U.S. The surveys were all conducted in English-speaking households, and with adults over the age of 18 years who were not institutionalized. In the NSAL sample there were 3570 African Americans (those who self-identified as Black), 1621 Black Caribbeans (those who self-identified as Black, but had Caribbean ancestry), and 891 non-Hispanic Whites (Jackson et al., 2004). The NCS-R was administered in two parts. The first part assessed 9282 individuals for core psychiatric diagnoses and the second part assessed 5692 individuals for other disorders, demographic information, and risk factors. The AA and BC participants for this study were identified from the subsample of the NSAL and from the NCS-R a subsample of 6696 non-Hispanic Whites.

Three measures were used to determine psychiatric diagnoses, severity of the mental disorder, and 30-day functioning and predictor variables. Five anxiety disorders were identified using the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV) (American Psychiatric Association, 1994). These included generalized anxiety disorder (GAD), social anxiety disorder (SAD), post-traumatic stress disorder (PTSD), personality disorder (PD), and agoraphobia (AGO). Diagnoses of major depressive disorder, dysthymia, bipolar I and II, alcohol or drug abuse/dependence, anorexia, bulimia and binge eating disorders were also considered. Participants were asked to recall the date of onset of disorder as best as they could.

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The severity of a mental disorder was defined in terms of it lasting longer than 12 months. The disorders were then divided into three categories. *Severe* mental disorders were identified as having met one of the following criteria: (1) assessed and treated for non-affective psychosis, (2) met the criteria for bipolar I or II, (3) had a suicide attempt in the prior 12 months, (4) had a Global Assessment of Functioning scale (GAF) below 50, (5) experienced substance dependence with severe role impairment, and (6) scored between 7 and 10 on the Sheehan Disability Scale (Leon, Olfson, Portera, Farber, & Sheehan, 1997). *Moderately severe* disorders were associated with participants with (1) suicidal ideations, (2) gestures or a plan, (3) substance abuse dependence without severe role impairment, and (4) moderate role impairment in the presence of a mental disorder. All of the other cases that did not meet these criteria were considered to be *mild*. Functional impairment for all cases was examined for quality and quantity over a 30-day period. Researchers also measured predictor variables, which included race/ethnicity, sex, age cohort, years of education, marital status and income.

Of significant difference in the 12-month prevalence rate across the three race/ethnic groups were GAD and SAD with AAs and BCs having similar lower rates; in contrast, non-Hispanic Whites were significantly higher. Having 11 or fewer years of education was also linked with an elevated chance of both SAD and AGO. Participants of lower income status or below the poverty line were at increased risk for all 12-month anxiety disorders except for GAD. When compared with the other racial/ethnic groups, BCs had the highest rate of severity for each disorder. With age as a factor, all three racial/ethnic groups had elevated risks for GAD in their 20s, which declined as they got older. They were also at risk for developing SAD before the age of 20.

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The PTSD-related results for all three racial/ethnic groups were as follows. Both ethnic groups of AAs and BCs were at equally significant risk for PTSD across the lifetime, although it must be noted that compared to BC women, BC males had significantly higher prevalence rates of PTSD. A related finding was suggested by Butterfield (2004), who described BC women as acculturating differently than BC men because they had more employment options than what they were used to as primarily homemakers, and thus have a better chance of providing for their families, which can adversely affect the men who were once were the primary breadwinners of their families (Butterfield, 2004; Mitchell & Bryan, 2007). The authors' finding that the PTSD risk was similar for all Blacks is consistent with other studies that Blacks, in general, are at increased risk for PTSD due to the injustices associated with racism, as well as BCs' introduction to this harshness and its related acculturative stresses. The fact that BC men have the highest rates of PTSD across gender and racial/ethnic groups is also consistent with prior studies showing that they are at higher risk for suicide as well (Joe et al., 2006; Williams et al., 2007).

One limitation of the study was that the non-Hispanic White population was double that of the AA sample, and almost triple that of the BC sample population, which can skew the results for generalizability and statistical power. Another limitation was that the study was cross-sectional in nature. Since it relied on information from both the NSAL and the NCS-R, it would be difficult to identify trustworthy relationship between causative factors and the diagnosis of the disorders, as well as conduct ongoing assessments given the differing data pool.

Broman et al. (2008)

Broman et al. (2008) also utilized participant data from the NSAL to conduct their investigation of the prevalence of substance abuse disorders (defined as meeting DSM-IV criteria) for AAs and BCs in the U.S. This type of study had not really been possible in the past

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since available substance abuse data had not accounted for cultural/ethnic differences between the two groups. To reiterate, the NSAL sample comprised 3570 AAs, 1621 BCs, and 891 non-Hispanic Whites of non-institutionalized individuals over the age of 18 years. Although both AAs and BCs were identified in the “Black” race category, the distinction of BC was made when the NSAL interviewer specifically asked participants if they were of Caribbean descent. Face-to-face interviews lasting about 2 and a half hours were conducted using a computer-assisted instrument. The overall response rate was 72.3%, with a 70.7% response rate for AAs, 77.7% for BCs, and 67.7% for non-Hispanic Whites. Social, demographic, and mental health disorder included the following information:

- Age group: 18-29 years, 30-44 years, 45-59 years, >60 years
- Gender: male or female
- Employment status: employed, unemployed, not in the labor force
- Years of education completed: 0-11years, 12 years, 13-15 years, >16 years
- Household income: < \$18,000; \$18,000 - \$31,999; \$32,000 - \$54,999; >\$55,000
- Marital status: married or cohabitating, previously married, never married
- Place of birth: in the U.S., outside the U.S.
- Region in the U.S.: North, Midwest, South, West
- Urbanicity: urban >2500 people, rural < 2500 people
- Immigration status: how long they resided in the U.S.
- Generation status (for BC responders only: 1st generation, born outside the U.S.; 2nd generation, born in the U.S., but at least one parent born outside the U.S.; 3rd generation, born in the U.S. and both parents born in the U.S.

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- Mental disorder(s): The study utilized the DSM-IV World Mental Health Composite International Diagnostic Interview (WMH-CIDI) to assess the extensive list of mental disorders.

The results indicated that in comparison to AAs, BCs were more likely to have higher levels of education, to be employed, to be earning a higher income, and to be residing in the Northeast. The data also showed that overall rates of substance abuse and substance dependence were only marginally higher for the AA population at 11.5%; the analogous rate for BCs was 9.6%. However, a significant difference was noted in the 45-59 age group for AAs, who had higher prevalence rates for both substance abuse (15%) and substance dependence (7.9%) in comparison to the Black Caribbean respondents (3.6% and 1.7%, respectively). When gender was factored in, AA women had a higher rate of substance abuse (6.3%) compared to BC women (2.8%). Overall, across both ethnic groups, men exhibited higher substance abuse and substance dependence than did women. There was also a significant difference in the substance dependence of AAs (4.9%) in comparison to BCs (.9%) when education (12 year or less) and income (\$18,000 to \$31,999) were delimiting factors. The results showed no difference in lifetime prevalence rates between AAs and BCs when examining the demographics of place of birth, urbanicity, work status, and place of birth. AAs and BCs with the lowest levels of education and income had the highest prevalence of substance dependence. In contrast AAs in this group also demonstrated the highest prevalence for substance abuse. When accounting for place of birth, those born outside the U.S. had much lower rates of substance abuse than those born in the U.S. Generation status also impacted substance dependence within the BC sample population: first generation was 1.9%, second generation was 3.0%, and third generation was 15.8%. When looking regional differences, the AAs living in the South and BCs living in the

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Northeast had the lowest prevalence rates of substance dependence. However, AAs living in urban areas had higher prevalence rates of substance disorders, but due to small sample size of BCs no data could be calculated.

Although Broman et al. (2008) observed no stark contrasts when looking at the prevalence rate of substance abuse and substance dependence across all measures, they did report some notable differences in certain areas. For instance, significantly higher prevalence rates were noted for AA women over a 12-month period in comparison to BC women. These numbers decreased with age, but decreased even more significantly for BC women. Generation status also played a role. Importantly, the rates for both substance abuse and substance dependence converged when looking at third-generation BCs. Specifically, when compared to AAs, there was little difference in substance abuse/dependence among third-generation BCs who were born in the U.S. to U.S.-born parents. In contrast, second-generation BCs were twice as likely as AAs to engage in substance abuse. This generational difference can likely be associated with the conflict and stress from having a parent born outside the U.S. and the child trying to balance the two cultures. The first-generation BCs were significantly lower than AAs for meeting the criteria for substance disorders—no doubt in part due certain protective factors associated with being born outside the U.S. and having that family support from their home country (Himle et al., 2009; Jackson et al., 2004; Williams et al., 2007). In comparison, second-generation BCs appeared to be less predisposed to these protective factors, which is probably linked to their generationally-weakened ties to their Caribbean homeland and ancestry.

This study was limited in that the sample populations included individuals residing in households; thus, is it not representative of the homeless and institutionalized populations—both of which are strongly associated with drug abuse and dependence. Moreover, all the interviews

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were conducted in English, so it did not capture the BC populations that spoke other languages. Another limitation was that the sample size of BCs was relatively small and clustered as compared to the AA sample, which was larger and more varied demographically. These important differences will create a larger standard error and result in fewer significant differences that might exist in the population. Despite the limitations of all the investigations detailed in this review of the literature, each of them highlights the need for further research to examine the mental health status and treatment of BC immigrants.

Summary

This literature review was intended to synthesize available studies of BC immigrants and their challenging experiences in the U.S. Each investigation confirms that the mental health of BC immigrants must be intentionally considered in a number of ways (e.g., generational status) for counselors to work with them in culturally-competent ways. This study was designed to respond to what the available literature identified as lacking. Chapter Three, the Methodology section, will details now this study was carried out, including the three research questions that guided this investigation.

CHAPTER THREE

METHODOLOGY

Due to lack of available research about the experiences of Black Caribbean immigrants in counseling, this qualitative investigation was designed to explore the lived experiences of Black Caribbean immigrants who sought professional mental health/counseling services in the United States. The chapter includes a description of the methods and procedures that were utilized to carry out this study, with the following research questions serving as a guide.

1. What are the lived experiences of BC immigrants as they access mental health treatment?
2. How, if at all, does the counselor address the cultural and ethnic heritage of BC immigrants during mental health counseling?
3. How do BC immigrants experience their culture and ethnicity in the counseling relationship?

This chapter provides the rationale for using a qualitative research design for this investigation, detail the proposed data collection and analysis approach—including the role of the researcher and selection of participants—as well as discuss the ethical considerations associated with this study.

Research Design

Robson (2002) and Crotty (1998) both emphasized how the choice of an inquiry method shapes everything from research questions to how the resulting data is analyzed. As noted in the Introduction, the cultural and ethnic background of Black Caribbean immigrants is distinctly different from African Americans—which can be problematic in a counseling setting. Therefore, this investigation was designed to elucidate how the cultural and ethnic heritage of BC immigrants impacts the counseling process, with the goal of increasing the capacity of mental

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health providers to provide culturally-appropriate care. Because no prior research had been done on this topic, it seemed logical to move forward with a qualitative design. Indeed, a qualitative methodology facilitated a more detailed and in-depth exploration of a phenomenon that would be difficult to assess any other way (Patton, 2002). Moreover, a qualitative research design will enable the Black Caribbean immigrant participants in this study to provide rich descriptive information about their lives, and in so doing increase counselors' knowledge of how to provide culturally-sensitive therapeutic interventions.

Ultimately, this qualitative research study canvassed the opinions of eight BC immigrants and their lived experiences with counseling and mental health treatment in the U.S. With sparse qualitative research on BC immigrants and mental health treatment, this study examined if and how they experienced their cultural identities in counseling and what impact that had (if any) on counseling approaches. Through semi-structured, one-on-one interviews, the participants had a voice that was more culturally authentic because this approach enabled them to relate their experiences in their own words (Hays & Singh, 2012). The researcher explored how the participants identified themselves in counseling and their personal experiences with a counselor, which was intended to fill a research gap, as well as establish a foundation for both future research and therapeutic interventions.

Research Methods: The Phenomenology Approach

Qualitative research methods, such as grounded theory, have found favor among researchers interested in exploring, understanding and explaining human interactions. This study employed a phenomenological approach to attempt to understand the lived experiences of BCs and how they make sense of formal mental health counseling. Aspens (2009) stated that phenomenology is simply that which appears—meaning that what the researcher eventually

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reports must be what study participants found for themselves to be true. Moustakas (1994) noted that a phenomenological research approach returns to experience for descriptions of what is taking place, asks open-ended questions, and permits additional dialogue on the subject being studied. The researcher, in the end, is able to determine general meanings of the experiences the participants have lived through.

Similarly, Patton (2002) described phenomenology as the meaning, structure, and essence of a particular lived experience for an individual or group of people, while Hays and Singh (2012) stressed that phenomenology focuses on understanding the meaning of the lived experiences of study subjects—i.e., how people perceive and interpret their own life events. Research using this approach relies on experiential descriptions of what is taking place by asking open-ended questions and allowing dialogue on the subject being studied. Accordingly, the researcher is able to determine general meanings of the experiences the participants have lived through. A second point of this approach is that it seeks to discover how a participant interprets his or her experiences. The findings from a phenomenological study are more experiential and personal, rather than solely derived from statistical procedures. Understanding that the participants can be viewed as co-researchers is integral because they have the experience and knowledge of the phenomenon. Focusing on events as they occur in their natural settings gives better insight into what life is really like (Miles & Huberman, 1994). Accordingly, phenomenology was utilized for exploring and understanding how the ethnic identity of Black Caribbean immigrants played a role within the mental health counseling field.

Ethical Considerations

Qualitative approaches have been used to explore a vast number of phenomena from the viewpoint of the participant. As such, an important goal of this approach is to protect the rights

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of the participants—especially in cases where the nature of the study is highly personal, as was the case with this investigation (Creswell, 2007; Hays & Singh, 2012). According to the American Counseling Association (2014) and Patton (2002), it is the responsibility of the researcher to protect the emotional, physical, and social welfare of participants. Throughout this investigation, adherence to ethical considerations ensured that participant rights were maintained at all times. Once approved by the Virginia Polytechnic Institute and State University (Virginia Tech) Institutional Review Board (IRB), I adhered to all required institutional policies and research protocols throughout the study.

Confidentiality

Qualitative research requires participants to share in-depth experiences, but it does not negate their right to privacy (Hays & Singh, 2012). Accordingly, I followed specific protocol to ensure that participants felt safe and completely trust that their privacy and anonymity were fully maintained: (1) All interviewing was done in person, or over the phone and conducted in a private location of the client's choosing; (2) Data collection procedures was approved by the Virginia Tech IRB; (3) Participants who took part in this study were assigned a non-identifying pseudonym in order to protect their anonymity; (4) A paid transcriptionist was hired to transcribe the audio recording, and I ensured that there was a confidentiality agreement in place that all recordings would be destroyed upon completion of the transcription process; (5) All audio recordings and interview transcripts were stored in a secure location that were only accessed for data collection purposes by the researcher; (6) All data sources will be destroyed after data analysis and dissemination of results is completed.

Informed Consent

The Virginia Tech IRB required the researcher to provide an informed consent form (ICF) to research participants prior to the onset of a study; this directive corresponded to Patton (2002), who suggested that the ICF should be presented before the interview process, and again when interviewing begins. An ICF should be constructed in a manner that accurately details the purpose of the study and is easy to understand. The ICF for this investigation, which is shown in Appendix B, included detailed information about the researcher, the risks and benefits of participation and nonparticipation, as well as emphasized that participation was voluntary (i.e., any participant may withdraw from the study at any time without penalty) (Hays & Singh, 2012). Each participant was presented with a copy of the ICF for signature. The researcher reviewed the informed consent form in its entirety with participants and provided ongoing opportunities for them to ask questions at any time throughout the study. It should be noted that while I protected participant confidentiality to the fullest extent possible, the risks associated with participation in this study included the burden of participation and limitations of confidentiality. This included information about who will be viewing the information and the extent of their data access. Possible benefits of participation included providing information on how taking part in the study could improve mental health services for other BC immigrants.

The Role of the Researcher

Hays and Singh (2012) claimed that a phenomenological research design requires researchers to immerse themselves in the data. Nonetheless, in striving for “thick, rich, and deep descriptions” (Patton, 2002), the researcher should at all times be mindful to bracket all assumptions and biases about the study. Another word for bracketing is “epoche,” where the researcher removes or sets aside any preconceived views or assumptions about her knowledge of

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a given experience of interest (Moustakas, 1994; Patton, 2002). This researcher is a Black Caribbean immigrant who works in the mental health profession. I acknowledged that I have opinions and biases about the mental health treatment of people with dark-skinned complexion; as such, I recognized the need to bracket these opinions. As much as possible, I set aside any assumptions and avoided drawing any unsupported conclusions about the lives of BC immigrants. However, I acknowledge that my perspectives and background may have contributed to being more sensitive to the nuanced meanings of the participants. In order to prevent researcher bias, I collaborated with a team of three coders who were not of BC descent. One coder was Caucasian and an immigrant, one was Black and not an immigrant, and the third was Caucasian and not an immigrant. Miles and Huberman (2002) discussed that having more than one coder can capture different perspectives of the essence of the phenomenon that is not so obvious to one researcher. The three coders were given the same two transcribed interviews and asked to develop the codes as they interpreted the data. I also maintained journal notes, and utilized member checking—each of which is detailed in a subsequent section in this chapter.

As noted, I studied the lived experiences of Black Caribbean immigrants as they accessed mental health treatment. “Authentic researchers” are the mirrors through which one can interpret this lived data (Hays & Singh, 2012). In addition to displaying authenticity, a core condition for researcher reflexivity is unconditional positive regard and empathy, which ensures that participants do not feel judged and that their thoughts and feelings are accurately reported (Hays & Singh, 2012). In keeping with this directive, I strived to be reflexive and objective, and remained in the here-and-now throughout the data collection and analysis processes. Additionally, I endeavored to record any emotions expressed verbally and nonverbally by the participant through field notes, and asked appropriate follow-up questions ensuring that I

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interpreted those displayed emotions correctly (Hays & Singh, 2012). This approach was crucial to the integrity of the researcher, the quality of the data, and the ability of the researcher to respect the experiences of the participants.

Selection of Participants

The literature is mixed with respect to appropriate sample size in a qualitative study (Mason, 2010). “Qualitative samples must be large enough to assure that most or all of the perceptions that might be important are uncovered, but at the same time if the sample is too large data becomes repetitive and, eventually, superfluous” (Mason, 2010, para. 3). Ritchie, Lewis & Elam (2003) asserted that sample size should ideally be based upon the concept of saturation—that at some point in a study additional data does not lead to new or useful information. Moreover, a qualitative study that employs a large sample can be unwieldy to interpret and costly to undertake, which is why qualitative research tends to rely on relatively small and purposeful samples (Hays & Singh, 2012; Patton, 2002). Mason (2010) also reported that sample size in qualitative research could be guided by the choice of methodology (e.g., grounded theory, ethnography, phenomenology, etc.). Given that this study was a phenomenological investigation, I followed the recommendations of Creswell (2007), who suggested that 8 - 10 participants represents a good sample size. After obtaining approval from Virginia Tech IRB (see Appendix E), I began to recruit participants. Using a Recruitment script (see Appendix D), I recruited potential participants for the study by informing them about who I am, my personal information about how best to get in contact with me should they decide to participate, and all details of how the study would be conducted and reported. After they contacted me, I used a screening script (see Appendix F) to ensure that they met the criteria for the study. Accordingly, I solicited the participation of 8 Black Caribbean immigrants (see Table

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1) who met the following criteria: (1) self-identified as a Black Caribbean immigrant, (2) were 18 years or older; (3) born in the Caribbean or migrated to the U.S. as a child of 7 years or older; and (4) had attended at least one therapeutic counseling session with a trained counselor with a Master's degree (or higher) in a mental health field in the U.S. Including 8 - 10 participants allowed for a deeper understanding of their lived experiences; moreover, a manageable sample size permitted the use of multiple interviews if needed to clarify findings. However, due to BC immigrants' fear of stigmatization and their general reluctance to disclose information about mental illnesses, it was difficult to identify participants for this investigation. Hence, I recruited participants by word of mouth among my network of contacts within the Caribbean community in the greater Washington DC and New York metropolitan regions. In keeping with the need to avoid researcher bias, I did not interview any close family or friends or former clients for this study.

Table 1.

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Pseudonym	Age group	Gender	Age at migration	Education completed	Race of mental health professional
Jade	50-59	Female	7 years	Masters	Caucasian
Cecilia	40-49	Female	19 years	PhD	Caucasian
Irene	50-59	Female	30 years	Nursing Certificate	Caucasian
Jaylene	40-49	Female	20 years	JD	Caucasian
Raphaela	40-49	Female	32 years	PhD	Black
Cynthia	50-59	Female	40 years	Bachelors	Black
Alfonzo	50-59	Male	30 years	Masters	Caucasian
Bess	50-59	Female	10 years	Masters	Caucasian & Black

According to Patton (2002), there are more than a dozen sampling strategies that fall under the broad umbrella of “purposeful sampling,” which requires the researcher to establish

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participant eligibility criteria for a study before selecting members (Hays & Singh, 2012). The three “sub-strategies” that apply to this study were snowball sampling, criterion sampling, and convenience sampling. The study cohort was a homogeneous sample in that they shared many similarities (e.g., ethnic origin, certain cultural traditions, and disclosed mental health treatment). Thus, criterion sampling was employed because the participants met the pre-determined criteria of being a BC immigrant and having a mental health experience (e.g. pastoral counseling, licensed counselor or social worker, therapist or psychiatrist). In order to ensure greater access to this “difficult-to-access” population, I employed snowball sampling (a subset of purposeful sampling), which means I asked confirmed participants (and others) to suggest additional candidates who met the criteria and were willing to take part in this investigation (Creswell, 2007; Patton, 2002). This approach is especially useful in populations where the subject of interest is sensitive or prospective participants may be hard to track down.

I informed all identified potential participants of the anticipated time commitment. Specifically, they were told that that the study involved one in-depth interview lasting about 60-90 minutes—but that there might be follow-up questions lasting approximately 30 minutes over the phone. They were given the opportunity to review the printed transcript of their interview for accuracy, during which time they could add any additional comments or thoughts; however, none of the eight participants opted to do that. Finally, they were informed that care would be exercised throughout the study to ensure that they remained anonymous.

Data Collection

This study used a qualitative approach, which typically relies on specific data-collection methods to achieve an enhanced understanding of a phenomenon. Most such studies involve interviews of some kind. Indeed, Patton (2002) reported that we cannot observe everything, so

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we interview participants to gain their perspectives. Creswell (2007) discussed that interviewing is fundamental to data collection; therefore, interviews, observations, and field notes were used to gather data for this qualitative study. Using multiple sources of data facilitated a richer description of the experiences of BC immigrants with mental health treatment.

Semi-structured Interviews

According to Robson (2006), there are three types of interview questions that a researcher can utilize to obtain data: structured, semi-structured, and unstructured. Structured interviews use questions with fixed wording; moreover, the questions are in a specific order that build on core concepts. The second type, the semi-structured interview, is also predetermined to some extent; however, the order of the questions and the way the questions are worded can be modified if the interviewer believes the situation warrants it. The interviewer is also allowed to explain a question or even omit a query if it might be offensive or inappropriate; in such cases new questions may be substituted. A significant level of rigidity separates the semi-structured interview from the unstructured, which is used when the interviewer does not have a specific area of interest and the intent is to tailor each interview according to participant (Cooper & Schindler, 2011). Although an unstructured interview can be adjusted or refined based on participant feedback, it was deemed to be too unfocused for the proposed investigation.

Therefore, this qualitative phenomenological research study used a semi-structured interview questionnaire (see Appendix C), which enabled use of additional probing questions when initial answers were too short or enigmatic. Moreover, the use of semi-structured interviewing promoted flexibility in order to respond to each participant's uniqueness, as well as allowed participants to have more of a voice in the structure and process of the interview (Hays

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& Singh, 2012). Allowing participants to speak freely hopefully reduced any anxiety, thereby allowing them to build trust with the researcher.

Prior to beginning each 60- to 90-minute interview, participants completed a brief demographic survey designed to determine their age, gender, educational level, years in the U.S., how they racially/ethnically self-identify and the race/ethnicity of the mental health professional they worked with Appendix A. I then conducted the interview according to the protocol shown in Appendix C. The questions focused on the participant's life history, and hopefully allowed each participant to open up and speak freely. All interviews were then transcribed verbatim. I crosschecked all transcriptions and made any necessary edits before sending the document to the individual for an accuracy check—although as noted earlier, no participant reviewed his or her printed transcript. Participants were assigned a pseudonym in order to protect their identity.

Observations

Patton (2002) discussed the advantages of direct observation as being essential to understanding the context in which participants engage in a topic. He also stressed that, either consciously or unconsciously, participants may not disclose pertinent information over the course of an interview. As such, observations are beneficial to qualitative data in that they can amplify the context of participants' experiences (Hays & Singh, 2012). Hays and Singh (2012) noted that observation is an ongoing process where the researcher continually reflects on the participants. Accordingly, I used observations to support (or possibly question) the verbal replies that emerge during the semi-structured interview by focusing on each participant and closely examining his or her behaviors. In addition, I refrained from conveying any judgmental replies or gestures so as not to influence the participants. Observations were coded and organized in support of meaningful themes that emerge from this research.

Field Notes

Hays and Singh (2012) described the research field as being an important window into participants' lives, in that it provides the researcher with a better understanding of a participant's reality. Patton (2002) recommended that field notes should include the following information: (1) direct quotes from participants that support the topic, (2) the researcher's reactions to what is being observed, and (3) the researcher's insights and interpretation of what being observed (i.e., what does it all mean?). To the best of my ability I developed accurate field notes of my observations that were representative of the participants' behaviors and feelings (Hays & Singh, 2012). Specifically, I documented all noteworthy observations of participants, as well as maintained comprehensive notes of my feelings, thoughts and experiences immediately following the interview session, or as soon as possible thereafter, to reduce the possibility of bias creeping into the analysis process. My descriptive field notes also contained detailed descriptions such as dates, locations, settings, the participants' dress, and any incidents that occurred during the interview that may have affected their responses. According to Hays and Singh (2012), throughout these descriptive field notes there should be brief reflective observations about the researcher's perspective of the physical setting. Finally, a journal was kept to document my thoughts and potential biases.

Data Analysis

The goal of data analysis in a phenomenological investigation is to more effectively organize the data in order to obtain a fuller description of the findings (Hays & Singh, 2012; Patton, 2002). According to Hays and Singh (2012), data analysis should focus on the generating a rich description that will reveal the deeper fundamental structures underlying a particular human experience. In other words, the researcher should stay focused on the research questions

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and not get distracted by other issues that might influence the investigation—in this case, the fact that the researcher belongs to the same race as many of the participants, is of Caribbean descent, and has experience counseling BC immigrants. As stated previously, I bracketed all my assumptions and personal beliefs prior to data analysis so that these similarities would not interfere with or contaminate my objective data collection. According to Moustakas (1994), bracketing is essential to ensure that the participants' experiences and perspectives remain at the forefront of an investigation.

Creswell's (2007) defined data analysis as a three-step process: (a) sorting data such as transcripts and notes, (b) coding and sorting data into themes, and (c) displaying the data in charts and/or tables. Relevant data from any point in the interview was utilized, and Table 2 shows the questions developed to gather the data needed for each research question. For this investigation, coding began even before formal data collection by noting key phrases from the reviewed literature. Throughout all phases of data analysis, interview results were continuously reviewed for any new emerging themes, ideas, or constructs until all had been identified. Hays and Singh (2012) identified this as the point of saturation when the researcher identifies all the data as being similar.

Table 2.

Research Questions and Related Semi-Structured Interview Questions

Research Question	Related Semi-Structured Interview Questions
RQ1: What are the lived experiences of BC immigrants as they access mental health treatment?	<ol style="list-style-type: none"> 1. Tell me about when you first went to Mental Health treatment? 2. Was there anything about your culture/ethnicity that lead you to seek treatment? 3. How would you describe your mental health treatment experiences here in the U.S.?
RQ 2: How, if at all, does the counselor address the cultural and ethnic heritage of BC immigrants during mental health counseling?	<ol style="list-style-type: none"> 4. Can you tell me more about how the counselor addressing how your culture or ethnic identity impacts your daily life?
RQ 3: How do BC immigrants experience their culture and ethnicity in the counseling relationship?	<ol style="list-style-type: none"> 5. How did you address or discuss any part of your BC immigrant experience in counseling? Why or why not? 6. How well, if at all, do you think your counselor understood your culture and ethnic identity? 7. Would you say your culture and immigrant experience were important to discuss in counseling? Can you tell me more about that? 8. Do you think you are getting your most important needs addressed in counseling? Can you tell me more about that? 9. How if at all, was the counselor’s race or culture important to your choice of treatment? 10. Do you think you had an option for the kind of mental health treatment you were seeking? Can you tell me more about that?

Data Reduction

Miles and Huberman (1994) described data reduction as “the process of selecting, focusing, simplifying, abstracting, and transforming the data” (p. 10) from field notes, interview transcripts

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and observations. Creswell (2007) defined data reduction as coding the data and dividing them into specific sections. In order to do this effectively, however, the researcher must make careful decisions about how to narrow the data while still capturing the full meaning of the participant's story. I followed the guidelines of Hays and Singh (2012) for data reduction and created a list of keywords and terms to link with each of the data reducing techniques below.

- Topic
- Research questions
- My role and assumptions of the study
- Previous literature reviewed
- Access to the participants and setting
- Trustworthiness strategies

Hays and Singh (2012) also described this process as summarizing the notes into “codes, themes, clusters of themes, and patterns” (p. 295), which must be accomplished thoughtfully so as not to discard important concepts, and/or incorporate researcher bias into findings. Care was also taken to ensure that the codes are well described before shortening them so that coders could work with them. Moreover, if a code was used frequently, I created subcodes, as well as added memos about the codes/subcodes to a master codebook. To ensure the trustworthiness of the data, I utilized conformability, which ensured that the data was fully reported “as is” and contained no researcher bias. I also employed reflexivity by being mindful of my feelings and thoughts throughout the coding process; indeed, I entered personal observations in a journal in order to avoid researcher bias throughout the data analysis process. Finally, in order to better organize my data, I converted meaningful words into phrases in order to identify themes (Hays & Singh, 2012) so that I could uncover meaning and depth—namely the “what” and “how” of the BC

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immigrant experience with mental health counseling. These themes were chunked together to better describe this phenomenon.

Conclusion Drawing and Verification

Throughout this iterative process, the researcher must continually make decisions on what the information means, as well as identify existing patterns or additional themes for further exploration. The codes/subcodes developed earlier, which consisted of phrases and sentences that speak to the topic, assisted me in interpreting the data and forming conclusions (Creswell, 2013; Hays & Singh, 2012). Final codebooks consisted of a combination of codes by phrases and sentences. I continued this process until the point of saturation, or until no new themes or ideas emerged from the data (Hays & Singh, 2012). At that point, I meticulously documented a description of the phenomena to better understand my research questions.

Validity and Credibility

A research can and should establish the trustworthiness of qualitative research by addressing the four concerns discussed by Guba and Lincoln (1985): (a) internal validity or credibility, (b) applicability or external validity/generalizability, (c) consistency or reliability, and (d) objectivity or confirmability. This can be done, in part, through careful study design. For this investigation, these concerns were addressed through a well-crafted research instrument (the semi-structured interview), ongoing observations and journaling to produce rich descriptions that added to the context and could better inform readers, triangulation of multiple data sources, and, finally, member checks (Guba, 1981).

To increase the internal validity of this investigation and ensure credibility/rigor, I solicited peer and committee member feedback. The study's reliability was safeguarded by documented field notes, as well as by requiring coders to analyze the data without prior

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knowledge or outcome expectations. Three coders who were not of BC descent looked at the data; two were former doctoral students who had taken several research courses and thus were familiar with coding techniques, and the other coder was a counseling professor. One coder was of African descent (but was born in the U.S.), the second coder was an immigrant to the U.S. of European Caucasian descent, and the third coder was Caucasian who was born in the U.S. To ensure continued credibility, I also solicited feedback from dissertation committee members who had expertise in qualitative research.

Patton (2002) discussed that using triangulation—namely, the use of more than one approach for investigating a research topic in order to increase confidence in a study’s findings—will increase the validity of data analysis. This researcher used analyst and theory/perspective triangulation in order to maximize credibility. Analyst triangulation refers to using diverse coders to look at the findings, while theory/perspective triangulation then utilizes these varied frames of references to interpret and explain the data (Patton, 2002). To further increase trustworthiness, I used member checking to ensure that the identified themes accurately described the participants’ lived experiences. Hays and Singh (2012) pointed out that member checking is more than just discussing the transcriptions with the participants; rather, it has to do with discussing if the data accurately reflects their experiences. Additionally, although I asked participants to review their transcripts to ensure that they accurately captured their lived experiences in counseling, no one opted to do that.

Limitations of the Study

This study features some limitations that typically go hand-in-hand with a phenomenological qualitative research approach. First, the small participant population for this investigation (N=8)—although purposefully sampled—drew from a limited number of

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volunteers who met the study criteria and were willing to share their experiences with mental health counseling. Thus, the findings detailed and discussed in Chapters Four and Five, while adding to the literature, may not be generalized to the larger population of Black Caribbean immigrants. Additionally, the study cohort all resided in large urban areas; as such, their experiences may not be representative of BCs in other areas of the country—and particularly in suburban or rural areas. Finally, the researcher as participant-observer, collecting ethnographic data and using constant comparative analysis, created an inevitable risk for bias in the interpretation of the data.

Summary

This chapter includes a detailed description and a rationale for conducting this qualitative study using a phenomenological approach. It described the process I utilized to identify the eight participants for this investigation, as well as the data collection procedures I employed to obtain a rich description of the participants' lived experiences. As noted, I used purposeful sampling to identify study members, and semi-structured interviews, observations, and field notes to elucidate the meaning of the counseling experiences of BC immigrants. Ethical considerations are outlined, and the method I used to ensure confidentiality is described. This chapter then details the data analysis methods I used, including reducing data, identifying emerging themes, patterns, concepts, insights, multiple codes and establishing reliability and validity. Finally, this chapter includes a description of the potential limitations of this investigation.

CHAPTER FOUR

RESULTS

This qualitative study was designed to explore the lived experiences of a small cohort of Black Caribbean immigrants who have sought professional mental health/counseling services in the United States in order to examine if and how such services impacted this little-studied sub-population of Black Americans. Results from this investigation are expected to increase counselors' awareness of the specialized needs of this cultural subgroup, which are tied to the immigrant history of BCs, the role of generation, and the development of their racial and ethnic identity. This increased awareness may enable counselors to deliver more culturally-appropriate counseling services that take into account the lived experiences of BCs.

The following questions guided this research study:

1. What are the lived experiences of BC immigrants as they access mental health treatment?
2. How, if at all, do the views and actions of the counselor address the BC cultural and ethnic heritage?
3. How do BC immigrants experience their culture and ethnicity in the counseling relationship?

This chapter contains a demographic description of the participants who took part in this study. Analysis and results of the research questions are also presented. The final section of this chapter contains an in-depth analysis and synthesis of interviews that emerged in eight themes for all three research questions.

Participants

In order to gather data, I utilized a phenomenological approach that relied on one-on-one interviews to canvas the experiences and opinions of a purposeful sample of Black Caribbean immigrants who met the two essential study criteria: over the age of 18 and had experienced mental health treatment in the U.S. The interviews for this study took place between May 2015 and June 2015. Initially, I recruited 20 potential participants, but with snowball sampling I independently contacted another 12 potential participants. During subsequent recruitment interviews, several participants indicated that the counseling they had received could not be considered mental health treatment, making them ineligible for this study. Additionally, a number of other potential participants did not want to sign the informed consent because they did not want their names to be associated with mental health treatment. These BC immigrants, too, did not participate in the study.

Of the 32 invitations, eight Black Caribbean immigrants 18 years or older and who had received mental health treatment in the U.S. agreed to be interviewed for this study. Each was assigned a pseudonym to maintain their confidentiality. They resided primarily in the New York and Washington DC metropolitan areas. The study cohort included seven females and one male, which was not surprising since “studies have indicated that women tend to have more positive attitudes than men do regarding seeking professional help and, at least for less severe diagnoses (e.g., depression), women tend to seek help often than men do” (Vogel, Wester, & Larson, 2007, p. 413).

The eight participants self-identified as being from various Caribbean countries. Six of the participants migrated to the U.S. over the age of 18 years and two migrated as children before the age of ten. In response to the open-ended question (see Appendix C), the participants self-

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identified their ethnicity using various terms: one identified as Caribbean, two identified as Caribbean American, one identified as African American, one identified as mixed race, two identified as Black, and one as Trinidadian. Five of the participants were between 50 and 59 years old; the remaining three were between 40 and 49 years old. The eight participants were all employed and had differing educational levels. One had a Bachelor's degree; three had a Master's degree; two had doctorate degrees; one had earned a Juris Doctorate; and the final participant had earned her nursing certification. In terms of their experiences with mental healthcare, they either described the length of time that they worked with a mental health professional in number of sessions or according to length of time. Two reported receiving mental health treatment for four sessions; two reported being in treatment for one year; one reported receiving treatment for two years; two reported receiving treatment for one month and the other for three years. Five participants reported that the race of their mental health professional was White, and three reported having received mental health treatment from a Black mental health professional.

Data Analysis Procedures

Firstly, the interviews were completed and transcribed verbatim. Each participant was then asked to review his or her transcript for accuracy. I also kept field notes about any aspect of the interview that targeted the research topic, including any body language or intonation differences that seemed to be relevant at the time. I used my reflective journal as a place to record and articulate my reactions to the research experience. In order to ensure that my opinions, beliefs, and biases were eliminated to the greatest extent possible, I incorporated the concept of bracketing (Creswell, 2007). This both increased the credibility and dependability of the study by reducing my personal thoughts and feelings about the phenomena. I relied on my

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clinical training and professional experience in order to better focus on the phenomena. By focusing on the discussed phenomena, I utilized conformability and described all my observations “as is” and did not try to determine what was important at the time (Miles & Huberman, 2002). Creswell (2013) described this approach as a way to identify the “essence” of the experience—namely, the “what” of participant experiences and “how” they experienced the phenomenon. According to Miles and Huberman (2002), this technique is useful because the researcher does not always immediately recognize what will be useful as the study progresses.

Throughout the entire data analysis process, all interviews, transcripts, and field notes were stored on my password-protected computer. Coding, using the constant comparative method, requires the researcher to attach labels to observations, interactions, and collected materials that were sorted and synthesized in order to identify tentative categories. Miles and Huberman (2002) discussed that choosing a couple of interviews and different coders to review them can reveal new concepts that might not have been evident to a single researcher—in other words, what Creswell (2013) described as unforeseen information that the researcher did not anticipate. Three women who held doctoral degrees and had experience with qualitative research were enlisted to serve as a coding team. Coding teams increase credibility through triangulation. In addition to their research expertise, the women were selected because of their experiences relevant to the focus of the study. One woman was a first generation immigrant to the United States, one woman was an African American, and one woman was a Caucasian American. Each coder reviewed two complete transcripts and identified themes related to the research questions. After reviewing the coders’ ideas, I combined their codes with mine to create themes. According to Janesick (2003), I acted as the “choreographer” of my own “dance” and organized the themes.

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Secondly, I reviewed all the transcribed data several times in their entirety to obtain a better context for the phenomenon being investigated—namely, the lived experiences of BCs who engaged in mental health counseling. Then, following Creswell (2013), I developed an initial list of 25-30 codes, which aids the researcher in interpreting the data and identifying any lessons learned. Further, Bradley, Curry, and Devers (2007) asserted that coding helps the researcher to arrange the data, which will make it easier to identify any connections between the ideas and experiences from the collected data. Once those 25-30 initial codes were established, I began to reduce those codes into 5-6 broad themes (Creswell, 2013). As noted earlier, I incorporated the available codes that the three coders had identified from two interviews and intertwined them with the codes that I had for all the interviews. Once all codes were integrated, I re-read all the codes from the coders and myself to ensure that there were no new patterns. Eventually, distinct themes emerged for each of the three research questions.

Themes from the Interviews

The eight participants who agreed to be interviewed for this study were surprisingly candid as they narrated their lived experiences of being Black Caribbean immigrants who at some point had sought professional mental health treatment in the U.S. Saturation was achieved when the same themes kept occurring in the interviews. Direct quotes (*italicized herein*) are used to share participant voices.

Research Question 1

From Research Question 1 (What are the lived experiences of BC immigrants as they access mental health treatment?), three themes emerged:

1. Black Caribbean immigrants are highly reluctant to seek mental health treatment.

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2. Black Caribbean immigrants are more inclined to seek such services when they have easy access to mental health treatment.
3. Black Caribbean immigrants did not think their presenting issues were related to their culture.

RQ1/Theme 1: Black Caribbean immigrants are highly reluctant to seek mental health treatment. During the recruitment phase of this study, several individuals remarked how Black people, especially Black Caribbean immigrants, do not seek mental health treatment. They added that even if they were “crazy enough” to seek mental health treatment they would not talk to me about it. Some explained that this topic is typically off limits for discussion, and the stigma is simply too much for some of them to deal with, even with a Black Caribbean interviewer. Although the participants participated fully in the study (as evidenced by their sincere responses), their answers highlight how difficult it must have been to share their mental health treatment stories. Several participants in the study also made similar remarks when asked if there was anything about their culture or ethnicity that led them to seek, or prevented them from seeking, treatment. Raphaela stated, “*You know Black people don’t really seek mental health treatment,*” and Irene remarked “*...in our culture we are not used to going to a therapist or getting treatment like that because we are a very strong people.*” One participant even declared that it was “*taboo*” to discuss being in treatment. Similarly, some individuals discussed that people from the Caribbean are strong people; in fact, as Cynthia stated, “*We were told that we have to handle our situations by ourselves.*”

RQ1/Theme 2: Black Caribbean immigrants are more inclined to seek such services when they have easy access to mental health treatment. Fully 50% of this study’s cohort (four out of the eight) only sought mental health treatment because they had easy access to

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services. Specifically, two participants noted that at the time they sought treatment they were in graduate school and it was free; the other two went because their insurance paid for it and there was a mental health professional in close proximity to their residence. An example of the latter instance is Cecilia, who reported that she found someone who was convenient to both her job and her home and who accepted her insurance. Jade stated, “...it was because of my insurance we can easily go and get a list of people.” Five of the participants had insurance, which no doubt played a role in feeling that they had some flexibility with respect to treatment options. It should be noted, however, that one of the insured participants still ended up terminating counseling because he could not find what he was looking for in a counselor. Some of the participants went to treatment because it was either free or affordable because they were graduate students and it was offered through their university’s insurance plan. Bess stated, “*She [her counselor] was a school counselor, and I went because it was free. I think counselors are very expensive, and a lot of people want to go, but they associate it with being expensive so that’s why they don’t go.*” Jaylene reported that when she told her mental health professional that she was in school and had no job at the time, the counselor told her “*not to worry about it but just keep coming.*”

RQ1/Theme 3: Black Caribbean immigrants did not think of their presenting issue was related to their culture. Seven out of eight participants agreed that they did not address their culture in counseling. Alfonzo adamantly stated, “*My issue was my depression when I was going through a divorce, so it had no relation to my culture.*” Similarly, Bess indicated the following: “*I didn’t go to her as a Caribbean woman needing counseling. I came to her as a woman who was trying to find my career path.*” When asked if there was anything about her

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culture or ethnicity that led her to treatment, Jade responded, *“No. It had nothing to do with that. It was basically based on some issues we were going through.”*

Research Question 2

From Research Question 2 (How, if at all, do the views and actions of the counselor address the BC culture and ethnic heritage?), two themes emerged:

1. Some Black Caribbean immigrants felt the counseling effectiveness was related to counselor race and culture.
2. Gender was also important in counselor selection.

RQ2/Theme 1: Some Black Caribbean immigrants felt the counseling effectiveness was related to counselor race and culture. Reflecting on this theme, six of the eight participants felt that the outcome would have been different if the counselor had been of a different race. The quotes above demonstrate the experiences of Cecilia, Bess, and Raphaela in regard to racial identity of the counselor. Raphaela further discussed the advantage of engaging in mental health treatment with an individual with whom she felt some connection:

What happened to me she understood. And that she was also from the Caribbean and goes back there on vacation...she got what I wanted to say to her and didn't ask me to say it again and to translate it to her. That was very helpful.

In addition, Jade described the limited availability of Black Caribbean counselors when she stated, *“If I went to somebody outside of her who can identify with me, the outcome might be different you know because we don't find too many people in that profession.”* Similarly, Alfonzo also shared that he felt things would have been different if the mental health professional had been of a different race: *“I think it would seem likely for me to relate to somebody who was Trinidadian or even a Caribbean professional. I probably would have more*

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likely stayed in counseling or more likely to have discussed more things.” Cynthia also echoed the advantage of engaging with someone from her background who might better understand her mental health needs: *“Yeah, I think it would have been good because it would have probably given her more insight of where I come from and how we people do things.”*

Raphaela discussed how the race of the counselor impacted her when she stated, *“I knew I couldn’t talk to somebody white. I knew somebody white won’t understand my Caribbean perspective, and probably won’t understand my accent.”*

RQ2/Theme 2: Gender was also important in counselor selection.

Four out of the eight participants agreed that the gender of the mental health professional was crucial to success in treatment. Both Jade and Jaylene remarked that if they were to seek mental health treatment for their sons, the counselor would have to be a male—and in particular a Black male. Jade added the variable of ethnicity in her statement about identifying a male mental health provider for her son:

I think it was very important, but I was wondering if maybe I should have gotten him a male from the Caribbean versus a woman even from the Caribbean. Because I don’t know if he would identify better with a male more than a female, and he could express himself more.

Jaylene discussed the gender role when she stated, *“If I were a male person, I probably wouldn’t be seeing her. I would seek out someone more like myself. In that case I would mean a man. That person would have to be black, or at least mixed.”*

As noted, half of the participants felt that gender was important, which means that half did not. Bess was among those who felt that gender was not a critical variable—although she

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herself had worked with a female mental health professional. However, she did discuss gender preferences in the following statement:

If I were referring friends and they were male, I'd say you probably need to get an African American male counselor, because when I'm referring friends, I kind of think they may need somebody who may understand their world a little bit better.

Cynthia reinforced how personally helpful it was for her to see a female mental health professional: *"I was thinking that being Black like myself she would be able to identify with maybe some of the things I was going through, but being female she would definitely be able to identify with some of the things."*

Research Question 3

From Research Question Three (RQ3) (How do BC immigrants experience their culture and ethnicity in the counseling relationship?), the following three themes emerged:

1. Sometimes effective counseling requires changing counselors.
2. Some Black Caribbean immigrants felt poorly understood in counseling.
3. The ability to discuss culture in the counseling session was important.

RQ3/Theme 1: Sometimes effective counseling requires changing counselors. Cecilia reflected this theme in her statement about racial differences in the counseling setting:

That particular treatment I felt wasn't the best and but subsequently I had interaction with mental health professionals who I felt were better, and I think it had something to do honestly with the racial differences in terms of the racial background of the psychologist and myself.

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She recognized that there was a marked difference in her mental health treatment when she changed mental health professionals. Likewise, Bess also remarked on the difference she experienced after changing counselors:

Then she recommended me to go to an African-American woman who she felt would get better movement. We both agreed that maybe that would be a better fit for me. That this woman would understand me a little bit better in growing up in New York with West Indian parents versus her upbringing. [The first therapist] was from the Midwest or something.

Raphaela also made a comparison between her different counselors: “*When working with the good one, she really started asking me to tell her about me and I was able to tell her about my story and emigrating from the Caribbean. I think she had some Caribbean heritage from Jamaica.*”

RQ3/Theme 2: Some Black Caribbean immigrants felt poorly understood in counseling. With respect to Theme 2, five out of the eight participants felt the counselor could not relate to them. Cynthia admitted that her previous therapist recognized that she could not relate to her and referred her to someone whom she believed could connect with her: “*She was the one that noticed that maybe I needed somebody who may be able to relate to my Caribbean-ness better than she was.*” Alfonzo also discussed his counselor not being able to relate to him, even as he identified himself as being only Caribbean:

I don't think he would have understood at all. He had no frame of reference. I'd see him; I would go back and ask him for someone else. I'm not African American, I'm not Caribbean-American. as I identified, there is a big difference.

RQ3/Theme 3: The ability to discuss culture in the counseling session was important. For this theme, five out of the eight participants felt that the ability to discuss culture was important. This factor, in fact, became evident when participants were completing the demographic questionnaire in that they were very specific about the terminology they used to self-identify. For instance, from identifying themselves simply as Trinidadian or just Caribbean highlights how much their culture mattered to them. Cecilia discussed the importance of culture in the following excerpt:

I think it is part of who you are in terms of culture and who I am in terms of immigrant.

In my everyday life I am both a Caribbean and an American. There is a combination, but

I would never say that I am American alone because everywhere I go, you hear my

accent so everyone sees me as Caribbean and I am happy about that.

Even Bess, who was pretty comfortable with her mental health professional and did not target culture as a critical variable, felt it should be considered when seeking mental health treatment:

Now I would look for somebody who at least would know what I'm talking about. My

father's people are from Barbados and my mother's people are from Trinidad. There is

how he was raised versus how my mother was raised and now I'm married to a

Jamaican. I'm way more Caribbean now and would look for that Caribbean flavor.

Whereas, back then I was identifying as being just American, not even Black American.

Summary

Chapter Four details the results of interviews with eight BC immigrants and their lived experiences as they accessed mental health treatment in the U.S. Participants agreed that Black Caribbean people generally do not seek mental health care beyond the confines of family, friends, and church affiliations. They also detailed some experiences they encountered in

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treatment as a BC immigrant. Overall, although seven out of eight participants did not specifically address their cultural background and culture-based needs in counseling, five out of eight of them felt that it was important to do so. Moreover, six out of the eight participants discussed how the outcome of their mental health treatment might have been different if they had connected with a mental health professional who understood their specific cultural background. About half of the participants engaged in counseling because they had access through their insurance policies, as well as located mental health treatment providers that were conveniently located near to their jobs or homes. Participants also discussed the advantages of “gender-fit,” as well as the fact that it was probably disadvantageous to have a counselor who did not understand their Caribbean and immigrant experiences.

The fact that some participants identified with their Caribbean heritage is significant in that it reinforces their cultural ties to their place of birth. Moreover, one participant revealed that while she was growing up she never recognized the difference in races until she migrated to the U.S. So in her case, her identification with American culture did not take hold until she migrated to the U.S. However, with the ubiquitous presence of American culture throughout the world, one’s identification with a new culture is more complex and likely occurs along a continuum that may or may not begin with the act of emigrating.

CHAPTER FIVE

DISCUSSION

The purpose of this study was to examine the lived experiences of a small cohort of BC immigrants who have sought professional mental health counseling services in the United States. Although a review of the literature did uncover a number of studies addressing the counseling experiences of African Americans, by comparison there is a distinct paucity of research about Black Caribbean immigrant and mental health treatment. Indeed, most of the available scholarly reports have lumped Black Caribbean immigrants who have sought mental health treatment together with African Americans and other individuals with “Black” features (Broman et al., 2008). However, BC immigrants present distinct cultural needs that have not been adequately studied in counseling research (Baptiste et al., 1997; Joe et al., 2006). Therefore, this study sought to address this scholarly gap by exploring the lived experiences of BC immigrants who accessed mental health treatment in the U.S. by investigating and describing the essence of their lived mental health treatment experiences through their stories.

Using semi-structured interviews, I interviewed eight BC immigrants who had accessed mental health treatment in the U.S. This study was guided by the following research questions:

- 1) What are the lived experiences of BC immigrants as they access mental health treatment?
- 2) How, if at all, do the views and actions of the counselor address the BC cultural and ethnic heritage?
- 3) How do BC immigrants experience their culture and ethnicity in the counseling relationship?

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A purposeful sampling of eight BC immigrants from Guyana, and Trinidad and Tobago who had accessed mental health treatment in the Washington DC and New York metropolitan areas participated in the study. It should be noted that the duration of their clinical treatment ranged from one month to three years.

The analysis of the interviews resulted in eight themes. This chapter will synthesize the findings from this study and present clinical implications for BC immigrants seeking mental health counseling, as well as implications for the training, supervision, and clinical approaches of counselors and mental health professionals. Finally, this chapter will discuss some study limitations and make suggestions for future research.

A Synthesis of the Results

Six of the eight themes point to compelling information about this sub-population of Blacks living in the U.S. and their mental health experiences. These themes are detailed in the below.

Theme 1: Black Caribbean immigrants are highly reluctant to seek mental health treatment. This study's findings support available literature that Blacks born in the U.S. are more likely to access mental health treatment in comparison to BC immigrants who migrated to the U.S. (Jackson et al., 2007). This can in part be attributed to the fact that BC immigrants tend to have negative perceptions and beliefs about mental health treatment (Bailey et al., 2010), which reflects deeply-ingrained beliefs that those receiving treatment are, to some extent, "mad." This stigma and negative stereotype associated with mental health treatment was evident in some of the interviews. Seeking mental health treatment was considered "a taboo" (Cynthia) because people of Caribbean descent do not really pursue mental health treatment (Raphaella)—and if they do they are afraid to discuss it with others (Cecilia). In short, seeking mental treatment is

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still seen as something that is not accepted in BC society and should not really be discussed with anyone. In fact, Raphaela was told by her close friends and family that if she was experiencing a problem, that she should discuss it with her church pastors and seek help within that framework. Indeed, this is a theme that tends to be common among both BC immigrants and African Americans—that one's church is a more acceptable place to discuss one's issues in comparison to professional mental health treatment options. According to Gopaul-McNicol (1998), psychological problems are considered internal and should be kept within the family and only discussed with religious/spiritual leaders.

Theme 3: Black Caribbean immigrants do not believe that their presenting issue (or issues) can be tied to their culture. It was clear from the interviews that although each of the participants expressed a sense of pride in their Caribbean identity, seven out of eight of them did not address their Caribbean identity in counseling. Indeed, some participants felt that seeking counseling had nothing to do with their ethnicity (Bess); rather, they just wanted a safe place where they could voice their problems and have someone listen to them. Some participants in fact were adamant about disconnecting their mental health treatment with their culture. When asked if there was anything about her culture or ethnicity that led her to seek treatment, Jade asserted: *"It has nothing to do with my ethnicity or culture. It was basically based on my son and the issues he was going through."* It should be noted, however, that after the interview she remarked that she never thought about if and how her culture had influence her counseling experiences until now. She added that participating in the interview made her realize that it might have played a role, but she never put the two together until that point.

Theme 4: Sometimes effective counseling requires changing counselors. Two of the participants changed counselors on their own when they realized that their specific therapeutic

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needs were not being met. In fact, one woman asked her counselor to refer her to another counselor who might be a better fit for her. The two participants who changed counselors agreed that they were not being understood and felt that the counselor could not relate to them.

Specifically, Raphaela noted that she often had to repeat herself because her counselor could not understand her accent. More importantly, both women voiced feelings of being misunderstood because their counselors could not fully relate to their perspectives. Cecilia remarked, *“She was just looking at it basically from her American perspective.”* After unfavorable initial experiences in counseling, they both came to the conclusion that they needed someone who could more fully understand their unique cultural needs, as well as be more aware that those needs were tied to specific cultural influences. Raphaela affirmed this perspective when she discussed her second counseling experience: *“American people have different values about life. I wanted somebody who understood that as well.”*

Theme 5: Some Black Caribbean immigrants believe that counseling effectiveness is related to counselor race and culture. Although participants were somewhat split as to whether the outcome of their mental health treatment would have been different if the counselor had been of a different race, findings do indicate that cultural symmetry does enhance the counseling experience. Jaylene, who had a Caucasian counselor, felt that she had a good experience in counseling, as evidenced by her statement that she felt “supported” and “her issues were addressed.” Similarly, Bess stated that even though her Caucasian counselor was from the Midwest, she did make an attempt to understand Bess’s cultural background and those specific influences. In the end, however, that particular counselor recognized that she could not help her and referred her to an AA counselor who could better understand her needs. Among the four participants who voiced that the outcome would have been different had the counselor not been

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Caucasian. Alfonzo stated that if he had to do it over again he would ask for a mental health professional with a Caribbean background. Similarly, Cecilia remarked,

Having someone understand that your culture is who you are and everything you say, how your thoughts is, and how you interact with individuals. When you're walking you say "good morning" versus you say hi or what's up. You know so all the interaction has to do with your culture, so start there and you have a good shot to getting to individuals.

Similarly, Jade revealed after the interview that she had not considered how much more effective the counseling relationship could have been if she had engaged with a clinician with a Caribbean background.

Theme 7: Gender is also important in counselor selection. This theme reflects how men and women tend to view mental health treatment differently. Echoing the findings of Butterfield (2004), this study's findings reinforced that women and men rely on different coping strategies on how to handle life's challenging issues. Moreover, although a few of the participants were not adamant about the gender of their counselor, most did agree that when it came to males, they believed that a male client would have a better counseling experience with a male counselor—and preferably a Black male counselor. This finding supports the literature that men may view counseling differently—that they don't just need someone to listen to them, they need someone who has directly experienced their issues or at the very least can relate to their specific needs (Vogel et al., 2007).

Theme 8: The ability to discuss culture in the counseling session is important.

Even though seven of the eight participants agreed in principle that culture was important to discuss in their counseling sessions, most did not actually raise their Black Caribbean heritage and influences as an issue. In fact, it appeared that they purposefully did not want to bring their

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culture into the counseling relationship. However, they did agree that understanding their BC values and language was important in feeling understood by the counselor. Black Caribbean culture carries with it so much pride, that some of the participants appeared not to want to draw that concept into the counseling equation. Moreover, the notion of “BC pride” appeared to be so embedded in all of the participants, that they really had not considered that influence until the interview. And this appeared to be the case no matter what age they migrated.

Limitations of the Study

There are several limitations to this investigation that must be discussed. First, due to a small selection of participants who were purposefully sampled from the Washington D.C. and New York areas, the results of this study cannot be generalized to all BC immigrants seeking mental health in the U.S. This is not to say, however, that the findings detailed herein will not be useful in future research involving a wider population of BC immigrants and how they experience and view mental health treatment options. Indeed, this qualitative study has revealed the lived experiences of a small, targeted population of BC immigrants receiving mental health treatment—but whose experiences are likely to resonate with other BCs regardless of where they live.

Another limitation of this study is that the findings detailed herein are based on participants’ self-reported experiences. The fear and stigma associated with mental health treatment might have influenced some of their responses in that they were cautious and measured in what they discussed. Because each revealed socially undesirable experiences, it seems that the participants were at least somewhat open and candid throughout the interview. Because many of the individuals invited to participate were too reluctant to do so, it must be acknowledged that their stories could be different from those who were willing to participate.

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An additional limitation of this study is the lack of male participants in the sample—seven of the eight individuals who agreed to take part in this invitation were female. Although I attempted to recruit a balanced sample, I had anticipated this likelihood since in general women utilize mental health services more than men (Vogel et al., 2007). This limitation represents a persistent problem in studies targeting mental health treatment utilization, as evidenced by the fact that many of the men recruited did not want to be identified or admit that they received mental health treatment. Moreover, several of the female participants reinforced this issue in that it would be especially difficult for Caribbean males to self-disclose in this way—in part due to the issue of ethnic and gender pride.

The educational level of the participants represents another significant limitation of this study in that only one participant was not in possession of a graduate degree. In other words, their advanced level of education may have influenced the likelihood of them seeking mental health treatment—not to mention their willingness to discuss their experiences. As such, their experiences cannot be considered to be representative of the majority of the Black Caribbean population.

A final limitation of this qualitative study is the use of semi-structured interviews. In other words, an open-ended question will inevitably guide a participant's responses to some degree. Although I structured each question carefully and encouraged follow-up discussion, a subsequent study should be designed to include more informal interviewing, which would have allowed the participants to go more in-depth with their responses about their lived experiences.

Implications

This investigation revealed that BC immigrants in mental health treatment want the option to discuss their Caribbean identity in counseling; moreover, they expect their mental

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health professional to understand their unique cultural needs, including for example, a deep reluctance to engage in counseling. In many cases the participants in the study discussed the negative impact of a clinician's lack of knowledge about their culture and the effects that could have on the counseling relationship. This section will address the importance of culturally-appropriate counselors to work with the BC immigrant population. Given that this ethnic group continues to grow in both urban and suburban areas of the U.S, this section will also address (1) strategies that clinicians should consider as they work within this population, and (2) some suggestions for BC immigrants who currently are in mental health treatment (as well as those who want to access it).

Counselors and Counselor Educators

Counselors and other mental health professionals inevitably bring their own beliefs, perceptions, and therapeutic training into the counseling relationship. In order to reduce bias and sociocultural/ethnic stereotypes, however, mental health clinicians are required to undergo diversity and multicultural training in order to better serve their diverse clientele. The AMCD and the ACA Code of Ethics (2014) both require counselor educators to provide culturally aware training opportunities. As issues pertaining to multiculturalism continue to unfold and expand, Day-Vines et al. (2007) asserted that factors such as race, ethnicity and culture should be addressed in order to strengthen the counseling relationship. Raphaela's account of her counselor inviting her to describe her immigration experience models the broaching of cultural differences that Day-Vines and colleagues suggested.

This study's findings reinforce the importance of assisting and advising mental health professionals with respect to encouraging a BC immigrant to discuss his or her culture or ethnic heritage in counseling. It also highlights the fact that counselors who are African-American also

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need to work to understand the BC immigrant culture despite shared skin color or other physical traits. Training opportunities for African American counseling and other minority counseling should also be inclusive of the within-race ethnic differences—in this case those pertaining to Black Caribbean immigrants. All mental health professionals, including school counselors, should acknowledge and recognize the psychological importance for a client to be able to openly discuss his or her unique cultural/ethnic identity. When clients feel safe to discuss their concerns, as well as how those concerns may be impacted by cultural influences and heritage, they are much more likely to have a positive counseling experience.

It would also be helpful for counselors and counselor educators to detail in their professional biography and/or practice details any information about their Caribbean heritage, or more importantly, any experience they may have working with the Black Caribbean population. For instance, clinicians should be encouraged to provide a description of their clinical experience and approaches to working with Caribbean immigrants. Any information pointing to both an interest in Caribbean culture, as well as some sensitivity with respect to counseling this population, would essentially be a win-win for both counselor and client. Such information would be particularly helpful for clients who have not experienced counseling before, and this would be essential to getting them through the counselor's door and into the capable hands of someone who is more likely to relate to them and their issues.

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BC immigrants are more likely to seek mental health treatment when they have ready access to services and it is affordable to them. This literature also indicates that BC immigrants are more open to pursuing mental health treatment the longer they live in the U.S.; this option is also impacted by the age at which they migrated to the U.S. (Jackson et al., 2007). This finding

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indicates that acculturation/socialization and access to mental health services are positive factors in them seeking counseling.

BC immigrants who are fortunate to have insurance coverage for mental health counseling should be encouraged to research the mental health providers offered by their plan to see if it will be a good fit prior to engaging that individual. As some of the participants indicated, they sought treatment through their schools or community centers because the suggested providers were free or low cost. BC immigrants need to “do their homework” and identify a counselor with whom they can connect. For instance, most community centers that serve Caribbean immigrants are likely to be able to provide assistance with identifying capable health providers (Bashi, 2007; Taylor & Chatters, 2010). Additionally, some churches and non-profit agencies also provide financial assistance and affordable counseling options to the BC community (Mitchell & Bryan, 2007). In short, BC immigrants should explore all options in order to secure the help they need.

This study also reinforces the fact that most counselors and mental health professionals in the U.S. are not Black—and only a small portion of those who are Black have Caribbean descent. Thus, it is unrealistic to assume that finding a Black therapist will automatically guarantee awareness about Black Caribbean culture. As such, it is essential to encourage an individual in need of mental health services to seek a counselor who has some knowledge of Black Caribbean culture and is willing to broach the topic in counseling.

The eight participants in this study who sought mental health treatment were all successful, well-educated BC immigrants. They engaged in counseling despite the prevailing stigma within the BC community that mental health problems should stay within the family or church setting and not be discussed with “strangers.” All found the counseling experience to be

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beneficial to them. The more mental health treatment is discussed within the BC community—and BC immigrants acknowledge that they have sought and benefited from mental health treatment—the more likely it will help to break down the negativity and the stigma associated with seeking assistance from a professional counselor.

Future Research

Given the marked lack of scholarly reports about the experiences of BC immigrants in counseling, future research is needed to determine the issues that hinder or enhance mental health treatment for this growing ethnic population. Due to limited published reports and few available dissertations on BC immigrants, studies should be designed to explore how BC immigrants conceptualize mental health treatment, what influences them to seek treatment, and what prevents them from availing themselves of such services even when they are affordable and easily accessed. It would be worthwhile to explore mental health treatment trends in society and at what point BC immigrants decide to seek treatment. Additionally, the impact of BC immigrants' age at migration and the length of time in the U.S. represent important factors that should be explored in terms of their relation to seeking and remaining in treatment.

The results of this study also confirm that BC immigrants *want* to talk about their culture in counseling and thus should be encouraged to do so. Future studies should also examine if existing professional mental health training opportunities and educational degree programs are doing enough to be inclusive of the unique needs of BC immigrants and other ethnic minorities (e.g., Native Americans). As difficult as it can be to recruit participants for studies involving highly personal mental health counseling experiences, more qualitative and quantitative research is needed (perhaps involving longitudinal studies) to explore the influence of race and ethnic identity in mental health treatment.

Summary

The varied experiences of these Black Caribbean immigrants who sought mental health treatment in the US informed important implications for counselors, counselor educators, and BC immigrants. Counselors and Counselor Educators can increase the likelihood that BCs will seek their services and feel understood in their care, if they make clear their interest and knowledge in Black Caribbean culture. Professional training opportunities and degree programs that are more inclusive of the needs of growing ethnic populations in the U.S. are essential. Black Caribbean immigrants who are considering mental health counseling can feel encouraged by the positive experience of these peers, so bravely shared in this study. They may feel more confident if they explore local mental health resources and find a counselor who can understand their Black Caribbean identity. Reducing the stigma associated with seeking treatment may encourage others to take advantage of potentially helpful source of support.

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Appendix A
Interview Protocol

Participant Pseudonym: _____

Let me begin by thanking you for taking the time to speak with me about your experiences in the United States, including your experience with accessing mental health treatment. Before proceeding with the interview, the IRB requires all research participants to sign a consent form indicating consent to participate in this study. Additionally, it provides you with contact information if you have any questions or comments about the study. *(Give participant the forms. Go through the different sections, answer any questions, and participant will sign the consent form and fill out the pseudonym sheet).*
Proceed with demographic questions.

Demographic Questions

What Caribbean island do you self-identify with? _____

What is your gender? _____

How do you racially and ethnically identify yourself? e.g. African American, Caribbean American _____

At what age did you immigrate to the U.S.? _____

What is your age?
____ 21-29 ____ 30-39 ____ 40-49 ____ 50-59 ____ 60-69 ____ 70 and over

What is the highest level of education you completed? _____

Are you currently employed? _____

How long have you worked with this Mental Health professional? _____

What is/was the race/ethnicity of the Mental Health professional? _____

Appendix B

Informed Consent Form

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY

Informed Consent Form for Participants

in Research Projects Involving Human Subjects

Title of Project: Black Caribbean Immigrants and mental health treatment.

Introduction: My name is Heather Venner. I am currently pursuing my doctoral degree at Virginia Tech and I am the primary investigator in this study. Dr. Laura Welfare, Ph.D., LPC, , and a faculty member in the Department of Counselor Education will supervise this study. This form is intended to provide you with information to decide if you would or would not like to participate in this study.

Description of the Study: I am inviting you to participate because you meet the criteria of being a Black Caribbean immigrant that has received mental health treatment in the U.S. The purpose of this study is to increase counselors' understanding of the experiences of Black Caribbean immigrants in counseling. If you agree to participate, you will participate in one interview. The interview will be conducted face-to-face. The initial interview will last approximately 60-90 minutes in length and will be audio-recorded. All audiotapes will be destroyed after completion of this study.

Potential Risks of Discomfort: Due to the nature of this study, there are no identifiable risks to participants. All aspects of participation are voluntary and you as a participant can choose to conclude the interview at any point. If you would like to discuss these concerns and any other potential discomforts, you may contact my chair, Dr. Laura Welfare, the current IRB chair at Virginia Tech, Dr David M. Moore, or myself.

Heather Venner
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Counselor Education
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Black Caribbean Immigrants

welfare@vt.edu

Dr. David M. Moore
VT IRB Chair
Board for the Protection of Human Subjects
Office of Research Compliance
2000 Kraft Drive, Suite 2000 (0497)
Blacksburg, VA 24060
(540) 231-4991
moored@vt.edu

Potential Benefits to You or Others: The results of this study could be used to enhance the mental health and counseling relationship with people of Black Caribbean descent. No promise or guarantee of benefits has been made to encourage you to participate.

Alternative Procedures: There are no alternative procedures. Your participation is voluntary and you may withdraw consent and terminate participation at any point without consequence.

Protection of Confidentiality: Your name and all affiliations will be kept confidential at all times. Pseudonyms will be given for participants. The researcher will transcribe all audiotapes and all tapes will be destroyed five years after the completion of the study. At no time will the researchers release identifiable results of the study to anyone other than individuals working on the project without your written consent. The signed consent forms, audiotapes, interview transcripts, and any other materials related to this study will be maintained in a secure and confidential lockbox and kept by Heather Venner, the primary investigator and destroyed five years after the completion of the study.

The Virginia Tech (VT) Institutional Review Board (IRB) may view the study's data for auditing purposes. The IRB is responsible for the oversight of the protection of human subjects involved in research.

Voluntary Participation: Your participation in this study is completely voluntary. You have the right to withdraw from the study at any time. Throughout the interviews, you have the right to answer or not answer any questions. Even if you decide to participate and withdraw later, any comments you made will not be used in the study and will be destroyed.

Freedom to Withdraw: It is important for you to know that you are free to withdraw from this study at any time without penalty. You are free not to answer any questions that you choose or respond to what is being asked of you without penalty.

Please note that there may be circumstances under which the investigator may determine that a subject should not continue as a subject.

Questions or Concerns: Should you have any questions about this study, you may contact one of the research investigators, or the IRB Chair whose contact information is included at the beginning of this document.

Black Caribbean Immigrants

Subject's Consent:

I have read the Consent Form and conditions of this project. I have had all my questions answered. I will be given a complete copy of the signed Informed consent. I hereby acknowledge the above and give my voluntary consent:

Subject signature

Date_____

Subject printed name

Appendix C

Semi-Structured Interview

Introduction

As discussed earlier, this interview is about Black Caribbean immigrants and their experiences receiving mental health treatment in the U.S. Participation in this study is completely voluntary and you are free to withdraw or stop participating at any time, free of consequences. There are no right or wrong answers; I am just recording your experience. If any question becomes too difficult, you have the option not to answer. If you choose, we can come back to any questions that you choose not to discuss at this time. This interview will be audio recorded and transcribed, but your responses will only be viewed and analyzed by the researcher, coders, the transcriptionist and committee members and will be kept on a password protected computer. Do you have any questions before we begin?

Questions and Probes

1. Tell me about when you first went to Mental Health treatment?

Probe: What were the factors that prompted you to seek mental health treatment?

2. Was there anything about your culture/ethnicity that lead you to seek treatment?
3. How would you describe your mental health treatment experiences here in the U.S.?
4. Did the counselor address how your culture or ethnic identity impacts your daily life?

Probe: If so, when and how did they discuss it?

Probe: Did you address it or did the counselor broach it with you?

5. Did you address or discuss any part of your BC immigrant experience in counseling? Why or why not?
6. How well, if at all, do you think your counselor understood your culture and ethnic identity?
7. Would you say your culture and immigrant experience were important to discuss in counseling?
8. Do you think you are getting your most important needs addressed in counseling?

Black Caribbean Immigrants

Probe: Which needs are not getting addressed?

9. Was the counselor's race or culture important to your choice of treatment?

Probe: Was the counselor's race or cultural background a factor in you staying in treatment?

10. Do you think you had an option for the kind of mental health treatment you were seeking?

Probe: If you had a choice, what type of mental health treatment would you choose?

Thank you for your time and sharing your experiences with me. It has been great speaking with you. A copy of the transcript of this interview will be given to you once it has been transcribed. You are welcome to make any changes or additions at this point, and do not hesitate to contact me with questions or concerns at any time during this study.

Appendix D

Recruitment script

My name is Heather Venner. I am currently pursuing my doctoral degree at Virginia Tech and I am the primary investigator in this study. Dr. Laura Welfare, Ph.D., LPC, and a faculty member in the Department of Counselor Education will supervise this study. This form is intended to provide you with information to decide if you would or would not like to participate in this study.

The purpose of this study is to increase counselors' understanding of the experiences of Black Caribbean immigrants in counseling. Participation is totally voluntary and if you agree to participate, you will participate in one initial interview. You can choose to withdraw at anytime from the study and none of your information will be used. The interview will be conducted face-to-face at a time and place that is convenient to you. The initial interview will last approximately 60-90 minutes in length and will be audio-recorded. All audiotapes will be destroyed after completion of this study.

The results of this study will be used for dissertation purposes and later publication purposes. If you would like to participate, please feel free to contact me at my confidential voicemail at 240-643-5706.

Appendix E



Office of Research Compliance
Institutional Review Board
North End Center, Suite 4120, Virginia Tech
300 Turner Street NW
Blacksburg, Virginia 24061
540/231-4808 Fax 540/231-0950
email irb@vt.edu
website <http://www.irb.vt.edu>

MEMORANDUM

DATE: May 26, 2015
TO: Laura Everhart Welfare
FROM: Virginia Tech Institutional Review Board (FWA00000572, expires April 25, 2016)
PROTOCOL TITLE: Challenging Mental Health Issues among Black Caribbean Immigrants
IRB NUMBER: 15-538

Effective May 26, 2015, the Virginia Tech Institutional Review Board (IRB) Chair, David M Moore, approved the New Application request for the above-mentioned research protocol.

This approval provides permission to begin the human subject activities outlined in the IRB-approved protocol and supporting documents.

Plans to deviate from the approved protocol and/or supporting documents must be submitted to the IRB as an amendment request and approved by the IRB prior to the implementation of any changes, regardless of how minor, except where necessary to eliminate apparent immediate hazards to the subjects. Report within 5 business days to the IRB any injuries or other unanticipated or adverse events involving risks or harms to human research subjects or others.

All investigators (listed above) are required to comply with the researcher requirements outlined at:

<http://www.irb.vt.edu/pages/responsibilities.htm>

(Please review responsibilities before the commencement of your research.)

PROTOCOL INFORMATION:

Approved As: **Expedited, under 45 CFR 46.110 category(ies) 6,7**
Protocol Approval Date: **May 26, 2015**
Protocol Expiration Date: **May 25, 2016**
Continuing Review Due Date*: **May 11, 2016**

*Date a Continuing Review application is due to the IRB office if human subject activities covered under this protocol, including data analysis, are to continue beyond the Protocol Expiration Date.

FEDERALLY FUNDED RESEARCH REQUIREMENTS:

Per federal regulations, 45 CFR 46.103(f), the IRB is required to compare all federally funded grant proposals/work statements to the IRB protocol(s) which cover the human research activities included in the proposal / work statement before funds are released. Note that this requirement does not apply to Exempt and Interim IRB protocols, or grants for which VT is not the primary awardee.

The table on the following page indicates whether grant proposals are related to this IRB protocol, and which of the listed proposals, if any, have been compared to this IRB protocol, if required.

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An equal opportunity, affirmative action institution

Appendix F

Screening questions – To identify participants

I would like to have your verbal consent to ask you the following screening questions.

The following is the criteria that is needed to meet the requirement to participate in the study:

1. Are you a Black Caribbean Immigrant?
2. Are you over the age of 18 years?
3. Have you ever had mental health counseling in the United States?

Please know that this screening data will not be used in the research data set if you are not eligible for the study, and it will be discarded after the screening.

Thank you.