Mental Health: The Caribbean Immigrant Experience

Hope M. Shaw, MSN, RN, CNOR
Barry University, Miami, Florida

Abstract: In a multicultural environment like the United States, the United Kingdom, and Canada, mental health-care system must serve the needs of increasingly diverse populations. Today, there is much discussion around the concept of "global" mental health. This movement has stimulated a countermovement, proposing that mental health is a local matter and that systems for promoting mental health must take on board the traditions of local communities and what they want from health.

Keywords: Caribbean; ethics; mental health; immigration; nursing

The Caribbean region consists of 30 island countries as well as the South and Central American countries of Guyana and Belize and has an estimated total population of 42million. In 2000, the U.S. Department of Justice Immigration and Naturalization services estimated that there were 4million Caribbean immigrants living in the United States (Griffith & Grolnick, 2014). Although nations of the Anglophone Caribbean share some factors such as the history of colonization and slavery, there are differences in terms of culture and economic development, which makes it difficult to extrapolate from one country to another (Arthur et al., 2010). Similarly, Gibbs et al. (2013) posited that Caribbean Blacks and African Americans may share a racial identity and African origin, but they differ in ethnicity, culture, environmental exposures, educational attainment, economic status, and physical health.

In a multicultural environment like the United States, the United Kingdom, and Canada, mental health-care system must serve the needs of increasingly diverse populations (Fernando, 2012). The Brain and Behavior Research Foundation estimated that 26.2% of Americans or one in four adults aged 18 years and older suffers from one or more of the following mental disorders: attention deficit hyperactivity disorder, anxiety, autism, bipolar disorder, obsessive–compulsive disorder, posttraumatic stress disorder, schizophrenia, and other illnesses (Youssef et al., 2014). Who gets counted, and does everyone (legal or illegal) have a right to mental health care? Immigration status versus entitlement may relay the difference in mental health outcomes for individuals, families, and communities. Mental as well as physical health conditions are projected to become the leading cause of disease burden and mortality, respectively, in the world by 2030 (Pilgrim & Blum, 2012). People migrating from the Caribbean (English, French, and Spanish speaking) to the United States will need to access mental health resources thereby adding to the disease burden (Figure 1).

Mental Health and Disparities

Woodward, Taylor, Abelson, and Matusko (2013) reported that Blacks for the Caribbean make up the largest Black ethnic subgroup in the United States. The number of Black Caribbean immigrants in the

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Figure 1. Islands in and near the Caribbean Sea (Map of the Caribbean Sea and Islands, n.d.).

U.S. population numbered 1.5 million in 2000 and over 3 million in 2011. Heterogeneity and inequalities within the Caribbean immigrant population cannot be ignored. Theoretical and empirical evidence shows that Whites' physical health surpasses those of Blacks. Conversely, national epidemiological studies with household samples have consistently suggested that Blacks have better mental health than the more socially advantaged majority (Lo, Cheng, & Howell, 2014). According to this study (Lo et al., 2014), the minority exhibits worse physical yet better mental health or lower rates of psychiatric disorder than the more socially advantaged majority is a paradox characterizing racial health disparities. Lo et al. (2014) contend that explanation for this paradox has been attributed to strong religious commitment, expansive social network, and high resilience. However, Lo et al. (2014) articulate that social disadvantage generates hardship and stress, leaving individuals of low social status susceptible to physical and mental ailments and deteriorating overall health. Health and inequality have been researched; but reports on Caribbean immigrants are not always differentiated from the African American population.

A retrospective mixed method study (Earl et al., 2015) was conducted to examine racial/ethnic differences in endorsement and attribution of psychotic-like symptoms in a nationally representative sample of African Americans, Asians, Caribbean Blacks, and Latinos living in the United States. Complex patterns seem to emerge regarding the mental health status of Black Americans with varying patterns for indicators of mental health. The results of the study indicated dubious concern for biases in the diagnosis of psychiatric disorders for Black patients compared to Whites and other ethnic minorities (Earl et al., 2015). In view of this, the notion of disparity in diagnosis and treatment needs further probing. Similarly, Maranzan (2016) articulates that real-world discrimination of persons with mental illness is well documented. Reports include inequities in hiring, housing, and false charges for offenses.

Yorke, Voisin, and Baptiste (2016) contend that compared to native-born Americans, immigrants, especially racial/ethnic minorities, tend to have more mental health problems, are less likely to have a personal physician or medical insurance, have lower knowledge of available social services, and when they become aware of such services are more reluctant to use them. Ellis (2012) posits that pervasiveness of mental health disparities is well documented in the United States. This led to a request by Congress that the Institute of Medicine investigates the extent to which disparities were influencing the quality of services received by racial and ethnic minorities in the United States (Ellis, 2012).

The Institute of Medicine (IOM, 2002) report confirmed that racial and ethnic minorities receive lower quality health care than Whites, and even when they have the ability to pay, there is still unequal treatment. The report (IOM, 2002) also concluded that although myriad sources contribute to

these disparities, some evidence suggests that bias, prejudice, and stereotyping on the part of health-care providers may contribute to differences in care. Furthermore, IOM (2002) articulates that if health-care providers are sworn to beneficence and cannot by law discriminate against a patient on the basis of race, ethnicity, color, or national origin, how could bias, prejudice, and stereotyping contribute to unequal treatment?

Policy and practice are evident dichotomies in health, access, and treatment for minorities compared to Whites. Nevertheless, the United States must still traverse the political morass of immigration and rights, and health-care providers are tasked with the notion of culturally competent care. Curtis, Bultas, and Green (2016) posit the United States Census Bureau projecting in 2014 that if the current growth rate continues, the nation will be more racially and ethnically diverse. Minorities will comprise more than half of all children increasing from 48% in 2014 to 64.4% in 2060. Caring for an ethnically diverse population will not be a choice but a reality.

All individuals have a culture that needs to be recognized; thus, it is important for health professionals to be prepared to care for patients who are diverse (Curtis et al., 2016). Some of the governing bodies and regulatory bodies in nursing have invoked action. In 2008, the American Association of Colleges of Nursing implemented their new "Essentials of Baccalaureate Education for Professional Nursing Practice," which mandated teaching cultural competence. The National League for Nursing also called for a commitment for diversity to nursing education and the Joint Commission now requires health-care institutions provide evidence that they are providing cultural competent care (Curtis et al., 2016). It would appear that organizational framework and processes would eliminate inequalities, but evidence from the literature (Curtis et al., 2016; Ellis, 2012; IOM, 2002) elucidates another experience.

In 2013, only one national study (Ellis, 2012) examined differences in psychiatric disorders among African Americans, Caribbean Blacks, and non-Hispanic Whites. Ellis (2012) articulates that underreporting of Afro-Caribbean individuals in mental health data is rooted in culture-bound taboos as well as ignorance with respect to health, illness, and symptomatology. There was also the tendency Ellis (2012) posit to list Afro-Caribbean and African American as a homogenous group with respect to ethnicity. Nevertheless, Caribbean immigrants with their different histories and experiences must be viewed as subgroups. This sociological perspective indicates that a wide range of factors influence people's mental health and illness: age, gender, family and peer relations, communities, physical environment, and social determinants related to policies, equity, human rights, and globalization (Hilario, Oliffe, Wong, Browne, & Johnson, 2015). These factors validate the need for further discussion on health and illness among Caribbean immigrants as separate heterogeneity samples. This article aims to present a discourse on the Caribbean immigrant in the context of mental health, and ethical issues that may post-conflict in clinical nursing practice and research.

Ethical Issues and Dilemma

Health reform and policy have occupied the political agenda in the United States for decades. The fact that a first-world country cannot provide adequate health care for all residents and citizens sometimes puzzles the world stage. However, inherent in the demand for complete coverage for all is the inundated immigrant population and the debate on their right to health care. A review of the literature (Ellis, 2012, 2015) revealed a myriad of issues that Caribbean immigrants experience in a new culture: stereotype threat, prejudice, stigma, discrimination, identity conflict, separation from family and home country, and adjustment to a new life in the United States. McLeod (2015) supports the notion of a comprehensive analysis of the structural context of people's lives to understand how inequality is produced, maintained, and resisted. Because poor mental health is seen as a consequence of disadvantage, there is an inclination to develop ways to mitigate the damage. While some elements of this sociological process are still not completely understood, there are components that we know.

Accept that racism is ordinary or choose to challenge the walls of material determinism where moral, cultural, intellectual, and vocational choices are determined by human beings. McLeod (2015) postulated that systems of social stratification are most widely recognized in the United States, enabling greater access to resources for those with greater knowledge, power, and prestige. Furthermore, Caribbean immigrants living in the United States are at a disadvantage in a new social system that the immigrant does not understand, void of power, and dreams of prestige. This article does not aim to state the experiential context but will present arguments from empirical studies, sug-

gesting that the mental health of the Caribbean immigrant is contingent on sociological issues, and important questions remain regarding the mental health of Blacks in the United States in general and the Caribbean immigrant in particular (Gibbs et al., 2013).

Acculturation, Health Beliefs, and Practice

Archibald and Rhodd (2013) described acculturation as the psychological, behavioral adaptation that occurs when two cultures meet as a result of people migrating. It is well documented that immigrants from developing countries are in the United States to improve opportunities for themselves and for their families. When immigrants arrive in the United States, they are confronted with many psychosocial forces that alter the acculturation process (Archibald & Rhodd, 2013). These forces support the stress process framework, and it remains a dominant paradigm for mental health (McLeod, 2015). Why would this cause a dilemma in nursing practice and research? Nurses have to face numerous ethical challenges in daily practice, and cultural competence is one of many professional responsibilities.

On the one hand, Caribbean immigrants have a basic human right to be treated within the uniqueness of their culture. On the other hand, health-care practitioners and systems are tasked with expanding resources to meet preexisting and prevailing stressors that affect the mental health of immigrant groups. Health beliefs and practices influenced by religion and culture compete with cultural norms in the host country. Yorke et al. (2016) articulate that Caribbean immigrant groups tend not to use mental health services because of their reliance on family to deal with problems. The authors (Yorke et al., 2016) also suggest that Caribbean immigrants appear to hold the belief that the family shares the responsibility for the individual's problems, and that mental illness is best treated within the family. This is relevant to health-care system and Caribbean immigrants because culturally determined views about mental health and illness may influence care-seeking behavior. Yorke et al. (2016) further contend that the cultural viewpoint of family sharing the responsibility persists in many parts of the Caribbean and may still be present as immigrants restructure social and family relations in the United States.

Immigration Status

Many Caribbean immigrants who enter the United States undocumented or without financial support live in substandard communities, and some immigrants are taking on risky behavior to gain immigration security (Archibald & Rhodd, 2013). The issues of incarceration, HIV, sexually transmitted disease (STD), and living in a foreign country undocumented present a dilemma for mental health care. Practitioners are faced with how, when, why, and should the Caribbean immigrant get similar treatment as the American-born. The concept of identity and discrimination is also compounded by immigration status, relating to inequity in resources for mental health. Should an already limited mental health resource in the United States also serve the needs of the undocumented and incarcerated? Furthermore, what of the legal residents who have not yet obtained the status of U.S. citizens?

Health Policy and Mental Health

African Americans and Hispanics generally have poorer access to and lower quality of health, live in areas with fewer collective resources, higher rates of poverty, and lower levels of health-care supply (Caldwell, Ford, Wallace, Wang, & Takahashi, 2016). With insufficient evidence of the various Caribbean ethnic numbers, it is presumed that documented Caribbean immigrants are underreported in the African American and Hispanic populations.

Inherent in this inequality in reporting compared with White Americans are racial and ethnic disparities in access and receipt of quality mental health care, which are policy challenges (Caldwell et al., 2016). There is one argument that the United States has no responsibility to change policy to accommodate an immigrant group. Conversely, the deleterious effect on the population may surpass obligation. Furthermore, are these immigrants entitled to equal mental health services as their American-born counterpart? Changing the mental health legislation and policy framework to provide equal access for everyone would be a remarkable feat for the government.

Support for Culturally Competent Mental Health Care

Professional ethics is related to the conduct of a given profession engaged in practice. Nurses have a professional duty to provide culturally competent mental health service. Not only is culture a dilemma when caring for Caribbean immigrants, but nurses must also practice unrestricted by consideration of social or economic status, personal attributes, or nature of health problems (Ameri-

can Nurses Association, 2010). Psychological and behavioral adaptation is expected for the Caribbean immigrant. However, nursing practice and research should aim at understanding religious, folk, and health beliefs to achieve optimum mental health care.

Ethics should guide one's actions to treat others in ways consistent with human dignity and worth. The acts of caring through the lens of duty-based ethics are good in themselves (Israel & Hay, 2006), and they should also guide nursing praxis. Grace (2014) maintained that the beneficent act is to treat with minimum harm that may stem from overriding autonomy. Conflict between beneficence (doing good) and autonomy (individual with unique characteristics) permeates in mental health if and when patients do not meet the criteria for informed consent, and advocacy would be needed if mental capacity were compromised. Caring about improvement in the health of the community starts with addressing policy. In reviewing the literature, most of the studies on mental illness were found in Canada and the United Kingdom compared to the dearth of research in the United States. There is a gap in research on mental health in the United States and even less research among minorities and Caribbean immigrants. The lack of studies drives the need to advocate for major health-care reform to address inequalities in mental health care.

Furthermore, the stigma of mental health, the history of racial disparity, and policy issues on immigration may have stymied health and health care. Nevertheless, in ethically difficult situations, nurses still have a moral responsibility. The state of Caribbean immigrants and mental health in the United States appears monolithic when considering fair and just ways to mental health care, but emancipation must start somewhere. Culturally determined views about mental health problems, inadequate access, and lack of cultural humility among health-care professionals are factors that influence accessing and receiving appropriate mental health care (Ellis, 2012). The issues, conflicts, and dilemmas on mental health are many. However, let's acknowledge that there is inequitable distribution of services and prevailing factors that affect access and treatment of Caribbean immigrants.

Can sound ethical decisions be made for Caribbean immigrants without adequate care for Americans? One qualitative study done in Sweden explored moral responsibility in nursing students. The findings suggests that to act moral is relationally and contextually dependent (Lindh, Severinsson, & Berg, 2007). The context here is that of Caribbean immigrants, and Lindh et al.'s (2007) findings supported the relational as that which emanates from the inner self and dialectic process with others. This moral responsibility should not just be an expectation from every nurse but should be engendered by the nursing profession.

Summary

Today, there is much discussion around the concept of "global" mental health. This movement has stimulated a countermovement proposing that mental health is a local matter, and that systems for promoting mental health must take on board the traditions of local communities and what they want from health (Sutherland, Moodley, & Chevannes, 2014). Every individual is entitled to care regardless of race, ethnicity, and culture. To understand individuals, we must see the world through the eyes of the Caribbean immigrant and to understand mental health from their lens. Social and cultural determinants that influence mental health may be difficult to change. However, universal public and health policy with cultural relevance can aid nurses and health-care systems to optimize mental health care for Caribbean immigrants.

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Acknowledgments. In this article, I want to show the reader the issues surrounding the mental illness and the Caribbean immigrant experience. I want to remind people that mental illness affect individuals, families, and communities and needs further research in minority groups in the United States.

Correspondence regarding this article should be directed to Hope M. Shaw, MSN, RN, CNOR, Cleveland Clinic, 2950 Cleveland Clinic Blvd, Weston, FL 33331. E-mail: hope.shaw@comcast.net