

# An Introduction to Jamaican Culture for Rehabilitation Service Providers

Doreen Miller



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**Culture Brokering: Providing Culturally Competent  
Rehabilitation Services to Foreign-Born Persons**

# **An Introduction to Jamaican Culture for Rehabilitation Service Providers**

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Center for International Rehabilitation Research Information and Exchange

University at Buffalo  
The State University of New York

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## AN INTRODUCTION TO JAMAICAN CULTURE FOR REHABILITATION SERVICE PROVIDERS

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### *Preface*

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Among the ten principal countries of origin for immigration to the U.S., Jamaica is the only one in which English is the principal language. Partly for this reason, Jamaicans in the U.S. are not always thought of as a distinct cultural group. They are often identified with African Americans, and it is sometimes assumed that they share similar values and perspectives. Jamaicans, however, have a distinct history and culture. Professionals providing human services to Jamaicans in the U.S. may benefit from an introduction to some of the basic themes that run through Jamaican culture.

Jamaicans are often stereotyped as carefree and fun loving. While most Jamaicans do value a sense of humor, as well as music and dance, they also have a tradition of hard work and a strong respect for education. A history of slavery and resistance to it has resulted in an independent spirit that sometimes is manifested in a distrust of establishment organizations, if they are perceived as intrusive. Health and other human services are sometimes not sought until there is a dire need.

The history of slavery, as well as poverty, has had an impact on family structure and gender roles. The need to seek employment in locations distant from their families, both within Jamaica and abroad, has frequently resulted in households run by mothers or grandmothers.

This monograph reviews some of the historical influences on Jamaican culture and examines the cultural implications for the delivery of disability services to Jamaicans in the U.S. The author of this monograph is very well qualified to interpret Jamaican culture for U.S. rehabilitation service providers. Dr. Doreen Miller was born in Jamaica and lived in both urban and rural Jamaican communities. She received her undergraduate and graduate education in the U.S., including a Master's degree in guidance counseling from Washington State University and a Rh.D. in rehabilitation counseling from Southern Illinois University at Carbondale. She is currently a professor in the Department of Psychology and Rehabilitation Programs at Southern University, Baton Rouge, Louisiana where she has worked since 1977. Dr. Miller has been the recipient of grants from the Rehabilitation Services Administration for training programs in rehabilitation services.

This monograph is part of a series developed by CIRRIE -- the Center for International Rehabilitation Research Information and Exchange -- at the

University at Buffalo, State University of New York. The mission of CIRRIE is to facilitate the exchange of information and expertise between the U.S. and other countries in the field of rehabilitation. CIRRIE is supported by a grant from the National Institute on Disability and Rehabilitation Research of the U.S. Department of Education.

In addition to developing this monograph series, CIRRIE conducts workshops on providing rehabilitation services to foreign-born persons. We hope that this monograph will be useful to you in your work with persons born in Jamaica. We welcome your comments that will help us to deepen our understanding of ways to increase the effectiveness of rehabilitation services for persons born in other countries.

*John H. Stone, Ph.D., Director,  
Center for International Rehabilitation Research Information & Exchange (CIRRIE)  
Series Editor*

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## *Introduction*

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The literature in the field of rehabilitation is replete with information emphasizing the value of cultural awareness and competence for effective rehabilitation service delivery to minorities with disabilities (Walker, Belgrave, Banner and Nicholls, 1986; Walker, Belgrave, Nicholls, Turner, 1991; Rosenthal and Kosciulek, 1996; Schaller, Parker and Garcia, 1998). In general, a significant portion of the available material addresses the needs of minorities, with particular attention to African Americans (Fiest-Price and Ford-Harris, 1994; Belgrave and Walker, 1991; Harley and Alston, 1996; Dixon and Wright, 1996; McGoldrick, 1982). When African American rehabilitation issues have been discussed, the nature of the dialogue encompasses the rehabilitation concerns of all Africans who have been a part of the diaspora. Frequently all immigrants who share the same race as African Americans are subsumed under one heading. Little, if any distinction is made among immigrants from countries such as Jamaica.

Legislative mandates, such as section 21 of the 1992 amendments to the 1973 Rehabilitation Act, have established that adequate, equitable and effective rehabilitation service for minorities is imperative. Given the pluralistic nature of American society, there are many immigrants with minority status who would qualify for services. The fact that Jamaicans who migrated during the mass migration periods of the 1970s and 1980s may be vulnerable to age-related disabilities makes it likely that rehabilitation professionals will be required to provide services to them. This is particularly true in regions of the country where large pockets of Jamaicans reside. In states such as New York, there are more than 410,933 residents of West Indian decent, including many Jamaicans (U.S. Census Bureau, 1990). Also, every year for the last ten years more than 21,000 people emigrated from Jamaica, primarily to the United States.

While cultural awareness and cultural competence are paramount for effective service delivery, systematic integration of information about Jamaicans into rehabilitation training programs is lacking. If rehabilitation service providers are to meet the needs of Jamaicans with disabilities, it is necessary that they acquire knowledge about Jamaican culture, including views on disability and rehabilitation. The purpose of this monograph is to provide such information. The monograph will address the following topics: general background, history and reasons for emigration to the United States, Jamaicans' concept of disability; views on acquired and lifelong disabilities, concept of independence, Jamaican culture, typical patterns of interactions between consumers and rehabilitation service providers, family structure, role of community and gender differences in service provision, eating habits, recommendations to rehabilitation service providers and ways in which service providers can become more familiar with the culture.

Case examples are provided to clarify cultural concepts that might be unfamiliar to the reader. These case examples are based on personal experience and hypothetical scenarios.

## BACKGROUND

### *Geography*

The country of Jamaica is a West Indian island located near the center of the Caribbean Sea. It is among the group of islands that comprise the Greater Antilles (the others are Cuba, Haiti, Dominican Republic and Puerto Rico) and is the largest of the English-speaking islands in the region. It is 90 miles south of Cuba, 100 miles west of Haiti and 579 miles from Miami. Approximately the size of Connecticut, Jamaica has an area of 4,411 square miles and is 146 miles long. The breadth of the island varies from 22 miles at its narrowest point to 51 miles at the widest (Gleaner, 1995; Statistical Yearbook of Jamaica 1998; World Fact Book, 1999). Rugged chains of mountains extend from east to west. The Blue Mountains include the highest point on the island, a summit of 7,402 feet. Low elevations form a coastal belt around the island, but approximately two thirds of the landmass lies 1000 feet above sea level (Gleaner, 1995).

### *Population*

In 1999, the Statistical Institute of Jamaica reported that there were 2,590,400 people living on the island. Of this number 700,000 lived in the corporate area of the capital, Kingston and the city of St. Andrew. Montego Bay, the second largest city, had a population of 85,503 (Gleaner, 1995).

The ethnic composition of Jamaica reflects the historical legacy of African enslavement. Various historical and sociological reports (Black, 1997; Morrish, 1982) suggest that most of the Africans taken to Jamaica were from the West African coast and later from Angola and the Congo. Although African slaves in Jamaica were from among a variety of ethnic groups, they were predominantly Coromanties, Eboes and Mandingoes (Black, 1997; Moorish, 1982).

The cessation of the slave trade precipitated a need for new sources of labor to maintain the sugar estates. To meet the demand for labor, East Indian immigrants came to Jamaica in 1842. In 1854, Chinese immigrants were added. Even with the presence of Indians and Chinese, the need for workers remained high. In 1869, East Indian indentured servants were introduced ("Statistical Handbook of Jamaica," 1998). Today, the ethnic composition of Jamaica is as

follows: African descent, 90.4%, East Indian, 1.3%, white, 0.2%, mixed, 7.3% and other 0.6% ("World Fact Book," 1999).

### *Government*

On his second voyage to the New World, Columbus arrived in Jamaica on May 3, 1494. The island remained under Spanish rule until May 10, 1655 when British troops seized the island. British colonization was sustained until 1962 when Jamaica was granted independence. The Queen of England, represented by The Governor General, is the nominal head of state. The prime minister is the leader of the cabinet, which is the policy making body of the government. Jamaica has a bicameral parliament, which consists of the senate and the House of Representatives. There are two major political parties, The Peoples National Party and The Jamaican Labor Party.

### *Education*

Formal education in Jamaica is delivered via a four level system of education under the auspices of the Ministry of Education, Youth and Culture. The four levels include: pre-primary (early childhood), primary, secondary and tertiary (post-secondary) education. Education is compulsory from primary through secondary school.

Although basic education is compulsory for all children, literacy remains a national challenge ("Statistical Institute of Jamaica, 1998"). Overall, the literacy rate for the country is 86.5%. However, this figure may be misleading, since a literacy survey conducted in 1997 indicated that there might be a large group of people who can be categorized as functionally illiterate ("Planning Institute of Jamaica, 2000"). The literacy rate is higher among women (81%) than men (69%). It is also high among the younger population (86.5%) and declines among people 65 years and older (Statistical Institute of Jamaica, 1999).

Despite the literacy levels indicated by the 1997 survey, many Jamaicans residing in the United States may be functionally illiterate. Rehabilitation service providers must realize that rehabilitation outcomes might be affected by a lack of literacy competence.

In a country where education is highly valued, illiteracy carries a great deal of shame and stigma. It is sometimes carried as a family secret for many years. Tremendous effort is placed on keeping the secret because illiteracy indicates a lack of intellectual mastery and blight on the individual and family. One of the ultimate insults is to implicitly or explicitly suggest that someone is illiterate.

It is important for service providers to be aware that some consumers who are illiterate might be resistant to rehabilitation because they feel vulnerable to exposure. For example, some consumers may terminate the rehabilitation process prematurely or fail to keep evaluation and assessment appointments because of the desire to avoid embarrassment.

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### *Special Education*

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Special education is in the early stages of development. Most of the special needs programs are associated with private institutions and only a few are affiliated with public primary and secondary schools. Access to special education programs is limited and most are available in and near Kingston, the capital city. There is a paucity of services for rural consumers, so the special needs of this segment of the population remain unmet.

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### *Economy*

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The economy of Jamaica is based primarily on agriculture, tourism and bauxite mining. The predominant agricultural crops include bananas, sugar cane and citrus. The country is very dependent upon tourism, the main source of foreign exchange. Bauxite mining is the principal source of revenue for the country. A secondary sector of the economy is the manufacturing industry, which consists of food processing, beverage preparation and processing of chemical products.

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### *National Holidays*

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There are ten (10) national holidays observed in Jamaica. National holidays hold great significance for the people because they represent strong religious and historical values. Christmas, Easter, Emancipation Day and Independence Day are the most highly celebrated holidays. Extensive preparations are associated with these holidays. Festivities often begin long before the holiday and last for days. This is particularly true of the Christmas holidays. Christmas is a time for family gatherings. Family members living in the United States make special efforts to return to the country to celebrate the holiday with family.

The cultural import of national holidays must be taken into account when rehabilitation services are scheduled. Consumers may be less inclined to cooperate or comply with rehabilitation requests if they conflict with holiday plans for celebration.

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### *Religion*

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Religion is an integral component of Jamaican life. It is woven into the fabric of

the history, education and social behavior of the people. The religious fervor of Jamaicans has its genesis in the abolition of slavery and the slave experience. During the period of enslavement, religious groups played an important role in protecting the slaves from maltreatment and had a great deal to do with the eventual abolition of slavery. Groups such as the Baptists were fervent in their outcry against the inhumane system of slavery. Religion, therefore, was understood by many to be the only hope for a better life. The religious commitment of Jamaicans is a legacy from the period of enslavement.

Religious traditions are maintained through the Jamaican educational system. Religious education is a core subject in the curriculum in all levels of education from pre-primary through secondary. It is also a subject for examination in secondary school exit examinations. In the early years, the curriculum focused only on Christianity, but recently it has become more eclectic. Devotional periods are also important segments of a school day. Early religious indoctrination is considered to be important in the development of children. For example, parents who may not be members of a church usually ensure that their children attend Sunday school to receive proper religious education.

Early religious training is important because it provides the moral code for the society. It is the means by which children distinguish right from wrong and develop good character. For example, even pre-primary children can repeat passages from the Bible, such as the Ten Commandments. Religion dictates how individuals treat each other. Through religious training, personal and collective consciousness is developed.

Jamaicans are ardent churchgoers and they are affiliated with many religions and sects. There are more than one hundred Christian religions practiced in the country (Jamaica Information Service, 2000). The country is predominately Protestant (61%) with a small percentage of Roman Catholics (4.1%). While a large segment of the population subscribes to traditional religion, there are a number of people who belong to other religious groups, such as the Ethiopian Orthodox Church and the Hindu, Muslim and Bahai faiths. The largest religious group is the Church of God (Jamaica Information Service, 2000).

Some people spend an unusually large amount of time doing church related activities. For example, they may attend up to four hours of Sunday school and worship services on Sunday morning and return for an evening service. Many churchgoers regularly engage in daily activities such as prayer meetings, bible study and choir rehearsals. Tuesday morning prayer meetings and Wednesday night mid-week service are part of the religious tradition.

For those who are not regular churchgoers, holidays such as Easter, Christmas and New Year's Eve require almost mandatory attendance. The ritual of being in church at the dawn of the New Year bears special significance for regular,

irregular or even non-church goers. Many people stop whatever they are doing wherever they are and rush to the nearest church before midnight on New Year's eve. People leave parties, bars, and gala events to be in church before the stroke of midnight, and resume their pre-midnight activities after the church service. The New Year's ritual is sustained by the belief that whatever one is engaged in when the New Year arrives will set the tone for the year. So being in church at midnight on December 31st establishes a positive note for the coming year.

Membership in different religious groups is related to social class, status, prestige and religious practice. Upper and middle class people tend to gravitate to religions that are somewhat stoical and non-emotional. Religions that permit emotional expressions such as hand clapping and vocalizations are viewed by them with derision. Some middle and upper class members covertly believe that the more emotional religions are for the uneducated and ignorant. Upper and middle class people are more often members of traditional religions such as Anglican or Methodist.

Lower class people also have their view of upper and middle class religious affiliation. Among lower class people, memberships in certain churches are for the rich and powerful. For example, members of the Anglican church are sometimes described as "ristos" because it is perceived that participation is limited to the aristocrats. One explanation for this perception may be related to the historical relationship between the Anglican church and the early Jamaicans. During British colonial rule the Anglican church or Church of England was considered to be the "planters church," the church of aristocracy - the state church.

Church attendance serves many functions in the lives of Jamaicans. Status can be raised by attending churches where prominent community members are found. By association, individuals are viewed to be members of an elite group. Active participation as a lay reader or member of a church board is also a status enhancing practice.

Church attendance strengthens extended family and kinship bonds. The church is a source of information, emotional and financial support in times of crisis. For example, if a church member becomes ill, it is not unusual for other members to participate in family care-taking. Church members sometimes provide nightly respite care to relieve family members. This type of relationship between the church and congregation can be found in urban areas, but it is more characteristic of rural communities.

The church also provides a social outlet for members and the general community. Activities such as fairs, cricket matches, concerts, dinners, teas and harvest festivities are common church events. The annual harvest is a unique activity, symbolizing gratitude for the agricultural products and bi-products produced during the year. Church members provide produce from their cultivation, which

is displayed during a special harvest thanksgiving service. After the harvest service, the produce is sold to the general public. The proceeds are used for the benefit of the church. The harvest service is common in both urban and rural communities.

Among the traditional religions practiced in Jamaica are a number of religions of African origin. In general, the African themes are blended with Christian ideology. African centered religions are generally practiced by people who are poor or disenfranchised. The three main Afro-Christian religions are Kuminu, Revivalism and Rastafarianism. Among the African-centered religious groups, Rastafarianism is growing. Members of the middle class are now embracing the religion after many years of opposition.

Because the role of religion is integral to the lives of many Jamaicans, it is vital to the rehabilitation process. It would not be unusual for a consumer to inject religious beliefs into the rehabilitation experience, so service providers must be prepared to address religious/spiritual needs whenever they arise. Addressing the religious issues of the Jamaican consumer is paramount, because service providers are expected to deliver holistic rehabilitation services that are culturally relevant.

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### *Eating Habits*

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Jamaicans consume large amounts of carbohydrates such as rice, yams, sweet potatoes (U.S. yams), breadfruit, bananas, plantains, peas and pumpkin. Protein sources are available from fish, beef, pork, poultry and mutton (goat), but portion sizes tend to be small. For example, one chicken often serves a family of four to six people. Three ounces of protein (meat) is about the average serving size.

Many Jamaicans living in the United States have drastically altered their food consumption behaviors. For instance, many consume more meat and generally eat large amounts of food during one meal. Food portions in the United States tend to be very large, and many Jamaicans have adapted to this eating habit.

Fruit is abundant in Jamaica and is a daily staple. It serves as desert or snack. In the United States some Jamaicans have reduced their fruit intake and the number of vegetables in their daily diets. This may be related to the cost of such foods, so meals are often limited to basic meat and rice.

The availability of "fast foods," such as Kentucky Fried Chicken and Burger King, has influenced the eating habits of Jamaicans in the United States. Typically Jamaicans tend to eat most of their meals at home, but easy access to food already prepared not only influences the quality of their diet, but also the number of calories consumed on a daily basis.



There is also an increased amount of processed food in the diet of many Jamaican residents in the United States. Although Jamaicans living in Jamaica eat a large amount of carbohydrates, much of it consists of fresh foods often seasoned with fresh herbs such as thyme, onions and scallions, which are staple sources for adding flavors to food.

Despite the heavy carbohydrates and fats consumed in the Jamaican diet, an active life-style serves as a buffer from the deleterious effects of excessive amounts of these foods in the body. For instance, in Jamaica people get a great deal of exercise through walking and are able to metabolize the excess carbohydrates and fats consumed. Unlike United States citizens, many Jamaicans do not own a car and public transportation is less structured, particularly in rural areas. However, most Jamaicans living in the United States have developed a sedentary lifestyle. They continue to maintain heavy carbohydrate and fat diets, but tend to engage in less physical activity. Those who engage in physical activity must plan it since it is not part of the normal routine. Thus, weight gain is not uncommon among immigrants who previously had very lean bodies; they are now prone to illnesses that are diet related, such as cardiovascular disease and diabetes.

### ————— *History of Immigration to the United States* —————

Jamaicans have a strong migratory spirit. Motivated by ambition and a desire for better economic conditions, they migrate. Wherever they perceive opportunities for a better life they will move. In search of opportunity, Jamaicans have traveled to many distant places. The most frequent destination is the United States.

In the late nineteenth century, Jamaicans began to migrate to the United States. Presently, among Latin American and Caribbean U.S. immigrants, Jamaicans rank fourth (Planning Institute of Jamaica, 1999). Banana ports like Boston were the earliest destinations. Later migrants relocated to Baltimore, Philadelphia and New York. Today, the largest concentration of Jamaicans (350,000) is in New York, New Jersey and Connecticut. (Black, 1997).

Mass migration to the United States in the 1970s and 1980s can be tied to political violence and the threat of communism. During this period, Jamaicans left the country in droves because they feared that their lives were in danger as the Peoples National Party (PNP) and the Jamaican Labor Party (JLP) struggled for power. In the 1980s, approximately 800 people died in politically motivated violence (Virtue, 1999). People felt so threatened that they were willing to abandon everything in the name of safety. They left professions, belongings, family and a middle class standard of living for the uncertain living conditions in other countries.

For some, the sacrifices made in the name of safety did not pay off. Many middle class professionals and entrepreneurs found themselves grossly underemployed or unemployed. Some found work as cab drivers, bus drivers, restaurant workers or domestic care providers for elderly or terminally ill persons. Many who wished to return to Jamaica were unable to do so because they had uprooted their lives and there were no personal resources to allow them to remain in the country:

George and Hyacinth Rogers owned a thriving business in Kingston. The business had been in the family for more than 30 years. Fearful that they might be victims of violence, they sold their home and business for half of the value, asked friends to care for what could not be sold and fled to the United States. Unemployment, drastic changes in life style and status and dwindling financial resources began to take a toll on their marriage. Within a year, the marriage was in disarray. Mrs. Rogers wanted to return to Jamaica, but her husband, realizing that there was nothing to return to, refused. Eighteen months later, Mrs. Rogers returned alone because her husband had requested a divorce after twenty years of marriage. When she returned to Jamaica, squatters had taken over the property that she had left behind. She had no money, no place to live and was dependent on the goodwill of family and friends. Having suffered many major losses in a short period, it began to take a toll on her mental health. Six months after returning to Jamaica, she was hospitalized for severe depression.

The 1990s were reminiscent of the 1970s and 1980s. Jamaicans again fled the country in large numbers because of violence related to drug trafficking, particularly in Kingston. These periods of mass movement have had devastating consequences on the human resource capital of the country. Jamaicans with technical and professional skills are sought by countries such as the United States. The opportunity for increased income is enticing, so Jamaica has a great deal of difficulty retaining trained personnel.

Among Jamaicans residing in the United States, there are a considerable number who have entered the country as illegal aliens. Oftentimes, those who enter the United States illegally are less skilled and are generally confined to low paying and hazardous employment. These individuals may be predisposed to acquired disabilities and are likely to require rehabilitation services. In providing rehabilitation, personnel must be aware that consumers who are reticent and uncooperative may be concealing their immigration status in an effort to avoid deportation. For example:

Gladstone arrived in the United States as a visitor. When his visitor's permit expired, he did not return to Jamaica. His goal was to enter college once he had earned enough money and permanent resident status.

Under an assumed name and a fabricated social security number, he held a series of short-term jobs. He was a truck driver for about six months when he was involved in an accident and sustained a Lumbar 5 (L5) spinal injury. He was referred for rehabilitation services, but refused to keep appointments or return his counselor's telephone calls because he wanted to avoid answering questions that might expose his status and ineligibility for services. He earned income as a taxicab dispatcher until he received permanent residence through immigration amnesty. Later, he contacted his rehabilitation counselor and resumed services.

Emigrants have also been a source of revenue for Jamaica in general, and its residents in particular. Some émigrés with relatives in Jamaica provide regular financial support, which may be their only source of income. The following three examples illustrate patterns of remittance from the U.S. to Jamaica.

Etta migrated to the United States to attend college in 1969. She was supported by her parents while in college. Although her parents had planned for their retirement, devaluation of the Jamaican dollar in the 1980's coupled with an inadequate employment retirement plan placed them in a precarious financial situation. Since completing her degree, every month she sends money for their support in an effort to assist them in maintaining their standard of living and quality of life.

Cynthia was twelve when her father was killed in an accident. Along with two sisters and a brother, her mother became the sole support of the family. Her mother, a domestic worker, managed to educate all of her children, three of whom were trained as nurses in Jamaica. As a way of improving the quality of life for their mother, Cynthia (the oldest) migrated to New York to work in a hospital. Later she sponsored her sister, who sponsored the third sister. The sisters provided support for their mother, which included a new home and living expenses. As their mother aged, they were able to provide for her medical care and a domestic caretaker until her death.

Calvin is a 30-year old school bus driver by day and a taxi driver by night. All of his immediate family members have emigrated to New York. His mother's youngest sister, Mavis, lives in a rural community in Jamaica. Mavis has no income because her husband, who was the support of the family, died many years ago. Calvin has been supporting his aunt for the last five years. From his earnings he sends his aunt \$150 per month. Other relatives periodically send Mavis small amounts of money.

These examples are characteristic of Jamaicans living abroad and are consistent with their reasons for migrating (i.e., a better life for self and family). Given

their financial responsibilities for family residing in Jamaica, adjustment to disability might be difficult. Inability to work or a reduced income could create complex psychosocial problems for the consumer. It is important for service providers to understand that a consumer's insistence that they must retain pre-disability employment may be based more on the desire to continue family support rather than on refusal to accept the disability. The consumer may experience feelings of failure if they are unable to support a family dependent upon them. The problem may be exacerbated if the consumer can no longer maintain employment and must return to the family. For example:

Kristen was a surgical nurse who was the sole support for her mother and brother who was mentally ill. Fifteen years after she was employed at a hospital, she was diagnosed with Multiple Sclerosis. The condition deteriorated rapidly to the extent that she was incapable of performing her duties as a nurse. In support of Kristen, the hospital's administrator offered her a position in the medical records department, but she refused the offer. Fearful that she could no longer support her family, she became very angry and considered filing a discrimination lawsuit against the hospital. She was encouraged to seek counseling through the Employee Assistance Program at the hospital. Eventually, she accepted the position in the medical records department where she worked until she was eligible for retirement with benefits. Unable to adequately care for herself, she returned to Jamaica where her family could assist her.

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### *Cultural Concept of Disability*

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Cultural concepts that influence views of disability and illness originate in religious beliefs related to Christianity and Afro-Christian sects such as Pocomania and Kumina. There are major beliefs that may have an influence on the way Jamaicans view disability: for example, disability is a punishment for wrongdoing, obeah or guzu, evil spirits, ghosts or duppies, and natural causes (Heinz and Payne-Jackson, 1997; Leavitt, 1992). These belief systems are entrenched in Jamaican society. They have played a major role in shaping the attitudes toward disability and delayed the development of a comprehensive national rehabilitation program. Even professionals and the educated middle class tend to hold a strong belief that disability is a result of sin.

Jamaicans are firm believers in the power of God as a mediator between good and evil in their daily lives. God is seen as a force operating from a position of duality, at the same time forgiving and punishing. The nature of God is perceived to include a great capacity for a long-term vindictive memory. Those who sin or commit wrongful acts will always be punished. If the perpetrator escapes punishment, their offspring are certain to reap the negative effects of past

wrongs. Jamaicans frequently cite the biblical verse, "The sins of the father shall visit the third and fourth generations." Thus the cause of accidents or congenital deformities may be attributed to punishment deserved. This punishment can be the responsibility of past generations as well as the victim. For example, a child born with a birth defect may be seen as the recipient of punishment for wrongs committed by a grandparent. A young man who meets an accident and becomes paralyzed may be understood to have received punishment because of disrespectful behavior to his grandparents. Lack of respect for elders is unacceptable behavior.

The belief that disability is a result of punishment for past wrongs or sins is associated with tremendous shame and guilt. In an effort to minimize public shame, families often conceal the fact that a member of the family has a disability. Hiding a disability is particularly true when it is congenital. A child who has a birth defect may be hidden from public view for life. Neighbors or the community may be aware that a child with a disability lives near, but never have direct contact or a close view of the child:

Mr. Spence was a businessman in a rural community. His home was located about half of a mile from the main road in the village. When his grandson, Trevor, was born it was discovered that he had a bone disease. For years people in the community knew of Trevor, but had never seen him. When he was about three, caretakers pushing a pram could be seen from the main road. Stories circulated about the nature of Trevor's disability, but since he was never seen in public, the extent of his disability was unknown.

Obeah or Guzu is the belief that there are supernatural forces that can be harnessed for good or evil, for health or sickness. Obeah workers (witchcraft) are believed to have the ability to create conditions through which one's desires can be fulfilled. For example, they can cause illness, death, separation, divorce, love and prosperity. Any illness that cannot be explained by medical intervention is considered to be a result of obeah. If the condition is believed to be induced by obeah the victim is generally taken to a "balm yard" or mission that is the holy ground of the Pocomania religion. At the balm yard, the female leader, who is called "the mother" or "shepherdess" and the male leader (the "shepherd") may perform rituals, prepare herbs for ingestion or bath and oils for anointing the body. Clients are often given biblical scriptures to read. Selected psalms are generally the spiritual prescription and must be read for a designated period. For example selections from among Psalms 27, 30, 31, 33, 35, 36, 37, 40, 51, 59, 65, 66, 69, 71, 77, 91 or 139 may be given to be read three times each day for seven to nine days.

Some labels given to obeah practitioners include "Obeah man," "guzu man" or "four eye man." These references are not gender specific because the word

"man" refers to both male and female practitioners. The practice of obeah is illegal, so those who engage in it generally operate covertly in remote parts of the country. Both practitioners and those who seek them are viewed to be among the less educated constituent of the population. Although obeah workers use herbs in their practice, they should not be confused with the bush doctor or spiritual herbalist. Spiritual herbalists believe that the capacity of the body to combat physical illness can be enhanced by the use of herbs coupled with religious ritual (Lowe, 1975).

In general, Jamaicans tend to self-medicate and exhaust every possible home remedy before seeking professional medical assistance. Elders within the family are generally the repositories of herbal wisdom and they often insist on the practice of self-medication. It is even combined with traditional medicine. Herbs are also used for health maintenance. For example, children are often given cenna, epsom salt or castor oil to cleanse the bowel of worms and purify the body. This practice generally takes place just before the beginning of a new school year. Bowel cleansing for health maintenance is not limited to children. Adults also take different combinations of herbs periodically. Reliance on non-traditional medical practices can be related to spiritual practice, but there is also an economic component. People who lack the financial resources to seek medical treatment are forced to use home remedies to cure illnesses or maintain health.

Even those who scoff at the use of obeah to influence changes in one's life will go to great lengths to protect themselves from its effects. The response is contradictory because they say obeah does not exist, yet they take precautions against being affected. For example, obeah holds that personal items such as shoes and clothing should not be left outdoors overnight. The fear is that these possessions may be used to harm the owner. It is believed that potions placed in shoes will cause the body to swell and ultimately result in death. As a protection against attack, people are selective about eating food handled by persons believed to be involved in obeah. Ingesting food from such a person might cause bodily harm. Men are often cautioned about eating food from women with whom they are unfamiliar or women who are seeking marriage, because they could be obeahed into falling in love and marriage, or remaining in relationships against their will. The story of the White Witch of Rose Hall is a classic example of the use of obeah and belief in its power to gain one's desires.

Disability and illness are believed to be the result of contact with evil spirits sent by obeah or spirits that are simply malevolent. For example, an explanation for someone who becomes mentally ill is that a duppy or ghost attached itself to the individual's spirit. In such an instance, mental illness could be the work of an enemy imposing a vendetta. People in the community might say "a nu so im use to be a duppy dem set pan im. A imgal fren do im so. Das why im a wak an tak to imself." ("That is not his normal behavior. A duppy was sent to make him ill.

It is the work of his girlfriend. That is why he walks and talks to himself").

Spirits or ghosts are believed to be fond of babies. If a ghost plays with a child, that child could become harmed, sometimes fatally. In order to protect babies and toddlers, caretakers often place a Bible opened to one of the Psalms (preferably Psalm 27, 35, 37, 40, 91 or 139) above the sleeping child's head. If a child is thin and appears unhealthy, it is believed that ghosts or duppies might be sharing the child's food intake so the child is unable to gain weight. In such cases something red or black is tied on the body of the child to provide protection from spirits. Parents are uncomfortable with a fretful or crying child at night because they believe that the child is most vulnerable to spirits at that time. If a child cries loudly at night, duppies might take their voice and render them mute.

Duppies also have the power to cause accidents. For example, if a man falls from a tree it might be the act of a duppy that pushed him. In such a case the tree is marked and others will refrain from climbing it. The belief in spirits, ghosts or duppies can be traced to Pocomania and Kumina practices related to animistic African spiritual traditions.

Natural causes for illness and disabilities are generally the explanations used by those who are considered sophisticated. The disability may be deemed to be a mistake by the medical profession, a malfunction of a technique used to ameliorate a medical problem or germs. It can also be a result of the failure of the body's natural mechanism to heal itself. Those who subscribe to the belief in natural causes seek medical attention and believe in the medical profession's ability to alleviate suffering or cure the illness.

Acceptance of certain types of disabilities are affected by the views held about these disabilities. Physical disabilities are more readily accepted than mental or cognitive ones. Of all disabilities, mental illness is most stigmatizing and very little is expected from persons living with mental illness. Concerted rehabilitation efforts have been non-existent in meeting their needs. According to the Statistical Institute of Jamaica (1998):

Negative public perceptions of the mentally ill and their potential for productive lives limit interest and support for psychiatric services and a truly comprehensive, integrated psychiatric delivery system in Jamaica...while demand for care continues to increase...(p. 114).

The negative attitudes toward people with mental illness create dire conditions for them in Jamaica. Their plight has only recently been brought to the forefront of the disability discussion. On July 15, 1999, two police officers and a truck driver gathered a group of homeless mentally ill people in Montego Bay and transported them to Nain, St. Elizabeth where they were left without food and shelter. Reports from an inquiry revealed that they were left to die. The ire of the

country was raised because of the abuse perpetrated against persons who were powerless to advocate on their own behalf. The inquiry found that the police and the truck driver were responsible for the incident, and as a result they are being prosecuted. As a remedy, the judge demanded that the government award the victims of the abuse a generous monetary compensation for the remainder of their lives.

As a result of the incident, a number of groups, such the chamber of commerce, churches, hospitals and mental health practitioners, have joined forces to reunite families with their mentally ill relatives and provide food, clothing and shelter for others. The incident has galvanized tremendous support for persons with mental illness across the country. For the first time, the "benign neglect" of mentally ill persons was a major public issue.

Personal perceptions can have an impact on whether a parent will accept a child with a disability. Parents who experience intense shame because of giving birth to a disabled child may reject that child. There have been cases in which mothers have abandoned their offspring by refusing to take a child home from the hospital:

A young mother, 20 years old, gave birth to a baby with a facial abnormality. She told the doctors that the baby did not belong to her because she could not have given birth to a child with what appeared to her to be inhuman features. The hospital staff tried to coax her into accepting the baby but to no avail. She refused to touch the child and insisted that the doctors correct the face of the child otherwise she did not want to have any contact. When the staff failed to honor her request, she disappeared from the hospital leaving the baby behind.

In contrast to parents who abandon their children, there are those who provide very loving and nurturing environments for their children with disabilities. Overprotection of children with disabilities is another way in which parents may react. The tendency is to behave as if the child is incapacitated and totally dependent on others even when he or she might be quite capable of engaging in a variety of activities. Family members keep the child dependent by imposing a "sick" label. Everyone in the family knows that the child should not be expected to do very much since he or she is "sickly." A typical assumption is that a disabled person should not be required to work, but should be cared for by the family.

Seclusion of children with disabilities can occur as well. Some parents keep their children indoors away from public view and the disability is kept as a secret within the family for years. Residents in the community may be aware of the child, but would be unable to describe the nature of the disability. Keeping the child hidden can be attributed less to cruelty than to lack of information and education about the management of chronic disabilities. Parents are unaware of what

a child with a disability can achieve given the proper accommodations and resources.

While health beliefs about the causes of illness and disability are still quite ingrained in the Jamaican culture, there are a number of changes evolving that will have an impact on attitudes toward disability and receptivity to rehabilitation practice. Access to information technology, travel to the United States to undergo medical treatment, temporary employment of Jamaican residents in medical settings in countries such as the United States and Canada and governmental efforts to re-organize the healthcare system are among the social changes that will influence traditional health beliefs.

There are approximately 60,000 computers in Jamaica (NUA Internet Survey of Online Users in Latin America, 2001). The availability of computers and information technology has an enormous potential to make public health information readily available to online users.

Immigration patterns indicate that some Jamaicans frequently travel to the United States to undergo medical treatment (Statistical Institute of Jamaica, 2000). For example, individuals who sustain trauma, such as head or spinal injuries or amputations sometimes seek medical treatment in Miami, Florida. Generally, physical restoration and rehabilitation are a major component of medical care. Exposure to rehabilitation practice in the United States increases receptivity to rehabilitation in Jamaica. Travel outside of Jamaica to receive medical care is most common among affluent Jamaicans. It is common among many in the medical profession to leave Jamaica for a period to work in the United States. For instance, nurses customarily reside in the United States for periods of six to eighteen months while working in a variety of medical settings.

Part-time residency while working in the United States for short periods affords medical professionals the opportunity to acquire new skills and experiences that can be applied in healthcare service delivery in Jamaica. For example, familiarization with the rehabilitation system in the United States can be utilized in developing rehabilitation models and improving awareness of disability and rehabilitation issues.

Improvements in healthcare delivery have influenced traditional health beliefs in Jamaica, and, as a result, people are living longer. Longevity (now 69.97 years for men and 72.64 for women) has been increased steadily since the 1950s, when the average Jamaican life span was 55.73 years for men and 58.89 for women (Statistical Institute of Jamaica, 2000). Women have consistently enjoyed a longer life than their male counterparts because, historically, they have maintained contact with the health care system both as users and caregivers. Traditionally, women have demonstrated better self-care habits in monitoring their health than men. A byproduct of women's health habits is the acceptance

of pre-natal and post-natal care that has remarkably reduced infant mortality and birth defects (Planning Institute of Jamaica, 2000).

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### *Acquired and Lifelong Disabilities*

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One of the major similarities between lifelong and acquired disabilities pertain to causation, personal responsibility and preventability. In general, people tend to seek meaning in their life experiences and attempt to establish reason or blame. For instance, persons with disabilities might attempt to understand their experience of disability by determining "why" or "what" caused the disability. Acceptance becomes more likely when a reason outside of personal cause can be found. For example, if a genetic reason can be established there is a greater feeling of relief and ultimate acceptance.

When personal blame is the cause for the disability it is more difficult to accept. For example, a mother who neglected pre-natal care would experience more guilt than one who had done everything she could to prevent her child from developing a birth defect. Similarly, a man who falls off a moving truck during an epileptic seizure might feel less guilt than a man who falls because he consumed too much rum.

Among Jamaicans, causative factors are important not only for the individual with the disability, but for family and community as well. There is diminished compassion as well as anger directed at those who receive injuries or disabilities because of personal negligence. Although care is provided by the family, the person with the disability is reminded that he/she was responsible for the disability. For example in a conversation with the author, Ms. Cynthia Parchment stated:

"My son Michael graduated from Teacher's College and bought a little car. I was so proud of him. I never finished high school. He did what I could not do. Soon after graduation, he became friends with a group of boys who liked to drink rum. He stopped spending time with me and every weekend he was attending beach parties in Montego Bay. Before long he was a heavy drinker. I tried to tell him to stop but he would not listen. One morning, about 3:30 a.m., I heard a knock on my door. It was the police who had come to tell me that Michael was in the hospital. He was in a bad accident. Michael was paralyzed as a result of the accident. If he had not been drinking, the accident could have been avoided. Now, I have to take care of him. I have to provide food, medicine, wheelchair, money for doctor's visits-everything. Sometimes I look at him and get real angry. Sometimes I wish that I could leave him and go away. I don't know what I am going to do because it is so expensive to take care of him without any financial assistance. He is my son though; I have to do it. But he has caused all of our problems and I have

to tell him so. He does not like to be reminded, but it is true. If he had listened, we would not be having so much trouble".

With regard to adjustment, parents may find it easier to adjust to the fact that their child was born with a disability rather than one acquired during childhood. Grief over the loss of a child's potential is paramount. For instance:

Audrey McDonald's fifteen-year-old son, Delroy, was hit by a car on his way home from school. Three years have passed and she is still grieving. She carries his report card and a photograph of him in her handbag. She tries to tell anyone who will listen about her son's accident. She often offers the report card to show that he was a good student and show his picture to tell them, "This is the way he looked before the accident. He was going to be a doctor."

As can be noted from the above scenario, it is not unusual for family members to fixate on pre-disability status as a means of coping with loss. The views held by Jamaicans about life-long and acquired disabilities may not be unique to them. These responses may be common to other parts of the world, including the United States.

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### *Concept of Independence*

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The collective psyche of a people is often shaped by its history. In the case of Jamaica, the history of the *maroon* experience and many other slave rebellions are inexorably bound to the fierce sense of independence and resilience among many Jamaicans. Enslaved Africans in Jamaica waged fierce resistance to slavery, and in the case of the *maroons* it resulted in self-government and maroon communities that still exist today.

The indomitable will of the *maroon* is the spiritual essence that permeates the soul of many Jamaicans, and it is the legacy passed on from generation to generation. The attributes of survival, resistance, persistence and independence among many Jamaicans are visible in contemporary Jamaican society. These characteristics have been a double-edged sword for some Jamaicans residing in the United States. On one hand, these characteristics have helped many to succeed, but on the other hand they have been a scourge for those who are perceived to be pushy, aggressive and unable to take "no" for an answer.

The confidence, assertiveness and persistence observed among Jamaicans is often misconstrued. Some people describe Jamaicans as stubborn or intolerant of authority and authority figures. The historical experience of Jamaicans predispose them to a belief that they can and will do what they think they can. Generally, they do not accept "no" as the final answer because they truly believe there is another way to achieve their goal. Jamaicans have the opportunity to

observe other Jamaicans in powerful decision making positions (Prime Minister) and they serve as models for what they can become. Jamaicans are ambitious and goal oriented. Once a goal is set, the urge to achieve will not allow anyone to interfere or create obstacles. What is often seen as aggressive, pushy, stubborn, competitive and defiant behavior is really a single-minded desire to accomplish a goal.

Jamaicans see themselves as independent thinkers. They take pride in making their own decisions and controlling their own destiny. Many object to others telling them what they "should," "ought" or "must" do. They reject authority when they believe that their intellectual capacity to act on their own behalf is being disregarded or when the authority figure is perceived to be condescending. Intellectual condescension is a pet peeve of many. Those who are unable to read are particularly sensitive to patronizing intellectual behavior and are not afraid to confront those who disregard their capacity to think. One might say, "mi can't read but mi a no fool, mi know wa mi a do." ( I can't read, but I an not a fool, I know what I am doing).

In a rehabilitation setting the spirit of independence and resilience can be of value in helping consumers to reach their rehabilitation goals. Rehabilitation service providers may capitalize on the "can do attitude" and defiant spirit to help consumers regain control of their lives. These behaviors surface in very subtle ways and if the providers are not aware of them they might impede the rehabilitation process. For example:

Lorraine's 17-year-old son, Bryan, sustained a head injury during a motorcycle accident. Bryan was an honor roll high school student with a goal of becoming a doctor. Although his dream was no longer possible, Lorraine believed he still had an academic future. She wanted him to attend college but because of evaluations, his counselor, Jerome Porter, thought it was doubtful that Bryan would be successful in college. Lorraine had many discussions with the counselor. She insisted on making college a goal because she believed with support, her son would be successful. Unable to get satisfaction, she refused to continue the rehabilitation program. A few months later, she contacted the state director for rehabilitation services and requested a meeting with him and Mr. Porter. In discussing the problem with the state director, Mr. Porter reported that Lorraine was unrealistic, stubborn, pushy and demanding. He really did not enjoy working with her because she was difficult. During the meeting with Lorraine, the state director found that Lorraine was clear about the needs of her son but very insistent that he attend college as a goal for rehabilitation. Shortly after the meeting, Lorraine and Bryan moved to another state. Bryan re-entered the rehabilitation system. His new counselor felt that there was a chance that he might be successful, so she recommended that he attend the state jun-

ior college. In his first semester, Bryan was able to maintain a "C" average.

It is necessary for rehabilitation service providers to recognize that the desire for personal independence and an active role in decision making is essential for many Jamaicans with disabilities. The high regard for independence and self-reliance might affect consumer's views on independent living or institutionalization of family members. There is a strong sense of self-reliance as it relates to the use of public assistance. The Jamaican consumer might resist the concept of independent living because he believes that a family member with a disability is the responsibility of the family and that he should be cared for and not be forced to work. There is also a belief that a family member should not be placed in a facility outside of the home, unless it is a hospital or similar setting. Placing a family member in a group home would be considered an abdication of family obligations. Because of the belief that a disabled relative should not have to work, job placement might also be met with opposition.

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### *Rehabilitation Service Delivery*

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In contrast to the United States, rehabilitation service delivery is still in its infancy in Jamaica. The earliest rehabilitation program was established in 1954 as a result of a devastating polio epidemic. The Mona Rehabilitation Center was founded by Sir John Golding in whose honor the center was renamed. The center serves people with severe disabilities and is known for its care of individuals with spinal cord injuries, not only in Jamaica, but also in the entire English-speaking Caribbean.

In general, traditional service delivery in Jamaica is limited, and strong governmental interest is a recent development. Increased interest in the rehabilitation needs of Jamaicans with disabilities occurred as a result of the World Health Organization's (WHO) International Year of the Disabled Person (IYDP), observed in 1981. The commemoration of the IYDP served to galvanize grassroots efforts to improve the quality of life for Jamaicans with disabilities, highlight the unique needs of citizens with disabilities and harness governmental support.

Unlike the United States where there is a very structured and complex rehabilitation system, Jamaican rehabilitation efforts are limited and emphasis on comprehensive and long-term services is virtually non-existent. In the United States there is an established national policy regarding the needs of Americans with disabilities. Landmark legislation such as the 1973 Rehabilitation Act and its subsequent amendments and the American With Disabilities Act (ADA) have set the national tone for addressing issues faced by people with disabilities. In comparison to the long legislative history of rehabilitation service delivery in the United States, governmental action on behalf of people with disabilities in Jamaica is very recent. In 1994, grassroots efforts of the Committee of the

National Advisory Council on Disability (CNACD) submitted a draft of a national policy to the Ministry of Labor Welfare and Sports, the governmental body with portfolio responsibilities. In 2000, the national policy was enacted into law. The national policy will focus on ameliorative strategies in eleven key areas of rehabilitation: health, education, vocational training, employment, accommodation, communications, housing, accessibility, political and civil rights (National Advisory Council on Disability, 2000).

The Jamaican Council for Persons with Disabilities will function in a capacity similar to that of the U.S. Department of Education, Rehabilitation Services Administration (RSA) in that it will be responsible for the coordination and implementation of the national policy. Although a national policy has been legislated, whether it will have a national impact remains questionable. Specific legislation must be enacted to enforce the provisions of the policy. Presently, there are few legal mandates that deal with disability and rehabilitation. Delivery of services across the island and education of the community about disabilities and rehabilitation might remain secondary because of scarce national resources. Given the fact that rehabilitation is still very new in Jamaica, it is possible that Jamaicans living with disabilities in the United States may be quite unfamiliar with the concept of rehabilitation. They might find it overwhelming to navigate through the complex U.S. rehabilitation system. For example, as previously noted, the goal of employment for an individual with a disability might be in conflict with traditional Jamaican attitudes about persons with disabilities which hold that people with disabilities need not pursue employment or independent living, but should be cared for. This belief has the potential to thwart the rehabilitation process. Rehabilitation counselors could find it difficult to convince consumers that employment is a viable rehabilitation outcome.

Overall, rehabilitation service delivery in Jamaica is very limited. In addition to scarce resources, access to programs are most often, if not always, located in the corporate area. Persons residing in outlying or rural areas cannot avail themselves of rehabilitation services. Having a disability is life changing, but having a disability without any opportunity for rehabilitation can have devastating consequences for families and persons with disabilities. This is especially true if the person with the disability happens to be the breadwinner of the family.

The incidence of disability is buffered in the U. S. by the state-federal partnership, which offers financial relief in the form of disability benefits. In Jamaica, the financial status of a disability is solely a personal one. Unlike the United States, where products needed by persons with disabilities can be easily obtained and sometimes provided through state vocational rehabilitation services, Jamaicans with disabilities must rely on imported aids and appliances at a high personal cost. In an effort to ease the tremendous economic burden of having a disability, the Ministry of Finance has reduced import duties on some rehabilitation aids, appliances and other necessary equipment, and offers income tax

relief to those with disabilities (National Advisory Council on Disability, 2000). Such measures of economic relief are of importance only to those who have the financial resources to purchase rehabilitation aids, however. Indigent people with disabilities do without.

A disability coupled with poverty paints a dismal picture for those in a developing country like Jamaica. Unlike the U. S., few governmental funds are allocated for the care of people with disabilities, and few trained personnel exist to provide adequate and effective service.

In fact, there is a dire need for trained rehabilitation personnel in Jamaica's emerging rehabilitation program. Even where services are available, service providers are unable to reach most consumers because of limited staff. For example, the Jamaica Society for the Blind serves three parishes (counties) with three field officers (Bell, 1993). The first program designed to provide formal training for rehabilitation personnel was established in 1974. The School of Physical Therapy was founded at the Sir John Golding Rehabilitation Center to train physical therapists to meet personnel needs in Jamaica and the English-speaking Caribbean. The school offers a three-year program of study. In contrast to the U. S., there is no other program available for the training of rehabilitation specialists. Rehabilitation counselors are non-existent. Services for persons with disabilities are generally delivered by a social worker or community members who have personal experience with disability or are in contact with persons with disabilities (Bell, 1993). Often services are delivered by staff who receive only on-the-job-training.

Rehabilitation services are also fragmented. There are many organizations attacking a major problem, but they seldom pool resources. The U. S. rehabilitation system could serve as a model for what needs to be done to coordinate rehabilitation services in Jamaica.

An admirable feature of current rehabilitation service delivery efforts in Jamaica is the strong advocacy of people with disabilities for people with disabilities. Many public changes and vocational programs have resulted from the work of people with disabilities, which is very empowering and inspiring. The essence of a "can do" attitude, which pervades the rehabilitation movement in Jamaica, is setting the tone for a very strong program in the future.

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*Interaction Between Consumers and Rehabilitation  
Service Providers*

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Interaction between consumers and service providers may be influenced by the source of referral. Consumers who are referred by the medical profession will be apt to use the resources because physicians are among the authority figures

of the society. Rapport-building with physician-referred consumers will also be easier because of their desire to comply with the doctor's instruction.

The use of home remedies is a major health practice among Jamaicans. Traditional medical treatment is generally sought after home treatments have been exhausted. By the time medical intervention takes place, irreparable damage has often occurred. Even when medical care is employed, there is a practice of blending prescriptions with home remedies. It is very difficult for health professionals to convince consumers to rely solely on modern medicine. Cost is a factor. People may have to choose between going to the doctor and buying food. Second, there is a historical tradition of using home remedies that have successfully eliminated health problems. Elders, who are authority figures in the family, are more inclined to use home remedies before seeking medical attention.

Personal pride also can hamper the relationship between consumers and service providers. Some Jamaicans resist the use of public assistance because they are embarrassed by dependence on governmental or "poor relief" support. In an effort to maintain dignity and avoid being labeled 'indigent,' some will remain in dire need.

As mentioned previously, another source of potential conflict relates to the institutionalization of a family member with a disability. The belief is that home is the best place and institutional care cannot be compared to what can be provided by family. Resistance to institutional care is often very strong, because family members believe that they can manage without assistance. When placement occurs, it is under extreme conditions and with some pressure from physicians or other health care professionals. A factor that may influence placement is the lack of familiarity with rehabilitation facilities. Unlike the U. S., there are few residential rehabilitation institutions in the country and they are located in the corporate area (parishes of Kingston and St. Andrew). The family must also contend with covert community stigmatization because institutionalization is frowned upon by those who share the belief that families must care for their own.

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*Family Structure*

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The roots of the Jamaican family structure are embedded in the historical experience of slavery. Marriage and households with both parents were characteristic of the European planters while slaves cohabitated and were often separated from mates and children. Jamaican family relationships reflect the legacy of both planters and slaves. Upper and middle class Jamaicans tend to assimilate more European standards and aspire to create families that embody these values. Formal marriages occur more often among upper and middle class families or among those who can afford the cost of a wedding. Among the upper and middle class, cohabitation is frowned upon because it does not give legitimacy to



offspring, it lowers family status, and it is viewed as immoral. When children are born to unmarried parents in these groups, illegitimacy is often a source of derision for the children.

Tremendous pressure is sometimes placed on a cohabitating family members to marry their partners. This is particularly true for those who have children. Both maternal and paternal sides of the family often encourage the parties to marry or terminate cohabitation and find other mates who are considered "suitable" for marriage. Living together is a source of shame and moral guilt for family members.

Appropriate choice of a marriage partner is integral to the value system of those who marry. An upper or middle class person who marries someone who might be considered lower class would experience disapproval from parents and family members in general. Such a person would be considered lacking in ambition and self-worth. Criteria such as skin color, class, occupation, level of education and parental or family status in the community are important in considering mate selection.

Fundamentally, the selection criteria is also based on how well the man is able to provide for his family. It is a source of pride and dignity for a man to be able to support his family, and he will do what it takes to find work. If it means leaving the family for long periods, he will do so, as long as he is able to send money home for their care and support. A man who refuses to provide for his children is viewed with disdain. Conversations describing the man's behavior often includes statements such as "He is a bad seed"; "He has never given a copper penny to his children in Black River"; "He is no good." Parents warn their daughters against developing relationships with such a man because in their perception he is lacking in character. Marrying the wrong person is viewed as a step down among ambitious and status seeking members of the society. Marrying someone who is viewed as a lower class person is tantamount to "royalty marrying commoners." Factors influencing mate selection while known, are seldom discussed. It remains one of the social taboos derived from the colonial past of the country.

The residue of slavery on family structure and sexual behavior is still visible in contemporary Jamaica (Dechesnay, 1986). Although there have been an increasing number of marriages, cohabitation continues to be the union of choice among poor and lower class Jamaicans. This may be related to the historical precedence set by the obstruction and prohibition by slaveholders of stable unions through marriage. According to Dechesnay (1986), those who practiced legally-sanctioned marriages when it became possible were deemed "social climbers."

Many people remain in co-habitative relationships for years. Although not legally married, people in the community tend to recognize partners as husband

and wife and will address them as such. There is some level of respect given to cohabitants, especially when they have been together for a long time. Sometimes after rearing children into adulthood, parents will marry for a number of reasons such as imminent death or pressure from children who are embarrassed by their parents' marital status. Pressure can also be brought to bear through religious affiliation. Ministers who perceive cohabitation to be "sinful" will encourage partners to marry.

Even when partners are legally married or cohabitating, additional intimate relationships are not unusual. Jamaican men are known for having more than one partner at a time. Frequently there are children (family) resulting from extra unions. While maintaining a stable union, the man can become a visiting parent. For example:

Ralph had his first child when he was 18. Against his mother's wishes, he began to cohabit with Mary, the mother of his child. Ralph and Mary lived together for eight years and had two more children. While in the union, Ralph began to date two other women simultaneously and they each had four children by him. His mother and sister were unhappy with his lifestyle and after some coercion he married Mary. Ralph continued to visit the other women and children, however, and had occasional sexual relationships with the other women.

Professionals are not exempt from the experience of a visiting union. Professionals who are employed by civil service are subject to transfers from one part of the island to another. Quite often it is the male who has such a position and is expected to leave the family in order to comply with professional demands. This type of separation can sometimes be protracted. For example:

Judge Alton Freeman has been appointed as the resident magistrate for the Montego Bay court. He and his wife Myrtle live with their three children in Kingston. The children, nine, twelve and sixteen years old, attend a very reputable school where their parents want them to remain and complete their high school education through the General Certificate of Education (GCE) examination. Mrs. Freeman has a successful import/export business, which she wants to maintain. The couple agreed that Judge Freeman would rent a home in Montego Bay while the children and Mrs. Freeman remain at the family home in Kingston. For three years he commuted to Kingston on Friday evenings returning to Montego Bay on Monday mornings. Suddenly the two sons, Keith and Christopher, began to have difficulty in school. Mrs. Freeman insisted that their boys need their father so other arrangements had to be made. Judge Freeman tried to get a transfer back to Kingston but was unable to do so. As a remedy, he was forced to commute every other day.

Another form of visiting union may result from internal migration. Fathers who are the sole support of the family, may travel to urban areas to seek employment. In such cases, they may visit on weekends or major holidays, such as Easter and Christmas, or when work schedules permit. If conditions do not permit, money will be sent home. Fathers may be away from home for long periods of time, leaving the child rearing and decision making to the mother. As a result, there are many women who are heads of households. These women are often very independent because of the role that they have had to play. The legacy of independence is often passed on to their daughters who model the behaviors of their mothers. The independent nature of Jamaican women is often mislabeled as bossy and stubborn.

Improved transportation has reduced the length of time these family members must be away from home. Those who can afford bus fare or cars can commute daily. The increase in the number of taxis and buses traveling to different parts of the country has helped to keep families together. Sometimes, however, even when the man is in the home, the woman may remain the head of the household and the decision-maker because the man perceives his role to be only that of the breadwinner. It is generally the woman's job to manage the money and make sure the children are disciplined and educated. When children misbehave or err in some way the woman is usually blamed by the husband and sometimes by the community.

Traditional Jamaican families tend to be quite extended. Grandparents frequently live in the home of one of their children, and is not uncommon for a child to remain in his or her parents' home long past the age of eighteen. Some never leave home and remain to head the household of aging parents. For example:

All of Jennifer's siblings have migrated to the United States and Canada. She is the last of four children. She did not have an interest in permanently relocating so she remained in Jamaica. She lived with her parents until she was twenty-eight, when she married and moved into a home with her husband. The marriage was short-lived, so she returned home to be with her parents. At thirty, she had her child. She is now forty-six and remains with her parents and child in their home. Her father is eighty and her mother is seventy-three.

Aunts and uncles are considered close family members and they are often considered surrogate parents. Aunts and uncles are very significant in Jamaican families, and their role may include emotional and financial support. The successful development of the child is not the responsibility of the parents alone. Nieces and nephews are aware of the importance of their aunts and uncles, and respond to them with the same degree of respect and care that they extend to parents.

Andrea is a teacher in the United States. Her Aunt Patsy, who lives in Jamaica, was diagnosed with cancer and was given six months to a year to live. Patsy is childless, so Andrea went to Jamaica to support her aunt and uncle through the initial stages of the illness. She promised her aunt that she would return to assist whenever she was needed or when the illness became worse. Andrea returned to the United States and made preparations to take a leave of absence from her job when the need arose, although she had some difficulty doing so. Andrea was willing to sacrifice her job in order to fulfill her promise to her aunt. Three months later she returned to Jamaica to care for the aunt until her death a short while later.

Another example:

Vita Barnes is eighty-two and the last survivor of six siblings. She has become quite frail and needs someone to care for her. Relatives who could assist reside in the United States, and she has lost contact with many of them. She told a church member that if she could contact her niece, Sissy, she was sure that her problem would be solved. This information was circulated among church members who communicated with relatives in the United States to request information regarding the possible location of Vita's niece. A few months later, Sissy was located. Sissy then contacted other nieces and cousins to apprise them of their aunt's condition. Together they worked out a plan in which each family member contributed \$25 per month to provide for a caretaker and medical assistance.

Kinship bonds also extend to close friends and neighbors who contribute to the nurturing and rearing of children. On a variety of levels children receive support in areas in which parents may be lacking. For example, when a child misbehaves, corrective feedback is given by others even in the presence of parents, who usually are not offended. Such friends and neighbors provide activities that enhance the development of the child. As a result, children can have many maternal or paternal figures in their lives. Where these kinship bonds develop among non-relatives, children often refer to such individuals as aunts or uncles. For example:

Mrs. Glaze has been the neighbor of Ms. Clark for more than twenty years. Mrs. Glaze's grandson, Lloyd, who is now twelve, has known Ms. Clark all his life. Ms. Clark says, "In a way, Lloyd is my son. I was there when he took his first step, the first day he went to school...I have been there for all of it. I have dreams for him just like his mother and grandmother. That is why I try to spend my free time with him. What they miss, I will catch. Lloyd and I have a ritual. On Saturdays, we shop, go out to eat and we talk a lot. Sometimes I take him to work with me. I work at a hotel and I save my professional privileges at the hotel for

him. He gets to swim and play tennis. He is a Tiger Woods fan, so my next goal is to get someone to teach him how to play golf. I have a role in his life and I want to do my best with him. I often wonder what he will be like when he grows up. We are close. I get to hear those things that he can't tell his mother or grandmother. I try to give him guidance so that he can stay on the right track".

While extended family structures have been the norm, contemporary Jamaican families are becoming more nuclear. One of the major contributors to the erosion of close kinship bonds is internal and external migration. Within the country, young people are moving away from villages to urban centers for better employment opportunities. The trend is that they marry and have children who have little contact with relatives in the rural areas. In an effort to retard the erosion of traditional extended families, grandparents often relocate to live with their children whenever it is feasible.

External migration is another major threat to the disintegration of the traditional family structure. Individuals migrate with the intention of reuniting with their children who are left behind with relatives, friends or neighbors. The children are told by their parents that they must leave in order to create a better quality of life for the family. Sometimes the intentions of parents although honorable, fail to materialize. Low paying jobs, unemployment, illegal immigration status, establishment of second families or other difficulties prevent them from reuniting with their children. A husband might tell his wife that he will reunite with her and the children and never do so, although he continues to send financial support. Children may receive support from parent(s) for extended periods without ever seeing them. Some become adults before reuniting with their parents. There is a new phenomenon resulting from the abandonment of children by parents who support them but fail to reunite. The phenomenon of the "Barrel Children" is a growing concern for many communities. "Barrel Children" receive regular shipments of goods from their parents who reside in countries such as the United States and Canada. Children are left in the custody of grandparents, aunts, uncles, friends or neighbors who are told that care is temporary until the parents send for them. Sometimes children left at five and six years old don't see their parent(s) until they are 18 or may never see them. Margaret, a "Barrel Child," commented:

I have not seen my mother since I was five and I am 18 now. She left me with my grandmother who died when I was twelve and then I went to live with my Aunt Hilma. I don't think she cares about me. When she had me she wasn't ready for a child. She has been in the United States for 20 years and she is still not able to send for me. The barrels keep coming and sometimes money, but it does not make-up for her not being here. What is worse, I don't even get along with my aunt. I guess it is partly my fault because I am so angry with my mother. I used to get

into fights at school over the fact that a friend said that my mother did not want me. That really hurt for a long time.

I could have done better in school if I wasn't so worried about a future alone. In some ways I am lucky because my Aunt Jean, my mother's childhood friend, keeps encouraging me to stay focused on my school-work because I will be taking my Caribbean County Examinations (CXC) next month and that determines my future. Sometimes I use to feel cheated and sorry for myself especially when my Aunt Hilma tried to discipline me. I know that my aunts have helped me a lot, without their help I could have gone down the wrong road. During school hours, I went about my own business with my friends and could have gotten into trouble with drugs or the law. If I were to see my mother today I would hardly know her. I wouldn't know what to say to her. I don't feel close to her, but I know that I love her because she is my mother.

Although changing rapidly, strong kinship bonds are characteristic of the Jamaican family. Even when family members are scattered, they try to maintain some contact with each other, and if a family member needs support, the family is mobilized to assist. The oldest child is often the standard bearer whose responsibility it is to help to keep the family intact.

Responsibility for the family is a role for both sexes, but it is even more demanding when the oldest sibling is male. The male role is frequently that of a surrogate father who makes sure that his sisters make appropriate choices related to education or mate selection. His responsibilities may be compounded as he takes on a family of his own. The role of the oldest female is often that of a caregiver and decision maker for aging parents. When a health decision is to be made for a family member, it is not unusual to have siblings, as well as extended family (aunts, uncles), participate in consultations with health professionals. The final decision, however, rests with the oldest sibling.

Post-emigration, kinship bonds often continue to reflect an appreciation for the collective good of all the family, including cousins, aunts and uncles. For example, it is not uncommon to find two or more immigrant families living together to help one another achieve goals. The belief in family is very strong, and many take pride in their loyalty and care for one another. Even when there is a schism among family members, an outsider must be very careful not to raise the ire of quarreling relatives and receive the brunt of displaced anger. The saying, "Blood is thicker than water" reflects the keen sense of family loyalty among Jamaicans.

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### *Role of the Community*

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Community involvement in rehabilitation is limited, but increasing public aware-

ness through media promotion is helping to educate the community about issues faced by people who are physically or mentally challenged. The limited input from the community is particularly poignant as it relates to employment of people with disabilities. Most people with disabilities who are employed are in the governmental work force. The private sector has not yet become a major partner in providing employment.

The lack of private sector employment participation may reflect the general belief that people who have physical challenges should be cared for at home. The notion that a person who is challenged also can be a viable worker has not been fully communicated either to employers or to families of people with disabilities. An intensive effort by advocacy groups is helping to change these community perceptions.

The worldview of Jamaicans includes a keen sense of community and support for the collective. Based on this worldview, citizens are inclined to assist others however they are able. Such groups as the Kiwanis and Lions clubs, Food for the Poor, Alcan Jamaica, Grace Kennedy and Company have supported rehabilitation programs when solicited. The religious community also has been an informal partner in the rehabilitation process. Church members often deem it their responsibility to assist families with disabled members by doing domestic chores and offering respite care. If a disabled person has no family, church members sometimes assume caregiving roles. Churches also provide financial assistance for many people with disabilities.

In terms of community-based rehabilitation programs, the 3D Project has been very successful particularly in rural communities. It was the first community based program in Jamaica and was established in 1987. The 3D project has forged partnerships in rural communities with parents and children with disabilities. Projects are located in the parishes of St. Catherine, Manchester, St. Thomas and St. Mary. The 3D Project addresses the social, educational and economic needs of people with disabilities. Community-based rehabilitation for children with disabilities in Jamaica was pioneered by Dr. Molley Thorburn.

Other community-based rehabilitation organizations include: Concerned Citizens Association, Jamaica Association for Persons with Mental Retardation, Jamaica Association for the Deaf, Jamaica Society for the Blind, Private Voluntary Organization and the West Haven Children's Village. The organizations represent a sample of the many community groups determined to improve the quality of life for persons with disabilities in Jamaica.

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### *Gender Differences*

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Women tend to take the leadership role in securing and utilizing services for themselves and their families. If a family member is ill, it is the woman who

researches available resources and makes arrangements to get the person to the doctor or other medical professional, and women are more inclined to seek service for themselves than are men.

Men sometimes engage in denial of their own needs that may result in remedial rather than preventative services. As the chief breadwinners, they are reluctant to lose time and money from work to seek medical help, which may be indicative of their sense of duty and responsibility to the family. The denial of needs may also be related to the desire to appear "manly" and strong. Going to the doctor for what appears to be a minor illness is sometimes perceived to be a weakness.

When service is accessed, the woman accompanies the man to the doctor and is ultimately responsible for ensuring that the prescription is followed. For example, Audrey Guilling, a nurse at the Montego Bay Regional Hospital, says:

"Women tend to seek health care and will follow instructions; men tend to shy away...men come when they are dying or the problem has gotten out of control. It is difficult to get men to change lifestyle behaviors...they continue to engage in the same behaviors that got them in trouble."

Men will refrain from accessing service to avoid financial embarrassment. If both the man and woman need service, the man will generally make sure that the woman's need is met. This is rooted in the belief that a man must be able to provide for his "woman" or his family.

Women with disabilities also appear to be more aggressive in accessing services than their male counterparts. For example, there are more women with disabilities than men pursuing educational opportunities and making significant improvements in their quality of life. Women have also occupied more leadership roles in advocacy organizations. For example, three women have served as the President of Combined Disabilities Association (CDA) which is the major advocacy group for people with disabilities. Also, the committee convened to formulate a national policy on disability was spearheaded by a woman, Monica Bartley.

### *— Recommendations for Providing Rehabilitation Services — to Jamaicans in the U.S.*

When working with Jamaicans with disabilities, it is imperative that service providers attend to cultural nuances that might be deemed trivial in the American culture, but are very important in Jamaican culture. An understanding of these cultural idiosyncrasies can be vital in minimizing communication problems. Value-laden cultural beliefs can affect communication and result in

poor client retention or failure of the client to comply with prescriptive health measures. The following are suggestions for working with Jamaicans:

1. Greetings or acknowledgment of an individual's presence is an important cultural value. Before any professional or social interaction, Jamaicans customarily preface their interactions by saying "Good morning, good afternoon or good evening, how are you doing today?" Absence of the greeting implies a failure of interest in the well being of the individual. For example, one might ask "a wha mi do yu dis mawning, you naw say notin ti day?" (What have I done this morning, are you going to say hello today?)

The same value holds when an interaction is terminated. Some form of goodwill should be expressed. To depart without doing so is construed as disrespectful. For example, you might hear, "She left an she never even say she gone," "She left without saying so" or "She left without saying good-bye."

It is not unusual for friends and family to travel to another's home to wish them good-bye when they are leaving their residence for long-distance travel. Large groups of friends and family often gather at airports to "see someone off" to say good-bye.

For service providers, to take time to greet and engage in brief small talk can be very helpful for rapport building. Otherwise, clients might leave with the belief that the service provider does not care about their well being ("dat de man dry sah, im neva even sat mawning, mi naw go back de" - "that man is not warm, he never said good morning, I am not going back there.") Greeting as a practice with Jamaican clients can serve to set the tone for the agency-client relationship and a potentially positive service outcome.

2. The titles of Miss, Mr., Mrs., Doctor before one's name is important. If you visit a Jamaican office or observe people in social interaction, a title is always attached to a name. The last name (surname) is often used but in less formal settings a title precedes a first name, as in "Miss Mary". If someone has a title, such as Doctor, it is frowned upon to address them without the title. Even if given permission to omit the title, some people still have difficulty not using it. This custom is based on respect for each other. When individuals have been friends for a long time, use of the first name is appropriate. It is considered a breach of familiarity to address someone you are meeting for the first time or with whom you are only vaguely acquainted without the formal title. For example, for a service provider to request a patient by calling aloud "Mary Jones"

in a waiting room would be considered disrespectful by some Jamaicans.

3. Jamaicans pride themselves on being able to handle their own problems, so it is important to ensure that service delivery environments are supportive of this value. Individuals who feel that they might lose control in a service delivery system might not be inclined to use such services.
4. Jamaicans are very proud and will go to great lengths to maintain their dignity. Even in the face of tremendous distress they might appear quite stoic. This should not be misinterpreted as unfeeling or uncaring.
5. Privacy is highly valued, so discreet and confidential treatment of information is important. Physical or personal privacy is also expected. For example, a patient in a hospital might be very fussy about being able to wear his/her own sleepwear instead of a hospital gown which has the potential for unexpected exposure. So a request for one's own hospital wear should not result in the staff labeling the patient as difficult and hard to work with.
6. Caring for a family member is often an obligatory role. If someone is in the hospital, it is not unusual for family members to insist on providing routine care similar to the role of nurses. For example, family members might want to bathe and feed a patient. They might even prefer to prepare meals at home and bring them to the hospital. When possible, accommodating the family's desire to provide care can be helpful.
7. Family members have strong kinship bonds, which might appear unhealthy to some professionals. Providers should refrain from dismantling these bonds, particularly when a family member is ill or disabled. For example, an ill relative might be accompanied by four or five members to the doctor. It would be unusual for the patient to visit the doctor, physical therapist or rehabilitation office alone.
8. An aunt or uncle might accompany a child to the doctor or other service delivery agency. That aunt or uncle should be treated with the respect of a parent. To ask the aunt or uncle why they are the ones accompanying the child would be a surprising question because they consider their presence as good as the parents. For example, a rehabilitation professional questioned an aunt because she was making demands for special services for a niece. When he asked why the parents were not there, she replied. "I am here and

she needs the service, so you will have to deal with me.” The counselor reported that he thought that the aunt was difficult, stubborn and hard headed. The child did not return for services.

9. Appointments should be made as convenient as possible because Jamaicans have a strong work ethic and will miss an appointment before missing work. For example, a rehabilitation counselor set an appointment date for a family member to return with a child for evaluations. She informed the counselor that she could not keep the appointment that was given and requested other dates. The counselor reported that he was annoyed because the family member had the "nerve" to dictate appointment dates and she should have come when he told her. He felt that it was a sign of her stubborn behavior. The family member and child did not return for service. It is important to note that this example and the one above are actual events.
10. Treat the elderly with respect. Voice tone, physical handling (e.g. manipulation of limbs) and instructing the elderly should be done with care and sensitivity. Jamaicans have a great deal of respect for the elderly. Their experience is considered to be a source of wisdom and should be appreciated. Displays of honor and respect are often shown by total strangers who may refer to elderly women as mother (Madda), mamma, mammie or mumsy and elderly men as "pops", dads, daddy or "papa." The reference is generally accepted with grace and the elderly might respond by using the terms "mi son" or "mi daughter" (my son or my daughter). Disrespect of the elderly is frowned upon and will be brought to the attention of the offender. Strangers will stop to assist an elderly person, if they deem it necessary.
11. Jamaicans have a strong antipathy toward the placement of elders or ill family members in nursing homes. The placement of family members in a nursing home represents the ultimate rejection and abandonment of one's own flesh and blood. It is considered a gross failure and disgrace for a family to consider the use of nursing home facilities. To care for one's family until death is admired and applauded, so counseling and support must be available for families who must utilize the service of a nursing home. Families should be reminded that life in America is not conducive to the maintenance of such family loyalty. Work demands, family members scattered across the country or remaining in Jamaica, and lack of financial resources needed to provide care at home make the choice of a nursing home a necessary decision. The suggestion of nursing home placement must be approached with tact and sensitivity.

Family members might be receptive if they are coached into the decision.

12. Jamaicans place a high value on the intellect, therefore information regarding cognitive dysfunctions should be presented with tact and sensitivity. For example, prognosis related to mental illness, learning disabilities, head injuries and related neurological disorders might be sources of resistance for family members who might be in denial. Even if there is difficulty, family members often have high expectations for the patient and might refuse information that does not support their beliefs about the patient's capabilities. Again, tact and sensitivity are imperative.
13. Personal information is considered to be just that, so information gathering can be a tedious process. At the beginning, be sure that the client knows your reason for asking for personal information and how the information will be used. If the client feels as if questions are invasive, they may avoid direct questions or may not return for service. Questions from doctors might be more readily answered because Jamaicans have a great deal of respect for professionals like doctors, nurses, teachers and ministers.
14. Listen carefully to understand what is being said. While English is the language spoken in Jamaica, most Jamaicans, especially the less educated, speak Jamaican Creole. It is a mixture of English and West African languages, particularly of Ashanti origin. Speech patterns are fast and rhythmic and coupled with unfamiliar words, which may make communication difficult. American English accents may also pose communication problems for some Jamaicans. Simplify and clarify what has been said in order to prevent misunderstanding on behalf of both patient and service provider, but make sure that efforts to deliver clear communication are not conveyed in a condescending manner.
15. Acknowledge religious expressions of patients. Most Jamaicans are very religious and they see God as their spiritual refuge and strength in times of crisis. Basically the concept of God is fundamental to the Jamaican experience. Attention to referrals to God may be a bridge to rapport building and psychosocial adjustment to disability, because it validates what is important to them.
16. Network with Jamaica professionals in the field of rehabilitation who might serve as informal consultants/advocators on behalf of those Jamaicans receiving rehabilitation services. Communication

with these professionals can be helpful in understanding unfamiliar behaviors or attitudes of Jamaican clients.

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*Suggestions for Becoming more Familiar  
with Jamaican Culture*

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1. Be curious and willing to learn about other people and their way of life. Read Jamaican newspapers, novels and explore the Internet as a medium for listening to Jamaican radio stations to gain better insight into their way of life.
2. Recognize that Jamaicans bring with them a cultural history and a strong national identity based on their cultural experience.
3. Remember that "one size does not fit all" when it comes to culture. Refrain from imposing American culture on Jamaicans because many will resent it.
4. Ask when in doubt. Most Jamaicans are proud of their country and are happy to talk about it.
5. Be both a teacher/counselor and a student. The same goes for the client. Learning about each other is a "two way street."
6. Learn the symbols and meanings in the culture (national emblems) and value the national icons (national heroes). They provide insights into how the collective identity and consciousness of the country were developed.
7. Examine personal biases and stereotypes against Jamaican immigrants in the United States.
8. Examine personal religious beliefs and, when possible, create a safe space for patients to express their own.
9. Celebrate your own culture and heritage, but be open to the differences between people. Respect, rather than judge, the cultural background of others.

## CONCLUSION

Rehabilitation services in Jamaica are very young in comparison to those in the United States. Many Jamaican consumers are unfamiliar with the concept of rehabilitation as a process that can improve the lives of people with disabilities. Given this lack of familiarity, rehabilitation service providers in the United States face a challenge when it comes to educating Jamaican consumers not only to access the rehabilitation system, but also to complete the process. Jamaicans typically have many sources of strength that service providers can harness to assist them in this process. These include confidence in their ability to achieve goals, a strong work ethic and self-reliance. However, providers must also recognize that there are cultural barriers that can hinder the rehabilitation process. Such barriers include the belief that persons with disabilities should not work, live alone or pursue an independent life. The provider must work to minimize the impact of such beliefs to insure the success of the rehabilitation process.

If providers remain open to the culture of this group, they can provide holistic rehabilitation services to Jamaican consumers. Informing themselves about the differences and similarities between Jamaicans and the dominant culture will help providers step beyond cultural barriers and provide the quality of service that reflects the fundamental principles of American rehabilitation.

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