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ABSTRACT

Caribbean mental health professionals are concerned with the types of psychotherapy that are relevant to the needs of their clients, and with the uses of psychotherapy in a political context. They appear to be divided into two schools: one seeking to promote in clients a change from a traditional world view to a modern one, and the other seeking resolution within the client's lifestyle and belief system. This paper discusses mental health professionals' relationship to indigenous healing systems endemic to Caribbean people. For instance: (1) Haitians' Voudou, (2) Obeah, or witchcraft, which is prevalent in the British West Indies, the Virgin Islands, and the Bahamas, (3) Puerto Ricans' Espiritismo, and (4) Afro-Cubans' Santeria. These as well as other therapeutic modalities are discussed in terms of their applicability in clinical and community settings. A second component of the paper deals with empirical approaches to psychotherapy with Caribbean immigrant groups in Miami. The University of Miami-Jackson Memorial Hospital Community Mental Health Center, maintains six ethnic community teams, four of which are geared toward Caribbean populations (Bahamian, Cuban, Haitian, and Puerto Rican) with staff of matching ethnicity. This center has developed a range of various types of therapeutic interventions. Among them are the following: (1) a network of culturally homogenous mini clinics in six different communities, (2) group therapy within a social recreational context, (3) involvement of the extended family in family therapy, (4) knowledge of the various forms of "hexing", (5) consultation and informal referral to folk healers when this seems indicated, and (6) merger of traditional and scientific techniques in psychotherapy. (Author/AM)

PSYCHOTHERAPY IN CARIBBEAN CULTURES

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PSYCHOTHERAPY IN CARIBBEAN CULTURES

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When the newly organized Association of Caribbean Psychologists met for the first time in Haiti last year, it was not surprising that the conference theme was entitled "Psychotherapy: What Works in the Caribbean?" For a number of years now, Caribbean mental health professionals, like many others in other parts of the world, have been bemoaning the fact that the skills learned in the great universities of Europe and the United States were not always transferable to their work with their own populations. The emergence of a mental health capability in the less developed regions of the world has highlighted an old problem in the field; that is, the discrepancy between our elegant psychodynamic theories, which appear to have universal applicability, and our technologies, which do not. Indeed, the descriptive accuracy of psychodynamics inferred from overt behavior--and intellectual and perceptual functioning as well--appears to be highly subject to cultural specificity (See especially Draguns, 1973). Added to this are the problems of acceptance, relevance, cultural appropriateness, and remedial potential of treatment modalities transplanted from an alien culture.

When we speak of a mental health capability in the Caribbean area, we refer primarily to the long chain of islands that make up the West Indies; the Bahamas, too, fall under this rubric, although technically they do not bound the Caribbean sea. The people are multiracial, but primarily Black--descendants of slaves under various colonial administrations. As a heritage of colonialism, the languages are English, Spanish, French, and Dutch, together with their various Creoles.

There are other residuals of colonialism (in some cases replaced by native dictatorships). Most of the people are poor, by American standards,

Their work has historically been agriculture and fishing, but a significant portion of the labor force is now in the tourist industry. This growing reliance on service occupations as a major economic base is of great concern to many Caribbean governments--not only because of the fragility of tourism as an income source, but because of the perpetuation of servitude as a way of life. In newly independent countries in the Caribbean, with rapidly shifting power relationships and role changes, and rising economic expectations, people become dramatically dissatisfied with the old ways. Additionally, there is the inevitable acculturative stress that accompanies the transition from traditional to modern man--today a worldwide phenomenon (see Dawson, 1970).

The sociocultural context is of great concern to Caribbean professionals, who see a profound relationship between the developmental level of a given society and the ability of its members to benefit from traditional psychotherapy. Moreover, Caribbean psychologists discuss not only the types of psychotherapy that are relevant to the needs of their clientele, but the uses of psychotherapy in political context. This is not the old question of whether to adapt creatively deviant patients to a sick society. Rather, it is whether the psychotherapist should consciously try to promote in the client a change from a traditional worldview to a modern one--a process which will facilitate adaptation to the real world around him and - not coincidentally - also maximize the benefits of psychotherapy.

In summarizing the various positions at the Haiti conference, Antonio Diaz-Royo (1976a) found two global viewpoints with respect to modernization. The first position considered modernization inevitable and postulated that the client must adjust to it in order to solve his problems. Here, "psychotherapy is seen as a springboard for socialization or conversion to modernization, thus achieving the client's adjustment." The second position

conceptualized that modernization is not necessarily inevitable on an individual level, and seeks a solution within the style of life that the client selects.

The two viewpoints are probably best exemplified by a group of Puerto Rican psychologists on the one hand, and a group of Haitians on the other. Matlin and his associates (1976:1) took a hard look at the program for training local psychologists and decided that "the use of American styles tended to cure the patient of the disease of being Puerto Rican." The Haitian psychiatrist Bijoux (1976), on the other hand, expresses enormous frustration with his patients, whose traditionalism makes it almost impossible for him to use the psychoanalytic techniques in which he has been exquisitely trained. Haitian patients have a basically magical philosophy of life; like most people from traditional cultures they are high in external locus of control--hence the difficulty of introspection and certainly of seeking mastery over one's life through this non-magical mechanism. Additionally, financial limitations--ubiquitious problem in the Islands--forces the therapist into brief psychotherapy. But with industrial development, more education, and higher wages--the whole picture would change. "All the adverse conditions can be modified by an evolution from an agricultural magical mentality to a technical industrial positive orientation, so we are raising the question. Is the destiny of psychotherapy linked to the socio-economical development of a specific society?" (p. 5).

Throughout the islands there was a fairly uniform description of the Caribbean client seeking psychotherapeutic aid. Diaz-Royo gives the following summary picture:

> 1. Oriented toward a particular problem which is what brings him to seek psychological aid, with a non-contextual expectation of psychotherapy. He does not conceptualize the problem that brings him for psychotherapy as rooted in his style of life.

2. Expecting counsel or direction from the psychotherapist, and finally,

3. Arriving with the expectation that he can implement the psychotherapist's counsel or direction and thus resolve his problem relatively rapidly. (Ibid:1)

This description, however, does not differ substantively from that of the typical lower socioeconomic or minority group client in the United States. In fact, the description might apply to practically anyone who has little familiarity with the ethos and boundaries of psychodynamic therapies. What makes the Caribbean patient somewhat different, however, is that he often has alternative options, that is, his traditional healing systems. As Bestman et al (1976) have noted, while many health professionals view ethnic healing systems as alternates to scientific medicine or the orthodox mental health service delivery system, actually we are alternates to traditional therapists and their practices in a system which is historically an outgrowth of cultural beliefs and values specific to an ethnic population. Thus, Caribbean clients may use our clinics as a first or last resort, or in tandem with a native healer. Additionally, the belief system itself may be the source of mental malaiseor presenting symptomatology, requiring the services of a native healer for appropriate remediation. Common among these are possession crisis--in which the person is possessed by his personal or ancestral spirits or gods in ritual context; bizarre behavior--bowing, hand motions, dancing, etc.--which is actually ritualistic (see Griffith & Ruiz, 1976); or anxiety nerosis resulting from being "rooted," "hexed," or "fixed"--all conditions which ascribe causation of ill fortune or mental condition to the magical influence of others.

Belief Systems: Alternate Healers

Obeah, Voudou or (Vodun), Espiritismo, and Santeria are prominent belief systems in the West Indies. Although all share certain commonalities from the Christian and West African religions, each exhibits a unique form. In Obeah, normally there is no group involvement; healers work in a one-to-one relationship with their clients. In the other three systems adherents often gather as a group and receive additional benefits to memberships such as social support and recreation.

Voudou, subject of Western fear fantasies, appears to be a true religion, i.e., it is a set of beliefs and practices which claim to deal with the spiritual forces of the universe, and attempt to keep the individual in harmonious relationship with them as they affect his life (Leyburn, 1966:134). As in Santeria, there is a necessary propitiation of gods (loas). Dahomean slaves predominated in Haiti and their religious beliefs and practices formed the core from which contemporary voudou evolved. The greatest single influence during the years of evolutionary process was the Roman Catholic Church. The composite system which exists today in Haiti, as well as Miami, requires that one must maintain proper relationships with the Christian God, the Catholic Saints, the African gods and the dead (Simpson 1940: 95). Its practitioners, called houngans (males) and mambos (females) are sought by their clients to foretell the future, cure illness and give protection from the misfortunes of life. They are also thought to have the power to cause illness or harm to another. Ritual voudou ceremonies involve trance, possession, and animal sacrifices--primarily goats and chickens. Ritual dances to coudou drums are actually rites to exorcise bad loas which are presumed to be a cause of the dancer's misfortunes.

Bijoux (1976) has characterized Haitians--almost all of whom are Voudou adherents--as depersonalized individuals who are exposed very easily to dissociation. Relations with others are dominated by suspiciousness and envy. "The mental mechanisms of adaptation most used are magical rationalization, projection, and dissociation-identification." Remedies must clearly be culturally appropriate or they are bound to fail. Mathewson (1975), describing Haitian patients in Miami, cautions against diagnostic error when using standard psychological assessment procedures. First, she notes that the Haitian conceptualization of the world contains two major categories: the visible world including humans, and the invisible world of the dead, spirits, and other supernatural beings. Second, because of magical belief systems, others are seen as potential sources of danger and harm. Thus, so-called paranoid ideation is often within the boundaries of normative behavior. Standard assessment procedures for hallucinatory behavior, similarly, must take into account a cognitive system which attributes a communicative function to dreams. "At least one aspect of dreams for Haitians is their function in allowing communication between humans and members of the invisible sub-world... Thus, when dead relatives or spirits appear in a dream, Haitians tend to perceive the experience as something which really took place" (ibid, p. 8). Unless an examiner specified waking hours for the context of questions, a Haitian might very well respond that he indeed heard voices or saw things that others did not--without conveying a pathological hallucinatory experience.

Obeah, or witchcraft, prevalent in the British West Indies, the Virgin Islands, and the Bahamas, reflects the syncretism of Ashanti religious beliefs and the Protestant Church's influence in these countries. As in all these cult systems, there is a belief in spirits who may possess humans and require propitiation. Obeah is not a religion and has no collective rituals, according

to McCartney (1975). Obeah men deal on an individual basis with clients, causing or curing illness, casting spells, and countering the spells of other obeah men. Weinstein (1962) maintains that Obeah persists "because it serves as a mode of adaptation to stress, because it structures and expresses the most intense feelings, and because it organized what would otherwise be uncontrollable and unpredictable forces impinging on the individual" (Woodbury, 1975).

Espiritismo, a more benevolent system, is widely practiced in Puerto Rico. According to Garrison (1972), Espiritismo is a folk system of psychotherapy and a means of coping with psychiatric illness and lesser distress; it is both an alternative and a supplement to seeking help from professional mental health services. Studies of Puerto Rican samples in San Juan and New York have shown a range of 31% to 80% admitting to having sought help from an Espiritista at some time during their lives (ibid). Woodbury (1975) feels that practically all Puerto Rican patients manifesting psychosomatic, neurotic, or psychotic symptoms go to an Espiritista. As in Haitian Vodun, the belief system postulates both visible and invisible worlds, the latter populated by spirits or beings that communicate with the living. Through mediumship, the spirits give revelations that help to cure the living of presenting complaints. Rogler & Hollingshead (1961, 1965) have emphasized the supportive and maintenance functions of Spiritist practices, particularly in the case of chronic schizophrenics.

> Participation in a spiritualist group serves to structure, define, and render institutionally meaningful behavior that is otherwise perceived as aberrant. Spiritualism serves the afflicted without the stigma of attending a psychiatric clinic.

Afro-Cuban Santeria similarly, provides group support and, in some cases, a substitute for the disintegrating extended family, for Cuban exiles suffering the trauma of acculturation. Originally a cult system for lower-class blacks, the pantheon of Yoruba gods, syncretized with Catholic saints, has become

increasingly widespread among white middle-class and even upper class Cubans in Miami. The orichas, i.e., the saints or dieties of Santeria, are very complex and very human personifications of nature. By forming the right alliances with the orichas, an individual can manipulate his universe and thereby master it.(1) Problem solving and action orientation are central. Halifax and Weidman (1972) have described Santeria as an ego-integrative process in which denial, projection, and dissociation--i.e., the transfer of guilt in the individual to an outside locus, and the projection of unacceptable impulses and feelings through trance possession by an oricha--are metamorphized into a sense of mastery. In this process, the Santero, through his function of divination, acts as "change agent" and as "therapist." Through divination, options are revealed which enable the client to act, and to alleviate his sense of vulnerability through propitiatory offerings. The latter, in turn, place the powerful oricha in a position of indebtedness. In effect, the client is "buying power," generating not only an aid in solving discrete problems, but greater confidence in subsequent relationships and activities--a situation highly analogous with the aims of psychotherapy. Parenthetically, many Santeros, far from being outcasts from the mainstream, are licensed as religious practitioners by the State of Florida.

Native Healers and Mental Health Professionals

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

symptomatology. Possession crisis, or the bizarre behavior that often accompanies religious ritual are certainly best handled by consultation with a Houngan, Espiritista, or Santero. But certain of the so-called culture-bound syndromes, such as "Ataque," or "Susto"--regardless of their psychiatric classification--may also require such interventions. Sometime a psychiatrist will work in tandem with native healers, or use them as resource persons for interpreting behavior. At other times, the psychotherapist himself may actually adopt the role. McCartney, (1975) a Bahamian psychologist, has described for the University of Miami Department of Psychiatry faculty a very speedy cure of depressive neurosis facilitated by simulated Obeah rituals. In Miami's Jackson Memorial Hospital, our former chief of the Crisis Service, a highly trained psychiatrist from Guyana, successfully performed his own specialized ritual to cure a "rooted" patient. Dr. Mercedes Sandoval, a cultural historian-anthropologist who is director of the Cuban Unit of the University of Miami-Jackson Memorial Community Mental Health Center and a world authority on Santeria, deals with patient-believers within their conceptual frame of reference together with a psychiatrist co-therapist. But what defines a patient's aberrant behavior as truly pathological--requiring psychiatric intervention--or simply as a temporary artifact of a religious belief system? Griffith & Ruiz (1975), reporting on a hospitalized Espiritismo practitioner, looked to the patient's family for an explanation. Their criteria for psychopathology were as follows: (a) The patient's possession had lasted too long--it is typically a quick and transitory experience; (b) possession becomes abnormal when there is no perceivable stimulus or condition (e.g., a ceremony, thunder, lightening, accidents, etc.); (c) it occurs most often in the presence of believers (a secrecy condition); and (c) it can have positive or negative orientation. Positive orientation is <u>ritual</u> possession, negative

orientation is sickness possession. The authors state it is especially important for mental health professionals to understand this dichotomy for appropriate ethnopsychiatric evaluation.

Other Therapies

As in the United States, psychoanalytically trained Caribbean psychologists continue to practice traditional psychotherapy with a select, educated, and monied group who are able to afford and benefit from their art. With patients from the lower socioeconomic groups, therapeutic interventions seem to be largely supportive or rehabilitative. In rigorously psychoanalytic Haiti, for example, the different types of psychotherapy practiced with young people are: "[illegible] psychotherapy with occupational activities; emotional support strategies; and psychotherapy based on a regimen of rest" (Philippe, 1976). Haitians almost always ask for medication and are not willing to accept treatment without it, so chemotherapy or placebo are invariable adjuncts. Inevitably, there is a developmental lag in terms of the newer American therapies reaching the islands. However, while there is little mention of the practice of behavioral, transactional, or gestalt modalities Caribbean professionals seem to be well read and conversant with their techniques. Periodically, there are workshops in family or group therapy organized by out-of-country professionals, such as a Facilitator Development Institute held in Curacao 1st April, with Carl Rogers as a consultant.

Dance and movement therapies have been used in Surinam and Curacao, apparently with some degree of success. However, several innovative therapeutic approaches bear particular mention. One is Terapia de Metas, or Goal Therapy, developed by Norman Matlin and his associates and characterized by him as "the first system of psychotherapy indigenous to the Caribbean" (Matlin, 1976).

Goal Therapy appears to be a short-term step-by-step therapeutic intervention which dispenses with any initial accumulation of information on the client. Matlin rejects what he terms the "fishnet approach" of collecting diagnostic data which must then be filtered through the therapist's interpretive armamentarium, and in the end, has little functional relevance to treatment. Rather, goal therapists prefer the "spear" approach which calls for dealing with the client's statements one by one. The psychologist opens by asking the client to define the problem he would like to solve in counseling. The therapist then analyzes the implications of the statements, comments, raises questions, and proceeds in like manner with succeeding statements. "The interview continues until either the client is satisfied that he has solved a particular problem or the psychologist is stuck. In the latter case, he has a week to figure out what he did wrong." (ibid.) The essence of goal therapy seems to be to defuse the presenting complaint by teaching the client to reconceptualize his problems and to seek solutions in terms of realistic goals. Typically, the therapist's questions are geared to elicit a reconceptualization of the urgency, scope, or validity of the problem. The model has generalizability and can be used anywhere at any time--one paper described a five-minute backyard over-the-fence therapeutic intervention which ended in a mutually satisfactory solution.

Two very interesting therapeutic models evolved from the work of Michael Woodbury, a psychiatrist who is currently Executive Director of the Commission of Mental Health in Puerto Rico. The models were originally developed by Dr. Woodbury and his wife, a social worker, in France and were subsequently utilized in the Virgin Islands and in Puerto Rico. These involved a system of community-centered psychiatric interventions with the use of mobile emergency units and home hospitalization visiting teams, including indigenous homemakers. Essentially this was an attempt to treat the patient and family "in situ-in its sociocultural network (and ecological niche)--by the team as a therapeutic small group: (Woodbury, 1969:65). Two therapeutic modalities emerging from these

community team interventions were (a) the "continuous group" and (b) the "multiple-family group," both of which are currently utilized in Puerto Rico. The continuous group is actually a family walk-in clinic, which started as an extention of spontaneous meetings of the team itself in their treatment room-kitchen where they "metabolized" their anxieties about home visits. As Woodbury (1969:70) described it: "Patients and members of their families dropped in to say hello and talk things over, expecting us to return their hospitality." Although at first the team was opposed to this "psychiatrization," insisting that all interventions occur in "the patient's territory," they subsequently began to realize its usefulness. The continuous group offered patients and their families crisis intervention and group psychotherapy "on demand as a safety valve that in many cases prevented a real emergency later on." Approximately 20-30 persons utilized the service each day.

The second modality is a variant of family-group psychotherapy which at its inception involved 30 families being served in the community-intervention service, plus teams, center personnel and professional visitors. As Woodbury describes it, families with problems become therapists for other families with problems--rather like the extension of a self-help group with clinical back-up. "All members learn rather quickly our basic techniques of psychotherapy and are expected as a matter of principle to participate in the resolution of one another's conflicts. As the 30 families we have at any one time on our service become acquainted with each other's problems, they are encouraged to assist one another in their neighborhood without our mediation...Family treats family" (Woodbury, 1969:70).

It might be noted that this type of mutual aid is most likely to work in cultures where it is not considered shameful or threatening to talk about emotional problems in the family. Dr. Mercedes Sandoval, director of the Cuban

Unit of the University of Miami-Jackson Memorial Community Mental Health Center, has noted that the Anglo emphasis on confidentiality is alien to her patients, who are willing to discuss their problems openly and do not understand the need for closed doors, soft voices, locked record files, and our other paraphernalia of privileged communication. Ironically, the emphasis on privacy may be perceived by her patients as an overt indication that their disclosures are something shameful--else why should they be hidden and protected? In that sense, the superimposition of this most potent of Anglo taboos might even be counter-therapeutic. But while family might treat family in Latin cultures, it would be counterindicated for Haitians. In fact, because of normative suspiciousness of others--which Bijoux (1976) has described as core qualities of his culture--group therapy is not used with Haitian patients in Miami.

Caribbean Patients in Miami

Miami is the closest and most culturally congruent point of entry for Caribbean immigration. Three years ago, the University of Miami-Jackson Memorial Community Mental Health Center (CMHC) was initiated with an innovative ethnic community team model based on the needs, population distribution, and cultural configuration of its catchment area. The program has six teams specifically geared toward serving the following populations: Black-American, Bahamian, Cuban, Haitian, Puerto Rican, and Geriatric-the latter primarily Anglo. Teams are staffed by indigenous paraprofessionals and directed by social scientists, all of matching ethnicity to the populations served. Clinical staff, also, are almost entirely of the same cultural extraction.

The work of this innovative program has been comprehensively described elsewhere (Psychiatric Annals, August, 1975, whole issue; Lefley, 1974). Our

work with Caribbean clients has similarly been described in greater detail than can be afforded here (Bestman, Lefley, & Scott, 1976; Bestman & Lefley, 1976). However, since the present paper has largely been devoted to Caribbean psychotherapy *in situ*, it would be of interest to indicate possible commonalities and differences in dealing with transplanted populations.

First, the problems of adapting psychotherapy to the needs of "traditional" and "modern" cultural personalities, so well depicted by Antonio Diaz-Royo (1976b) are compounded in immigrant groups by the experiences of uprooting and subsequent acculturative stress. The move to an alien society, voluntary or not, inevitably brings anxiety and a sense of loss of the familiar. There are often reality problems to deal with--economic, linguistic, social, and in the case of Haitian illegal immigrants, political barriers as well. In all of our Caribbean groups, extended families have been broken up by the act of emigration, and there is mourning for significant others remaining in the home country. Anxiety and depression are common phenomena.

Our four Caribbean groups face different types and levels of acculturative stress. For Puerto Ricans, Diaz-Royo's (*ibid*) traditional-modern dichotomy is quite germane, with traditional male-female role relationships particularly vulnerable to cultural erosion. For Bahamians, the dichotomy lies rather in a "Bahamian" versus "Black-American" identity choice. Our Haitian clients, many of them illegal immigrants, face such overwhelming reality problems that attending to survival needs is the most basic type of psychosocial therapy-- in its clearest, Maslowian sense.

Of the four groups, it is probably the Cubans who experience acculturative problems most severly. As the predominant ethnic co-culture in Miami, Cubans are predominantly well educated, European, and primarily from non-poverty backgrounds. Briefly, acculturative problems include: value conflict; economic and often social role reversal; erosion of the close-knit extended family;

changes in male-female role relationships; and above all, intergenerational conflict, compounded by the culture gap between grandparents, parents, and English-speaking Americanized children. And overall is the overwhelming sense of loss for the old identities and the lost country. It is not surprising that mental health workers report rises in anxiety and depressive neuroses, paranoid ideation, and psychosomatic disorders.

In attempting to develop appropriate treatment modalities to deal with these multiple problems, it was first necessary to offer therapists who could communicate --both linguistically and culturally. This we have done with our ethnic community team model and with our culturally-knowledgeable clinical staff. While our program continues to offer more traditional forms of psychiatric treatment--chemotherapy, traditional psychotherapy, and the like, we have developed a range of other types of therapeutic interventions. Some examples are as follows:

1. A network of culturally homogeneous "mini-clinics" in six different communities, many of which function as neighborhood centers offering classes, recreational facilities, etc. In this setting, particularly good for aftercare cases, psychiatric patients mix eith neighborhood people, in the same position as other people seeking services--facilitating the deinstitutionalization process. The mini-clinics also have a "drop-in" quasi day-treatment atmosphere which haye some similarity to Woodbury's "continuous group."

2. Group therapy within a social-recreational context. In the Puerto Rican and Cuban teams, for example, group therapy may be conducted during a macrame class, with the focus on a shared task.

3. Involvement of extended family in family therapy. Bestman (1976) has written about the need, particularly in the Black-American and Caribbean cultures, for exploring the family structure to determine which adults play a significant

role in child-rearing and family dynamics. Involvement of the nuclear family alone is often inadequate in extended systems.

4. Merger of traditional and scientific techniques in psychotherapy. For example, a Bahamian child suffering from "falling out"(2) or blacking-out spells (attributed to seeing a dead cousin's spirit) was also using her condition to manipulate her parents. Since culturally appropriate treatment was required to get rid of the spirit, the girl was instructed to wear a cross and place coins around her bedroom door, while the parents were instructed in behavior modification techniques (see Bestman et al, 1976 for further description).

5. Knowledge of the various forms of "hexing"--their symptomatology and correlative therapies; knowledge of cultural norms--boundaries between normative and deviant behavior--in order to avoid inaccurate diagnoses and inappropriate case disposition. A prime example is the ubiquitous diagnosis of "paranoid schizophrenia" given to young Black males, particularly among Haitians, due to misinterpretation of verbalizations of persecution that were either based on reality or within the boundaries of culturally normative behavior.

6. Consultation and informal referral to folk healers when this seems indicated.

We concur with our Caribbean colleagues that traditional psychoanalytically oriented psychotherapy is largely inappropriate for the populations we serve. In the main, our clients share characteristics similar to the ones described by Diaz-Royo (ibid). From these clients and their expectations, come the following indicators for effective psychotherapy:

a) It must be problem-oriented, and focused on attainable goals. (We use goal-attainment scaling as a treatment plan and evaluation measure.) The vague, permissive ambience of the Freudian therapeutic hour is incomprehensible and sometimes anger-provoking to most of these clients.

b) The th apist must establish rapport through warmth, friendliness, and, for Latin clients, willingness to talk abo t himself. Many Spanish-speaking clients perceive therapy, like any other human interaction, as a quid pro quo. If you ask them to self-disclose, they request at least minimal self-disclosure from you (e.g., How many children do you have? Where do they go to school?). Such questions represent interpersonal contact, not resistance.

c) Although the therapist may be asked "personal" questions, he or she is nevertheless an authority figure. They are looked to as experts and are expected to counsel and give advice. It may take considerable skill to deflect this insistence, and the therapy may indeed require a directive posture in order to be successful.

d) It must be relatively short-term. Aside from financial considerations most patients want a quick solution and will not tolerate long-term psychotherapy. Some commentators have attributed th. impatience of lower socioeconomic clients to an inability-to-delay gratification ethos; however, it is more likely that a present-time value orientation is the critical variable. With people whose futures have always been problematical, looking ahead for relief seems an additional burden.

Finally, at each stage of the therapeutic process, from initial contact, through diagnostics and into the treatment process itself, cultural variables should, when necessary, be taken into account. With our Caribbean clients this is essential. When Abel (1973) for example, indicates that rotation on the Bender-Gestalt is normative rather than deviant in Caribbean children, we explore further before interpreting this as a diagnostic sign of organicity. Other tests, similarly, are evaluated in cultural context. In the treatment process, phenomena of transference, resistance, and the like must be reevaluated to determine whether the patient's behavior is actually reactive to a violation

of cultural norms. Finally, every effort is made to insure that psychotherapy is aimed toward behavior that will, in the long run, strengthen rather than weaken the client in his cultural milieu.

NOTES

1. Our inferences regarding the dynamics of Santeria are based largely on discussions with our colleague and Santeria expert Dr. Mercedes Sandoval, and on her unpublished paper "The Gods of Santeria." She has also published a book in Spanish: La Religion Afrocubana, Madrid: Playor, S.A., 1975.

2. "Falling-out" was initially identified as a discrete syndrome by Dr. Hazel Weidman, Professor of Social Anthropology and Principal Investigator of the University of Miami's Health Ecology Project, from data collected in this research effort. This work generated the subsequent paper: Sussex, James N. & Weidman, Hazel H. Some dynamic and functional characteristics of a culture-bound syndrome in urban U.S.A.: Falling-out in Miami. Paper presented at the 72nd Annual Meeting of the American Anthropological Association, New Orleans, November 28-December 2, 1973.

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