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Understanding Health Behavior in Caribbean Americans

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Walden University
2020

Abstract

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MS, Mercy College, 2008

BS, Mercy College, 2004

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Psychology

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Abstract

There has been a significant increase in the number of Caribbean immigrants to the United States with the population being over 4 million in 2014 and over 1 million of the immigrants residing in New York State. Among this population, there has been an increase in chronic diseases that has been linked to unhealthy eating behavior. Caribbean immigrants' approach to their health behavior was examined in this qualitative, phenomenological study. With a focus on the different aspects of the acculturation theory as the theoretical foundation, 9 participants from across the United States were interviewed about their approach to health, cultural influences on health care and behavior, and their health care challenges. Their responses were coded and analyzed for emergent themes. The results of this study showed that Caribbean Americans used natural remedies to cure their illnesses and if the illness was serious, they would go to the doctor. They said that they did not have any major health or health care challenges. When Caribbean Americans followed the social and cultural norms of the United States and their life stresses increased, their health was negatively affected, and they had an increase in diseases. They said that an improved health care system meant having culturally competent health professionals, more health education provided to immigrants, and more information from and about Caribbean American health professionals. The results of this study may encourage health professionals to seek ways to improve and promote health care tailored for Caribbean Americans in which Caribbean immigrants may be encouraged to participate.

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Dedication

I dedicate my dissertation to my wonderful parents, Dr. Garth and Mrs. Helga Alleyne, for their love, belief in my abilities and who have made me proud to have parents like them. I thank you for helping me to become the person I am today.

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Chapter 1: Introduction to the Study

Introduction

More than 60% of the 6 million Caribbean immigrants who have migrated worldwide go to the United States (Zong & Batalova, 2016). In 2014, the Caribbean immigrant population increased to over 4 million, and over 1 million of these immigrants resided in New York State (U.S. Department of Commerce, 2014). Caribbean immigrants in the United States are reported to have an increase in chronic diseases, and this has been linked to unhealthy eating behavior (King, 2012). The purpose of the present study was to explore Caribbean immigrants' approach to health care and healthy living as they adopted their new lifestyles in the United States in addition to how acculturation played a part in their new environment.

The increase in chronic diseases has caused Caribbean immigrants' premature mortality and an increase in the probability of individuals dying between the ages of 30 and 70 years old (Hennis, 2016). As immigrants and children of immigrants follow the social and cultural norms of the United States, their health becomes negatively affected, and chronic diseases, like diabetes and hypertension, may occur (Lacey et al., 2015). Poor diet, an increase in stressful circumstances, and poor economic lifestyles may be some of the reasons why some immigrants have an increase in diseases (Lacey et al., 2015).

I conducted this study to further examine the gap in the literature of Caribbean immigrants' approach to their health behavior in the United States and how acculturation affected their approach. Information about Caribbean immigrants' health behavior is lacking in research even though Caribbean, Black immigrants have contributed

significantly to the growth of the Black population in the United States. Caribbean, Black immigrants have different cultural backgrounds than U.S. Blacks and may engage in different health behavior (Archibald, 2011; Hamilton, 2014).

Background

There are more Black, Caribbean immigrants in the United States than there are Black immigrants coming from South America, Europe, Africa, and other regions worldwide (Thomas, 2012). The population of Black, African immigrants increased by more than 100% from 574,000 to 1.6 million between 2000 to 2016, thereby making Black, African immigrants having about 39% of the total number share of the foreign-born, Black population in the United States (Anderson & Lopez, 2018). While Black, African immigrants command a large share of the foreign-born, Black population, Black, Caribbean immigrants made up 49% of the foreign-born Blacks who were living in the United States in 2016 with most of the Caribbean immigrants coming from Jamaica and Haiti (Anderson & Lopez, 2018).

Migration was used to improve Caribbean immigrants' standards of living, reduce economic hardships, and reunify their families (Thomas, 2012). However, migration may also lead to their socioeconomic status being lowered and the occurrence of other factors, such as chronic stress, discrimination and lack of control, thereby promoting higher rates of disease and poor health outcomes (Bidulescu et al., 2015; Brathwaite & Lemonde, 2017). The longer Caribbean immigrants stay in the United States, the more their health behavior and health are influenced by their environment (Brathwaite & Lemonde, 2017; Lacey et al., 2015).

Problem Statement

There are about 1.7 million Black, Caribbean immigrants in the United States, and Caribbean immigrants' chronic diseases have increased because of unhealthy health behavior (King, 2012; Thomas, 2012; U.S. Department of Commerce, 2014). It is not clear whether health behavior stems from cultural factors specific to people from specific countries or what other issues affect immigrants' health behavior (Hamilton, 2014). According to Lacey (2015), the health of immigrants and their descendants is negatively affected as they follow social and cultural norms in the United States. To better understand the impact of these health issues, I conducted this study of the health approach immigrants take.

Purpose

The purpose of this qualitative study was to examine Caribbean immigrants' approach to health care. Immigrants can provide valuable information as to how an individual's health is affected while living in the United States (Teitler, Martinson, & Reichman, 2015). Previous research has shown that immigrants' health gets worse when they migrate to the United States, even amongst immigrants who come from low-income countries that have substandard health care (Teitler et al., 2015).

There has been a significant increase in the number of Caribbean immigrants coming to the United States, with research showing a 1,900% increase from 200,000 in 1960 to 4,000,000 in 2014 (Zong & Batalova, 2016). The findings of the present study can be used to help health professionals understand Caribbean immigrants' health experiences and how they have adapted through acculturation to manage their health

outcomes. The results of this study present information on the health behavior of Caribbean Americans, and this information may encourage health professionals to tailor health care for the growing Caribbean American population in the United States. In this study, I also provide detailed information on how acculturation played a role in Caribbean immigrants' health behavior.

Research Questions

Research Question (RQ): What is the shared experience of Caribbean immigrants' approach to health?

Subquestion 1 (SQ1): What are the cultural influences for Caribbean immigrants' health care?

Subquestion 2 (SQ2): What are the cultural influences for Caribbean immigrants' health behavior?

Subquestion 3 (SQ3): How do Caribbean immigrants approach their health care?

Subquestion 4 (SQ4): What do Caribbean immigrants perceive as their health care challenges?

Theoretical Framework for Study

I used the acculturation theory (Park, 1914) as the theoretical foundation of this study. In the acculturation theory, health behavior can be influenced by three stages: contact, accommodation, and assimilation (Padilla & Perez, 2003). The definition of acculturation has expanded over the years; therefore, I included areas like social and cultural identity and biculturalism in this theoretical foundation (see Schwartz, Montgomery, & Briones, 2006). Concerning social identity, people hold onto their ideas,

preferences, and fears so that they can nurture their group's uniqueness (Schwartz et al., 2006). Immigrants' culture may be so dissimilar from their host culture that immigrants' acculturative stress increases because it is difficult for them to integrate into their new culture and this negatively impacts their psychological and social adaptations (Ward & Geeraert, 2016). Acculturation can lead to stressors that can have a negative impact on immigrants' well-being as they try to cope with cultural challenges (Ward & Geeraert, 2016).

Concerning cultural identity, people feel a sense of being part of a group of people who have similar attitudes, beliefs, and behaviors (Schwartz et al., 2006). Immigrants who migrate with their families may experience positive outcomes if the family develops their acculturation process together with, for example, open communication and good relationships within the family (Ward & Geeraert, 2016).

Biculturalism is defined as immigrants adopting the values and practices of their former and host countries, and this tends to be the most adaptive acculturation strategy for them (Schwartz et al., 2006). This can also be called the two-culture matrix model in which immigrants do not fully accept the new host society's culture, try to keep their own culture, and may not feel a connection to either the former or host culture (Im, Chang, Chee, Chee, & Mao, 2015).

During the process of acculturation, immigrants go through stages of acquiring, maintaining, and changing their cultural behaviors, values, and identities that they have known from the original culture and learn from the new culture in their new environment (Ward & Geeraert, 2016). Different factors influence immigrants' acculturation process,

such as cultural influences in school and the workplace as well as societal influences like attitudes, policies, and prejudices they encounter as they cope with the changes in how they think and what they experience in the culture/s in society (Ward & Geeraert, 2016). Immigrants may also adopt new cultures according to the multidimensional acculturation theory where they would assimilate in the new culture while at work but use the separation strategy where they maintain their former culture at home (Im et al., 2015).

Caribbean immigrants may try to minimize or eliminate conflict with people from difficult cultures, so they try to accommodate them in various ways (Padilla & Perez, 2003). Acculturation can be multidimensional, and the different facets of acculturation can be associated with Caribbean immigrants' health behavior (Abraido-Lanza, Armbrister, Flórez, & Aguirre, 2006). Another aspect of the acculturation theory is the negative acculturation theory, which states that the longer immigrants live in the United States, the more likely they may adopt unhealthy cultural changes as they adopt the lifestyles of the Western culture (e.g., unhealthy eating patterns, like food that is processed and high in fat, and increased health risks; Ro, 2014). The rationale for using acculturation theory as the theoretical foundation of this study is that culture may influence how Caribbean immigrants' approach health care and health behavior, and in the present study, I focused on how acculturation plays a role in this.

Nature of the Study

I used a phenomenological design to gather health information from Caribbean Americans in this study. I selected a qualitative, phenomenological approach because it allowed me to understand participants' personal ideas and experiences as to how they

approached health care and their health behavior in the United States (see Rudestam & Newton, 2015). Various topics were addressed in the study, such as participants' cultural beliefs about health care, where they received their health care from, from whom they sought their health care, and what challenges they experienced with their health since migrating to the United States. I interviewed Caribbean American adults who had been in the United States for at least 5 years. Similar words or themes in participants' responses were coded and analyzed. The results of the study allowed me to share information and encourage health professionals to seek ways to improve the health care of Caribbean immigrants.

Definitions

Acculturation: The process by which immigrants learn and adopt the culture, behaviors, and attitudes of their host country because of their environmental influences (Lacey et al., 2015).

Caribbean Americans: People who self-identify as Black and/or of Caribbean descent, were born in a Caribbean country (e.g., Trinidad and Tobago, Barbados, Jamaica, or Dominican Republic), and who migrated to and have lived in the United States for at least 5 years (Briggs, 2016; Zong & Batalova, 2016)

Caribbean immigrants: People who migrated from Caribbean countries (e.g., Jamaica, Haiti, or Trinidad and Tobago) and who have various skill levels and racial compositions (Zong & Batalova, 2016).

Health behavior: A series of actions and habits that relate to how people maintain, restore, and improve their well-being or lifestyles (Conner & Norman, 2017).

Assumptions

This study was based on the experiences of Caribbean Americans who were 18 years old and older as they navigated their health behavior and the health care system in the United States. My primary assumption of these Caribbean Americans was that they would provide accurate information concerning their experiences.

Scope and Delimitations

Participants in this study were Caribbean Americans who were 18 years old or older and had lived in the United States for at least 5 or more years. They lived in different states in the United States. My research did not include any other immigrants or participants who were younger than 18 years of age.

Limitations

One limitation to this study was that the participants were Caribbean American adults. Therefore, this study was not a generalization of immigrants from other countries, and the results have little to no comparison to other immigrants who came to the United States. I also accessed English-speaking, Caribbean immigrants who lived in the United States and, therefore, non-English-speaking, Caribbean immigrants and Caribbean immigrants living in other countries were not included.

Significance

As there continues to be an increase in the U.S. population of Caribbean immigrants, health professionals need to understand the health needs of this population in various communities. The results of this qualitative study may encourage health professionals to investigate ways to improve the health behaviors of Caribbean

immigrants and promote health programs that are tailored to Caribbean Americans in which Caribbean immigrants may be encouraged to participate (see Archibald, 2011).

Summary

There has been an increase in chronic diseases in Caribbean Americans, which may have resulted from the unhealthy health behaviors they have adopted as they follow social and cultural norms in the United States (King, 2012; Lacey, 2015). Acculturation may play a role in how Caribbean Americans navigate their lifestyles in the United States. There are several stages of acculturation that Caribbean immigrants may go through as they navigate their health behaviors in their new country (Ward & Geeraert, 2016). Black, Caribbean immigrants make up the largest share of the Black immigrant population in the United States, and this study may help health professionals understand their health needs and tailor health programs specifically for this population (see Anderson & Lopez, 2018; Archibald, 2011). In Chapter 2, I present an overview of the relevant literature on the topic.

Chapter 2: Literature Review

Introduction

Between 2008 and 2009, there were over 3.4 million Caribbean immigrants in the United States, with about 1.7 million being Black, Caribbean immigrants (Thomas, 2012; U.S. Department of Commerce, 2014). The number of Black, Caribbean immigrants in the United States was greater than the combined total number of Black immigrants from South America, Europe, and other regions in the world (Thomas, 2012). There are about 6 million Caribbean emigrants worldwide, and more than 60% of them make the United States their top destination (Zong & Batalova, 2016). In 2014, the Caribbean immigrant population increased to over 4 million with over 1 million residing in New York State (U.S. Department of Commerce, 2014).

Caribbean immigrants to the United States have been reported to have had an increase in chronic diseases compared to nonimmigrants, and this is linked to unhealthy eating behavior (King, 2012). This increase in chronic diseases is evidenced in Caribbean immigrants' premature mortality and the probability of these individuals dying between the ages of 30 and 70 years old (Hennis, 2016). As immigrants and their offspring follow the social and cultural norms of the United States, their health is frequently negatively affected, and an increase in illnesses such as diabetes and hypertension may occur (Lacey et al., 2015). The increase in diseases may be caused by poor diet, an increase in stressful circumstances, and/or a poor economic lifestyle, which some immigrants, who were previously considered to be people of privilege, experience when they come to the United States (Lacey et al., 2015).

The purpose of this study was to explore Caribbean immigrants' approach to health care and healthy living as they adopted their new lifestyles in the United States as well as how acculturation played a part in their new environment. There was not enough current information specifically about Caribbean immigrants and their approach to health behavior and health care, so I conducted this study to expand on previous literature concerning Caribbean immigrants in the United States.

Caribbean immigrants have migrated to improve their standards of living and reduce economic hardships (Thomas, 2012). Caribbean immigrants have come to the United States to be reunited with their families who are already living in the United States and are usually from English-speaking, Caribbean countries and Haiti whose first language is French (Thomas, 2012). Some Caribbean immigrants seek refugee and asylum status (e.g., Cubans and Haitians; Thomas, 2012). Most Caribbean immigrants reside in New York and Florida, with 41% of Caribbean immigrants in the United States residing in Kings County (New York), Bronx County (New York), Miami-Dade County (Florida), and Broward County, (Florida; Zong & Batalova, 2016).

In many Caribbean countries, herbal medicines, "traditional foods" (e.g., fish broth and provisions to build up their strength), and "folk medicines" as well as spiritual healing are used to improve people's health (Brathwaite & Lemonde, 2017). Caribbean immigrants may experience racial and ethnic health disparities in diseases, such as hypertension, and their complications among the Afro-Caribbean populations (Bidulescu et al., 2015). In the United States, since Caribbean immigrants are accustomed to following natural, alternative ways of maintaining and improving health, they may have

concerns about following dietary health advice from U.S. health professionals because this advice may be different from what they are accustomed to following (Brathwaite & Lemonde, 2017). As Caribbean immigrants stay in the United States, their health behavior and overall health are influenced by their environment and factors like what they may see on television or the demands of their lifestyle (Brathwaite & Lemonde, 2017; Lacey et al., 2015).

When Caribbean immigrants come to the United States, their socioeconomic status may be lowered. In their Caribbean country, some may have been a manager, but when they come to the United States they may have to start at a low-level job (e.g., a clerk) because they may not have work experience in the United States or their educational qualifications may not be recognized in the United States. There may also be some Caribbean immigrants who may have had a low socioeconomic status in their original country. While they are in the United States, they may have to build up their economic status and with this lower socioeconomic status, they may also experience higher rates of disease and poorer health outcomes (Bidulescu et al., 2015). Other immigrants make no change in their socioeconomic status when coming to the United States. In addition to their socioeconomic status, Caribbean immigrants may face chronic stress, discrimination, lack of control, and behavioral factors that increase the risk/s of diseases like hypertension (Brathwaite & Lemonde, 2017).

Immigrants usually emotionally acculturate to their environments when they have more in common with a culture that they believe has fewer negative stressors (Consedine, Chentsova-Dutton, & Krivoshekova, 2014). On the other hand, if Caribbean immigrants

find that the culture in the United States is significantly different from their culture, then it may be harder for the immigrants to acculturate to the new environment (Consedine et al., 2014). Caribbean immigrants can minimize their stressors in their new environment by being more aware of the norms in their new environment and understanding that they do not have to totally give up their Caribbean culture while living in the United States (Consedine et al., 2014).

Sometimes disparate conditions in Black immigrants' birth countries help to explain why there are differences in immigrants' health after they have migrated (Hamilton, 2014). Previous research has shown that Black immigrants from countries where there are a fair number of different races of equal proportions and countries where Whites are in the minority (e.g., Africa and the Caribbean) tend to have lower stress levels and better health than Black immigrants who come from countries where Whites are in the majority (e.g., Europe; Read & Emerson, 2005). This may occur because Black immigrants from majority White countries experience higher levels of racism and discrimination (Read & Emerson, 2005). Black immigrants who came from countries that had better survival rates at birth, better educated people, and less income inequality had a more positive self-assessment of their health (Hamilton, 2014).

Literature on health disparities relating to Caribbean immigrants' culture is limited and future research should address this gap to explore how to address and partner with Caribbean immigrants on their overall health. More research is needed on how the various cultures of Black immigrants from different countries play a role in immigrants' health behavior.

Literature Search Strategy

I conducted this literature review using databases, such as PsycINFO and PsycARTICLES, accessed through the Walden University Library. Google Scholar was also used to locate other articles; in some cases, I had to select the articles that were linked to the Walden Library in order to get full access to the articles. The key search terms used as the root of all inquiries were *acculturation, chronic diseases,* and *immigrants.* To be more specific about the population that I was using, I used *Caribbean, Caribbean immigrants, Caribbean Americans,* and *New York* to narrow the search. A combination of terms, such as *Caribbean people and chronic diseases, Caribbean immigrants* and *diseases, Caribbean Americans* and *health behavior, Caribbean immigrants living in America* were also used. I also looked at the reference lists of articles that I reviewed and found a few articles that had some useful, additional information this way.

In the iterative search process, I used the word *Caribbean* and then would add on words like *immigrants, Americans, chronic diseases, increase in diseases,* and *New York.* When I did not find enough information from the above words, I would look at the cultures of various people from the Caribbean (e.g., Blacks and Hispanic immigrants). There was not much extant research on acculturation in Caribbean immigrants who move to the United States. I used the information that I gathered and even contacted two authors who wrote articles in journals, with one responding and attaching her work. I also researched dissertations about Caribbean immigrants in the Walden University Dissertation and Theses database and found information that helped with understanding

how I should move forward with writing this study as well as additional sources that were helpful.

Theoretical Foundation

The definition of acculturation was developed by Redfield, Linton, and Herskovits (1936) who interpreted it as resulting from groups of people who are from different cultures being affected culturally when they come into contact with another culture. In other words, acculturation is the result of experiences that different cultural groups of individuals have when they continuously interact directly with changes in their original cultural patterns (Redfield et al., 1936). Acculturation can change immigrants' cultural patterns (e.g., how they think about things in their lives and how they live their lives), and this change can affect them psychologically as well as how they live in society (Ward & Geeraert, 2016).

The original definition of acculturation continues to be expanded by theorists who have explained their meaning/understanding of acculturation, how acculturation evolves, different types of acculturation, and how people are affected by it. Graves (1967) stated that acculturation means a change in people's psychological thinking instead of a change in a group's culture. The degree to which acculturation is realized depends on how much of a person's original culture is retained and how much the person assimilates to the new culture's behaviors, customs, and norms (Berry, 1997). For example, cross-cultural psychology defines cultures as being able to change according to people's internal dynamics and exposure to other cultures (Berry, 1997). Immigrants experiencing cross-

cultural change may experience negative emotions towards their cultural challenges, and they may also experience different levels of acculturative stress (Ward & Geeraert, 2016).

One of the early definitions, from Park (1914), was that acculturation has three stages: contact, accommodation, and assimilation (Padilla & Perez, 2003). When people migrate to foreign countries, they come into contact with people from different cultures and this interaction causes people to try to minimize or eliminate conflict between/among them by trying to accommodate one another in various ways (Padilla & Perez, 2003). This gave rise to the term cultural assimilation because immigrants incorporated areas of the dominant culture into their own lives and, as a result, cultures were mixed (Padilla & Perez, 2003). At times, acculturation and assimilation had similar meanings or both words were used as synonyms for one another (Ngo, 2008). While immigrants acculturate, this change can be a result of their different environment, and they may see changes (e.g., in their psychological well-being years later and/or they may revert to their original culture to regain a more familiar way of life; Berry, 2017).

Acculturation has been studied among people who migrate to or live temporarily in other countries or regions in which they were not born (Schwartz, Unger, Zamboanga, & Szapocznik, 2010). For example, these people could be immigrants; refugees; people who seek asylum from their previous countries; and/or people who stay temporarily while they engage in certain activities, such as going to college or performing seasonal work (Schwartz et al., 2010).

International migration in the world increased at a significant rate, and one of the reasons was that as the influx of migrants increased in the United States, countries like

those in Western Europe, Canada, and Australia also became welcoming of people from the Latin American, Asian, African, Caribbean, and Middle Eastern countries (Schwartz et al., 2010). As at 2015, there were 245 million migrants living in countries in which they were not born or have citizenship; in other words, for every 30 people, there is about one person who is a migrant (Bornstein, 2017). These migrants favored going to North America, Western Europe, and Oceania as they brought with them their cultural habit of focusing on the well-being of their families, clans, nations, and/or religions as opposed to focusing on individual needs, which tends to be the culture in their new countries (Schwartz et al., 2010). This can cause a challenge for migrants and their cultural values as they try to be accepted into their new societies (Schwartz et al., 2010).

Different regions favor immigrants with specific skills, and different immigrants tend to gravitate towards regions where their skills may be most needed (e.g., agricultural workers may go to southeast of the United States; Schwartz et al., 2010). There are some immigrants whose skills may be needed in many regions of the United States (e.g., housekeepers or gardeners); however, there are also some individuals who may not be welcomed because of their lack of qualified education and low socioeconomic backgrounds (Schwartz et al., 2010).

Acculturation can be related to social and cultural identity. Identity has been seen as a process that helps people to live their life the way they want or the development of a task that results in an organization of "drives, abilities, beliefs and personal history" which helps people to grow (Schwartz, Montgomery, & Briones, 2006, p. 5). In social identity, people tend to hold onto their ideas, preferences, and fears to nurture their

group's uniqueness and have some identity within this group when they feel that they are being exposed to great changes in their environments (Schwartz et al., 2006). For example, before some Hispanic immigrants came to the United States, they did not think of themselves as Hispanic, however, when they migrated to the United States they were labeled Spanish speaking people of a Hispanic ethnicity (Schwartz et al., 2006; Schwartz et al., 2010). Many people who the Hispanic immigrants associated with were not Hispanic and the Hispanic immigrants were discriminated against because they were Hispanic (Schwartz et al., 2006). The Hispanic immigrants then decided to define and understand what makes them Hispanic and this then guided their acculturation into their new society (Schwartz et al., 2006; Schwartz et al., 2010). On the other hand, when they wanted to identify or "fit in" with a different group other than one of a Hispanic nature and with which they were affiliated they tended to develop the identities of that group (Moran & Sussman, 2014). Therefore, just as this may cause better health behavior among immigrants, it may also cause risky health behavior which could impact their health (Moran & Sussman, 2014). There are different ways in which immigrants socially identify with a particular group, for example, the media may play a significant role in motivating immigrants' health behavior. The media may target a specific group with which immigrants may want to identify, and the immigrants' interpretation of what is being communicated results in the immigrants adopting the behavior (good or bad) of the specific group that was targeted (Moran & Sussman, 2014).

In cultural identity, people tend to feel a sense of solidarity with the ideas of their group because the group identifies with similar attitudes, beliefs and behaviors that

people recognize in their own lives (Schwartz et al., 2006). Therefore, biculturalism where Caribbean immigrants adopt the ideals, values and practices of their former and new countries may be the most adaptive acculturation strategy for immigrants (Schwartz et al., 2006). Immigrants are able to integrate the differing beliefs from the different cultures with which they come into contact in their new home usually when the heritage and varying cultures have some similarity even if this similarity is actual or perceived (Schwartz et al., 2010). For example, English speaking immigrants may have less stressful experiences in the United States than non-English speaking immigrants because they may experience less discrimination and acculturative stress. However, when the new country's culture is very different, biculturalism may be difficult and distressing for immigrants (Schwartz et al., 2006).

Acculturation can be interpreted as the process by which immigrants learn and gradually adopt the culture, behaviors, and attitudes of the country in which they live as a result of influences in their environments (Lacey et al., 2015). The four categories of acculturation: assimilation, separation, integration, and marginalization (Behrens, del Pozo, Großhennig, Sieberer, & Graef-Calliess, 2015; Schwartz et al., 2010) mentioned in the present research study explain how immigrants phase into their new environments when they migrate to new countries, for example, when they migrate to the United States. Social and cultural identity can lead to these four different categories of acculturation.

Assimilation is when immigrants adopt the culture of their host country and get rid of the culture from their previous country (Schwartz et al., 2010). This type of acculturation is also known as unidimensional acculturation where immigrants adopt the

host country's values, practices and beliefs and discard their original country's values, practices and beliefs so that the immigrants may fit into their new environment/society (Adams & Van de Vijver, 2017; Schwartz et al., 2010). In the unidimensional method, immigrants who live within the mainstream culture see the loss of their ethnic group/identity as a separate entity and the eradication of their distinctive values (Gordon, 1964, p. 81). Identity allows people to define themselves through various aspects, for example, their values, goals, relationships, and affiliations (Adams & Van de Vijver, 2017). Therefore, in unidimensional acculturation immigrants do not experience prejudice or discrimination because the descendants of the original immigrants become more like members of the core society, and they tend to feel as if they are part of the "in-group" (Gordon, 1964, p. 80).

Separation is when immigrants hold on to their original culture without adopting their host country's culture (Schwartz et al., 2010). Integration is when immigrants integrate their host country's culture into their original culture (Schwartz et al., 2010). Marginalization is when immigrants reject both their original and host country's cultures (Schwartz et al., 2010).

There are approximately 38 million immigrants in the United States who are non-European and about 3 million of them are of African descent (Ferguson, Bornstein, & Pottinger, 2012). Caribbean immigrants make up more than half of the foreign-born Black population in the United States (Ferguson et al., 2012). Black U.S. immigrants acculturate towards three cultures, European American, African American and their own cultures (Ferguson et al., 2012).

Caribbean immigrants may assimilate into the African American culture in the United States; because they may identify more with African Americans, they may live nearer to African American communities because they may live modest lifestyles due to their migration to the United States as newcomers, and they may be treated like African Americans and face racial discrimination (Ferguson et al., 2012). Caribbean immigrants may be less likely to assimilate into the U.S. culture; however, they may share certain lifestyles of African Americans like similar neighborhoods, consumer needs, schools, and racial and societal challenges (Ferguson et al., 2012).

Immigrants who have assimilated into their new culture may approach health issues, for example, mental health, by seeking out mental health professionals more readily than they would have before because they develop a familiarity with the American cultural beliefs about psychology and mental health treatment (Sood, Mendez, & Kendall, 2012). In fact, immigrants who have assimilated may seek out health professionals more often when faced with health issues because they strongly identify with the American culture (Sood et al., 2012).

In the separation category, some Caribbean immigrants maintain their original culture as they hold on to the culture of their home country and not adopt the culture of their new country because of the discrimination that they experience, and this may give rise to reactive ethnicity (Schwartz et al., 2010). Reactive ethnicity causes immigrants to hold on even more tightly to their original culture – their cultural heritage – thus causing immigrants and their descendants to maintain their separation from their host culture (Schwartz et al., 2010).

Immigrants have idealized views of their original country's culture and this can reinforce certain patterns that influence how they think and react to their environment internally and externally (Sobral, Villar, Gómez-Fraguela, Romero, & Luengo, 2013). Immigrants who stay in contact with their own ethnic group, and who had similar lifestyles in their home country usually display separation attitudes in their new country (Safdar, Calvez, & Lewis, 2012). In separation, some immigrants display antisocial behavior, and this may be because they lack confidence in how competent they are, their problem-solving abilities and their effectiveness in taking on difficult tasks (Sobral et al., 2013). Sometimes, this can lead to immigrants feeling as if they cannot adjust to their environment, then this can reinforce how they see their limitations in society, and then this could lead to them being defiant to the rules, being excluded from society and developing antisocial behavior (Sobral et al., 2013). They tend to feel alienated, homesick and see their original culture as being better than their new country's culture (Sobral et al., 2013). These immigrants therefore separate from the norms of the new culture, are not successful in integrating in host communities, "reject bonds or ties with prosocial subjects, conventions and local institutions" (Sobral et al., 2013, pp. 30).

Integration is when immigrants integrate their host country's culture into their original culture (Schwartz et al., 2010). When immigrants maintain their original cultural identity, for example, by staying connected with people from their home country, and build relationships with people from the United States, this can be called an integration acculturation mode (Sullivan & Kashubeck-West, 2015). This acculturation type can also be called bidimensional acculturation which is a process where immigrants navigate their

original culture and the host country's culture (Adams & Van de Vijver, 2017). In the bidimensional model of acculturation, there are certain aspects like personal values, goals, personal relationships, and individual roles which significantly influence how individuals adopt a different culture into their own culture (Adams & Van de Vijver, 2017). Migrating to the United States can be stressful because of the adjustment phase that immigrants go through as they are expected to adapt to the ways of the American culture (Sullivan et al., 2015). Immigrants who integrated into their new culture tended to have less acculturative stress and higher levels of support from people from the host country and other immigrants (Sullivan et al., 2015). Some immigrants who come to the United States on their own, without family support, may find a significant interest in learning the culture of the United States because they may have greater access to people from the United States according to the environment in which they usually reside, for example, international students who are on a university campus (Sullivan et al., 2015).

Therefore, higher levels of communication with host nationals, maintaining a connection to immigrants' home culture, building positive connections to the host culture can be directly linked to lower levels of acculturative stress and a decrease in the negative aspects of cultural adaptation (Sullivan et al., 2015). Having a wider social network, i.e. with immigrants from similar backgrounds and host nationals is beneficial to adapting to the United States (Sullivan et al., 2015). On the other hand, having support from the home country and mainly maintaining ties to the immigrants' home culture do not seem to be beneficial to adapting to the United States culture (Sullivan et al, 2015). This could lead to having less knowledge about the host culture and may prevent immigrants from

developing ties to and adapting better to the environment in the host country (Sullivan et al., 2015). When immigrants expanded their connections, this tended to have a positive effect on host country friendships, increased immigrants' satisfaction, contentment and social connectedness in their community and decrease their level of feeling homesick (Sullivan et al., 2015).

Marginalization is when immigrants reject both their original and host country's cultures (Schwartz et al., 2010). Immigrants who have a marginalized acculturation process tend to have less life satisfaction and less social functioning since culture is not maintained and adoption of a new culture is not developed (Ward & Kus, 2012). Immigrants who have thought about returning to their home country, rejected integration and assimilation in their host country, and kept in contact with people from their home country (Tartakovsky, 2012). They may have negative attitudes towards the host country, so they reject the values and norms of the host country (Tartakovsky, 2012). Immigrants usually have pre-conceived ideas of the host country before they migrate to the country and then when they do migrate their ideas may be reinforced, so if their ideas were negative at first, according to what they experience after migration may reinforce their negative attitude towards the host country (Tartakovsky, 2012). Then, there are those immigrants who feel as if they are being rejected against tend to choose marginalization and are more likely to leave the host country (Tartakovsky, 2012).

Another type of acculturation is multidimensional acculturation. Multidimensional acculturation is a process by which heritage and host country's multiple cultural practices, values and identities are merged and followed by immigrants

(Schwartz et al., 2010). Immigrants learn how to navigate their identities in the various cultural environments that they are exposed to which arose out of globalization and diversity through migration (Adams & Van de Vijver, 2017). This existence of biculturalism where both cultures coexist in immigrants' lives develops in different ways because not all the elements of the heritage and host cultures may work for immigrants as they learn to live in the host country. Immigrants may select specific elements of their heritage culture and the host country's culture, thereby purposefully deciding on which cultural elements they would like to obtain or retain and which elements they want to discard or reject based on the circumstances in which they live (Huynh, Nguyen, & Benet-Martinez, 2011; Schwartz et al., 2010; Weinreich, 2009). This is called enculturation where immigrants adopt cultural aspects by a selection process (Schwartz et al., 2010).

The rationale for the choice of the acculturation theory was that in this study the cultural aspects of how Caribbean immigrants' approach to health care and how culture affected their health behavior was examined. This study focused on how acculturation played a part in Caribbean immigrants' health behavior which may have impacted their health outcomes.

The research questions, in the present study, related, challenged, or built upon existing theory. I gathered much needed information in the study which will help others including people in the health field understand Caribbean immigrants' approach to health care and health behavior because there is not enough information on this.

Effects of Stress on Caribbean Immigrants

Acculturative Stress

Migrating to a new country may mean learning a different language, values and customs in addition to managing losses and trauma which may cause an increase in emotional vulnerability (Behrens et al., 2015; Bhugra & Mastrogianni, 2004). Acculturation has an effect on psychosocial functioning and may promote poor mental and physical health among immigrants (Consedine et al., 2014; Duru & Poyrazli, 2007).

Acculturative stress is also affected by social connectedness which focuses on how well immigrants are aware of their close relationship with others in society (Duru & Poyrazli, 2007). Social connectedness affects emotions, cognitions and perceptions about one's environment and the people in the environment with those people who are less socially connected experiencing more acculturative stress than those who are more socially connected (Duru & Poyrazli, 2007). Caribbean immigrants who assimilate the host culture and reject their original culture may develop depressive symptoms (Behrens et al., 2015). Caribbean immigrants who do not adopt or limit their adoption of American emotional patterns may experience poorer emotional outcomes, such as feeling emotionally bullied as may happen with some Caribbean women who have a passive behavior (Consedine et al., 2014).

Caribbean immigrants in the United States may adopt American emotional patterns which could help them handle the stressors in their new environment (De Leersnyder, Mesquita, & Kim, 2011). Some Caribbean immigrants integrate the host culture and balance their original culture in their lives which helps them to suffer less

from negative emotions like depression (Behrens et al., 2015). Over the years Caribbean immigrants usually migrated to the United States voluntarily, that is they came to the United States for personal growth and/or to further their education – this is called the pull factor (Joseph & Baker, 2012). Caribbean people tend to have a strong work ethic and education is one of their priorities in life (Joseph & Baker, 2012). As a result, these Caribbean immigrants tend to have less acculturative stress and less culture shock (Joseph & Baker, 2012). On the other hand, there are some Caribbean immigrants who may have negative acculturation experiences because they may feel pressured to identify themselves only as Black and may be compared to Black Americans and even been mistaken for Black Americans (Joseph & Baker, 2012). This may lead to Caribbean immigrants not having their specific psychosocial issues being adequately addressed as other immigrants from other countries may have (Joseph & Baker, 2012).

There can be five stages of culture shock which are when immigrants: (a) feel excited about their new culture, (b) do not succeed they become dissatisfied with the host culture, (c) start to understand their host culture while having more self-awareness, (d) view the host culture as having positive and negative life experiences, and (e) return to their home country, and "experience reverse culture shock" (Joseph & Baker, 2012, p. 4). Culture shock stems from different factors.

Immigrants feel lonely because they may have left their family and friends back in their home country and visiting them may not be feasible for the Caribbean immigrants (Joseph & Baker, 2012). They may not feel as if they fit into their new environment because they feel alienated, the perception of how they are treated when they come to the

United States is one where they feel as if they cannot relate well to the people in their environment (Joseph & Baker, 2012). Some find it difficult to develop friendships, they withdraw from their environment, hardly interact with others and they feel lonely (Joseph & Baker, 2012). Caribbean immigrants are accustomed to having a sense of being a part of a community and togetherness which they experienced in their home country. Some Caribbean immigrants feel as if this is the opposite in the United States. It takes some time before they find a group they could fit into, where they feel they belong and this results in them being less affected by their new life in the United States (Joseph & Baker, 2012).

Anxiety and Depression

Caribbean immigrants may experience anxiety and depression (Joseph & Baker, 2012). Anxiety is an emotion where people feel tension, worry and experience changes in their body, for example an increase in their blood pressure (American Psychological Association [APA], 2018). Depression is a mental disorder that causes people to feel sadness and/or lose interest in their daily activities (American Psychiatric Association, 2018; APA, 2018). Immigrants' anxiety can come from feeling that they cannot fit into a part of a group they may want to join and feeling insecure in their new environment (Joseph & Baker, 2012). They may also develop anxiety and depression after talking to significant others back in their home country (Joseph & Baker, 2012). Money also causes anxiety because immigrants need to build credit, use credit cards as opposed to in their home country, they usually used cash as the main medium of paying for goods (Joseph & Baker, 2012). They have anxiety about learning a new financial system and how to adapt

to it (Joseph & Baker, 2012). Even Caribbean immigrant students feel anxiety because they feel as if they need to perform better than the norm in school and prove to their professors that they can succeed because their accent and culture/s are different (Joseph & Baker, 2012) from the ones in the United States. Some Caribbean immigrants experience a different sleeping pattern that they are not used to or not being able sleep because, for example, they are feeling unsafe in their new environment (Joseph & Baker, 2012). This also causes anxiety and depression.

Caribbean immigrants may think differently from groups in their host country. They may have a different value system and cultural differences versus their new environment's value system and cultural differences. Immigrants are taught to consider, for example, the groups' needs, however, in the United States, people are taught to be independent and being one's own individual (Joseph & Baker, 2012). In the Caribbean, people may arrive late for an event and this may not be seen as being disrespectful. In the United States being late may be frowned up because American people may see this as having little regard for their time (Joseph & Baker, 2012). In the home country, Caribbean immigrants tend to have more leisure time, get a free taxi ride and go by a friend's house unannounced for a free meal (Joseph & Baker, 2012). There tends to be a lot of waste in the United States, for example, loads of wasted material and food, money and the use of credit cards (Joseph & Baker, 2012). Language barriers may hamper Caribbean immigrants to make friendships with others who may not be familiar with the Caribbean immigrant's language or accent (Joseph & Baker, 2012).

Caribbean immigrants may feel more connected to White Americans rather than Black Americans, so they may question which race they should identify with in the United States (Joseph & Baker, 2012), thus, challenging their cultural identity. Caribbean immigrants' heritage teaches them how to be proud of who they are and how to be survivors (Joseph & Baker, 2012).

Caribbean immigrants who surround themselves with other people from the Caribbean community do not tend to experience culture shock which helps them transition into their new life in the United States (Joseph & Baker, 2012). More information is needed on how immigrants could lessen the effects of acculturative stress and cultural shock.

Culture influences immigrants' social norms and health behaviors (Viruell-Fuentes, Miranda, & Abdulrahim, 2012). These norms and behaviors have an impact on immigrants' health and when immigrants adopt new cultural practice and eliminate their previous cultural practices, their health may deteriorate (Viruell-Fuentes et al., 2012). Some researchers reported that when acculturation is used as the main explanation for immigrant health outcomes in the United States, the other factors like living in low-resource communities, low socioeconomic lifestyles, cultural identities and discrimination in health care treatment may be ignored even though they may play a role in affecting health care disparities (Viruell-Fuentes et al., 2012). Discrimination towards immigrants promotes social and economic inequality and may be one of a number of causes of disease, together with other types of oppression and marginalization which influence immigrants' health (Viruell-Fuentes et al., 2012).

Perceived discrimination by immigrants influences the negative effects of physical and mental health, limited access to quality health care services and practicing harmful health behaviors play a role in immigrants' getting the health care they need in order to maintain good health, for example, among Hispanic, and Black immigrants (Viruell-Fuentes et al., 2012). Immigrants like Hispanics and Blacks immigrants are considered to be minorities and with this label comes certain stigmatized meanings that may promote inequality in their host country as they try to become Americanized (Viruell-Fuentes et al., 2012). This stigmatization and inequality may cause limited access to better life opportunities, then this creates stress which results in negative effects on their health (Viruell-Fuentes et al., 2012). Immigrants try to build a positive self-image for their groups and as they pursue this, the constant fighting for positive recognition may cause a tense environment for them which impacts their health outcomes (Viruell-Fuentes et al., 2012).

Immigrants who surround themselves with immigrants from their own country and of their own ethnicity tend to protect their health in various ways (Viruell-Fuentes et al., 2012). They set up relationships, institutions and resources that help to maintain their existence in their host country and to lessen the negative effects of the disadvantages they experience in their new society (Viruell-Fuentes et al., 2012). Some of the results from maintaining their own ethnic identities is that they may indulge in eating foods that are more low fat, decrease symptoms of depression, and improve their access to health care (Viruell-Fuentes et al., 2012). On the other hand, sometimes maintaining their own community may have negative effects, for example, some immigrants may not be

accustomed to engaging in, for example, physical activity, or may not have proper/adequate access to health care for specialized treatment for illnesses like hypertension or cancer (Viruell-Fuentes et al., 2012). Immigrants who live in communities where their ethnicity is the main cultural population, may experience "higher levels of violence and poverty, poor housing conditions, less access to recreational facilities and other resources that could help with their mental and physical wellbeing" (Viruell-Fuentes et al., 2012, p. 4). More research should be done on how immigrant communities can be a protective force for their health outcomes.

Immigrant policies, in some respects, make immigrants seem to be unwanted and a threat to the United States whether or not the immigrants are documented – legally authorized to be in the United States (Viruell-Fuentes et al., 2012). The policies define immigrants' national belonging with race and ethnicity being used to define this and while some policies were instituted to help the integration of immigrants into the host country, there are some policies that restrict immigrants' rights (Viruell-Fuentes et al., 2012). These policies as a whole may have many negative effects on immigrants' health and access to adequate health care (Viruell-Fuentes et al., 2012). Immigrant policies as they limit access to health and social services impact whether or not immigrants have an increase on diseases because these policies influence the kind of life opportunities immigrants get in the host country, for example, education, and better jobs (Viruell-Fuentes et al., 2012). These policies then once again impact immigrants' health and wellbeing (Viruell-Fuentes et al., 2012).

Immigrant policies tend to increase the racialization of people who are seen as immigrants and regardless of which country they may have migrated from, these immigrants may be categorized under one heading (Viruell-Fuentes et al., 2012). For example, Hispanics are perceived as Mexicans, Mexicans are seen as immigrants and undocumented people in the United States (Viruell-Fuentes et al., 2012). This inaccuracy can cause a hostile environment for Hispanics because Mexicans are seen in a negative light and hate crimes are targeted towards Hispanics regardless of which country they belonged to before they came to the United States (Viruell-Fuentes et al., 2012). In the United States immigration is considered under the following: family reunification, skilled labor, protecting refugees and asylees, and encouraging diversity (American Immigration Council, 2019). Immigrants tend to develop relationships with others through their work, education, associations and social circles, for example through their friends (Oberman, 2017). Caribbean immigration tends to be for family reunification, job seeking and education which can provide more opportunities for them (Yorke, Voisin, Berringer, & Alexander, 2015).

Immigration policies may affect immigrants' health. Some immigrants may not trust employees at different agencies like agencies in health care, public safety, social services so they may not use these agencies' services (Rhodes et al., 2015). They feel that they may be, for example deported or detained because they may not have proper identification or even if they had a medical emergency they may not for example, drive to get help because they felt that law enforcement officers engaged in racial profiling when the immigrants were driving (Rhodes et al., 2015). Some immigrants feel that

immigration policies condone racism and that within health care systems they may be discriminated against because they felt that they may not have got quality health care, they were not attended to in a timely fashion (Rhodes et al., 2015). Other immigrants may prolong going to get health care services because of their fear of the immigration enforcement policies so they stay ill when they may have been able to get better if they got health care services (Rhodes et al., 2015).

Caribbean immigrants may use their spiritual beliefs, and social support system before they seek out formal health care systems (Yorke et al., 2015). For example, there may be a stigma attached to seeking out mental health care service or they were not satisfied with the service they got in the past (Yorke et al., 2015). Caribbean immigrants may also feel discriminated against, which may affect their status in life, which may affect their access to needed resources and their quality of life which may then affect their physical and mental health (Yorke et al., 2015).

Participants were asked about their health beliefs, cultural practices and health behavior towards addressing any illnesses that they may have experienced or prevented illnesses, like diabetes, and so forth (Brathwaite & Lemonde, 2017). I asked them about, for example, how prayer, faith healing, herbal medicines and foods that they were accustomed to in their original country helped with promoting health (Brathwaite & Lemonde, 2017). Understanding Caribbean immigrants' health beliefs and practices would also provide health professionals valuable information about how these factors influence health and management of illnesses so that health professionals could create specific interventions to Caribbean immigrants (Brathwaite & Lemonde, 2017).

Summary and Conclusions

Caribbean immigrants assimilate, integrate, separate, or marginalize cultures when they migrate to the United States (Sullivan et al., 2015). It is unclear whether health behavior comes from cultural factors or if other issues are specific to or affect immigrants who come from specific countries (Hamilton, 2014). Therefore, a better understanding of immigrants' health approach was needed to understand the impact of issues like the increase of chronic diseases in Caribbean immigrants in the United States (King, 2012).

In the study I focused on understanding the health behavior of Caribbean immigrants and how acculturation played a part in how Caribbean immigrants approach health care and health behavior. It was not clear how acculturation affects Caribbean immigrants' health behavior in the United States. Previous research usually grouped Caribbean Blacks and U.S. Blacks together in research even though Caribbean immigrants come from different cultures.

In Chapter 3, I explain the qualitative method in my study as I used individual face-to-face or phone interviews. By using interviews, I was able to ask open-ended questions on various topics concerning participants' cultural beliefs about health care, health care challenges and so forth. This information may help to expand further literature information on Caribbean immigrants' health behavior in the United States.

Chapter 3: Research Method

Introduction

In this study, I used a qualitative, phenomenological approach to explore Caribbean immigrants' health behaviors through acculturation and understand how they were personally experiencing and enacting their health behaviors while living in the United States. The purpose of this study was to address the gap in the literature concerning the acculturation process of Caribbean immigrants that affected their approach to health behaviors in the United States. There is a lack of information about Caribbean immigrants' health behavior even though Caribbean, Black immigrants (who have different cultural backgrounds than U.S. Blacks) have contributed significantly to the growth of the Black population in the United States (Archibald, 2011; Hamilton, 2014).

In Chapter 3, I describe the research design, why I used this design, and how I achieved my research goal. In this chapter, I present the sampling method, instrumentation, data collection, and analysis of collected data. Also included is a discussion of issues with trustworthiness and how they were minimized, ethical procedures, and a summary and transition to Chapter 4.

Research Design and Rationale

The qualitative research question for this study was: What is the shared experience of Caribbean immigrants' approach to health? The subquestions were:

SQ1: What are the cultural influences for Caribbean immigrants' health care?

SQ2: What are the cultural influences for Caribbean immigrants' health behavior?

SQ3: How do Caribbean immigrants approach their health care?

SQ4: What do Caribbean immigrants perceive as their health care challenges?

In this study, I used a qualitative method, conducting face-to-face interviews with the participants. The participants who could not do interviews face-to-face were asked to conduct a phone interview. When necessary, I asked probing questions of participants to get more thorough responses to the interview questions (see Ponterotto, 2013). Face-to-face and telephone interviews tend to produce significantly similar results, and self-reporting assessments are usually used in studies to assess personality characteristics and different health behaviors (Zhang, Kuhinke, Woud, Velten, & Margraf, 2017).

I conducted participant interviews to collect their responses concerning health information on various topics, such as their cultural beliefs about health care, where and from whom they got their health care, and challenges they have experienced in their health since coming to the United States. Participants were Caribbean, immigrant adults who had lived in the United States for 5 or more years. The participants were at least 18 years old when they migrated to the United States and resided in the United States at the time of the study. I sought participants through churches, using snowball sampling to ask people I knew to hand out flyers about participating in the study and post the information through social media. The goal was to have at least 9 participants complete the interviews. The selection process was ongoing until saturation of responses was reached.

I analyzed the participants' responses by using unit analysis where similar words or themes in responses were coded together (see Chenail, 2012). To ensure that validity was realized in the study, problems were minimized/eliminated (e.g., selection bias, instrumentation issues, and biasness in the implementation; Yarris et al., 2012).

Role of the Researcher

Qualitative research helps researchers gather information on people's thoughts and feelings that aides in developing an understanding of what meaning people give to their subjective life experiences (Sutton & Austin, 2015). Qualitative researchers seek to understand how and why people engage in certain behaviors (Sutton & Austin, 2015). My role as the researcher in this study was to facilitate the interview process with the participants to gather data while safeguarding them and their data (see Peredaryenko & Krauss, 2013; Sutton & Austin, 2015).

I used self-reflexivity to reflect on honesty and authenticity concerning my research and the audience (see Tracy, 2010). I was aware of my biases and understood my own strengths and shortcomings, seeing how these played a role in the methods and progress of the study (see Tracy, 2010). To minimize my biases, I kept an open mind and remembered that participants' responses were as they saw their health behaviors in their new host country, the United States, and not how I thought they should see their behaviors. I kept a personal journal, writing about my emotions and personal reactions.

Through respecting participant privacy and confidentiality, I minimized other ethical issues because some of the participants were people in the community I reside in who I was not associated with professionally. I ensured that they understood what their

role was in this study and obtained their informed consent to participate in the study before beginning data collection (see APA, 2017).

Methodology

Qualitative research is a process used to collect data to understand participants' perspectives about issues through identifying patterns in their responses surrounding these issues (Lewis, 2015). In the interviews, I used open-ended questions so that participants could respond as they wished and not be confined to answer with one-word answers or have to select from a list of answers that may not have captured exactly how they wanted to respond to the questions. The information that was gathered in the form of participants' responses to open-ended questions was organized and coded in order to interpret the results (see Lewis, 2015).

Exploring Caribbean immigrants' health behavior through acculturation was complex. The qualitative research method was effective because difficult issues were being investigated and the method provided me with the opportunity to conduct in-depth interviews that could also be flexible in order to encourage participants to share more in-depth responses (see Rudestam & Newton, 2015).

Population and Sampling Procedures

Adult, Caribbean immigrants were the target population for this study, and they had to have lived in the United States for at least 5 years or more to be included. I used a criterion sampling strategy to recruit participants (see Rudestam & Newton, 2015) because I needed participants who migrated from a Caribbean country to the United States when they were at least 18 years of age or older.

I sought participants through churches, using snowball sampling through asking people I knew to hand out flyers about participating in the study and posting the information through social media. I recruited nine Caribbean immigrants from the United States (i.e., six from New York, one from the Washington DC metro area, one from Georgia, and one from New Jersey). The interviewing process was conducted until saturation was reached where no new information brought about additional information collected from participants' responses (see Rudestam & Newton, 2015).

Inclusion and Exclusion Criteria

The criteria I used to determine volunteers' eligibility to participate in this study was that they must have been Caribbean immigrants who migrated to the United States when they were 18 years old or older and had lived in the United States for at least 5 years. I chose the duration of 5 years of residing in the United States because it allowed enough time for the immigrants to go through the stages of acculturation. They must have been able to speak, read, write, and comprehend English fluently. All the inclusion criteria had to be met to participate; volunteers were excluded if they were not born in a Caribbean country; did not migrate to the United States when they were 18 years old or older; had not lived in the United States for 5 years or more; and could not read, write, speak, and comprehend English fluently. They were informed if they did not meet the criteria, and I thanked them for their interest. Information on whether they met the criteria was gathered by their self-reporting.

The flyer that was handed out outlined the purpose of the study, identified me as the researcher who conducted the study, and included a phone number and e-mail address

for potential participants to contact me. After I was contacted, I planned on selecting at least 9 participants. If saturation had not been reached with this number of participants, then I would have continued to select participants and collect and analyze data until saturation.

Instrumentation

The purpose of this study was to gather qualitative information so that others would understand Caribbean immigrants' health behaviors and the information could be used to help health professionals understand the needs of the ever-growing Caribbean population in the United States. I wanted to examine the commonalities that Caribbean immigrants had towards their approaches to health care and health behaviors. As I researched topics on Caribbean immigrants' health, I noticed that studies focused on comparisons with African Americans or linked Caribbean people into the African American group when talking about health. Caribbean immigrants grew up in a different environment from African Americans and, therefore, understanding their specific approach to health is important.

To understand Caribbean immigrants' health and approach to health behaviors, I used 14 open-ended, semistructured interview questions (see Appendix) to gather primary data from the participants. An expert panel reviewed the interview questions to ensure that they aligned with the main research question and subquestions.

The interview questions were related to the four research questions concerning (a) Caribbean immigrants' shared experiences in their approach to health; (b) their cultural influences to health care; (c) their approach to health care; and (d) their challenges to

health care. I reviewed Archibald's (2011) qualitative research, and Consedine et al. (2014) quantitative research to assist with creating the interview instrument for the current study.

I expected the interviews to last about an hour each. The interviews were audio taped. If a participant was unable to finish the interview within that hour and wanted to stop, then another interview session would have been scheduled as soon as possible, preferably within 1 week. The first question that I started the interview with was "Define what health means to you," which was adapted from Consedine et al. (2014). This helped to understand the meaning of health to the participants because each participant may have had a different level of thought of what constituted being healthy.

Procedures for Pilot Study

I piloted the interview instrument with two participants from my social network. One of the participants lived in New York, and the interview was conducted at a location that was convenient to the participant. The second participant lived in Maryland, so I conducted a telephone interview with them. A pilot study can be seen as a miniature version of the study methods and procedures, which can help the researcher to see whether the different areas of the study (e.g., data collection method and recruitment) are feasible for use in a larger scale study and if any changes need to be made (Leon, Davis, & Kraemer, 2010). The pilot participants were Caribbean immigrants who migrated to the United States when they were 18 years old or older and had lived in the United States for at least 5 years. I explained my role as the researcher and the purpose of the study. Before the interviews, I went over the consent form for the pilot study. The pilot

participants were asked open-ended, semistructured questions, and the interviews took about 1 hour. The pilot study was audiotaped, and the participants' responses were transcribed. I summarized the responses, then verified and made any amendments needed as I went over their responses with them (see Kim, 2011) and answered any questions they may had. The pilot study helped with checking the clarity of questions, whether the questions were vague or ambiguous, and if any question was difficult (see Rudestam & Newton, 2015). At the end of each interview, I used the pilot study participants' suggestions to improve on the questions on the interview instrument. I forwarded a copy of the audiotapes and transcriptions to the chair of my dissertation committee so that I could receive comments and/or feedback.

Similar words and themes from the transcripts of the pilot interviews were coded together (see Chenail, 2012). If necessary, modifications were made to the interview instrument to ensure that the questions were broad enough (see Kim, 2011) so that participants could talk about their health behaviors as they lived in the United States. I kept a journal to document pilot participants' cues and reflect on my biases and feelings (see Kim, 2011).

Procedures for Recruitment, Participation, and Data Collection

All participants that were selected were Caribbean immigrants, at least 18 years of age when they migrated to the United States and have lived in the United States for at least 5 years. I conducted the interview with participants who lived in the United States. One interview was at a business office and the others were by telephone. I used a questionnaire made up of 14 open-ended semistructured questions to gather information

from participants about their health behavior. The interviews lasted about 1 hour and at the end of the interview each participant got a $10 Target Gift Card as appreciation for their participation in this study. The data collected was on audiotape and saved daily to ensure its safety and confidentiality while participants' privacy was maintained (Morse & Coulehan, 2015).

Data Analysis Plan

After I completed my interviews and collected my data, I transcribed the data I collected. I did the transcribing myself because it was cost effective, I was familiar with the data and I believed I would be more careful with the accuracy of the transcription. As I transcribed, I became more familiar with participants' responses to the interview questions. I transcribed word by word, and other observations like laughter, nonverbal cues/behavior and so forth from participants which enhanced the quality of my data analysis. The quality of my analysis depended upon the quality of my transcription and helped ensure that my study was reliable, dependable and trustworthy (Stuckey, 2014).

Transcription was a time-consuming effort because there was a lot of information that I went through and organized. As I read through the information, I tried to internalize what participants said so I could understand how their experiences affected them and the meaning of what they said. Some of the ethnic language that the participants used was understood by me because I understood their language being that I am also a Caribbean immigrant. I transcribed each interview one by one, reading over the information more than once and identifying what information related to the cultural aspects of participants' behavior towards health.

I used a coding system. I read, verified and organized my data in order to identify categories and patterns which were created from the meanings found in the interviews (Mikkonen, Kyngäs, & Kääriänen, 2015). I made a spreadsheet, listed each interview question and underneath each question I put each participant's response in a separate box. I looked for and made note of the key points that participants made in their responses to identify common themes in the data.

Issues of Trustworthiness

Qualitative research method is a systematic and objective way of explaining and measuring data in a study (Elo et al., 2014). The validity of my research was shown by how I got the results, and how I analyzed the results to reach my conclusion (Elo et al., 2014). I explained my content analysis process clearly and accurately to show that my study was trustworthy. I accurately identified and gave a description of my participants to show that the information I gathered was coming from credible sources. My goal was to have at least 9 participants. After interviewing 9 participants there was no new information from the responses, and this is considered to be saturation. Therefore, I conducted interviews until I reached saturation so that my study would have enough participants to show that the content in the data had validity. Data saturation can be used as a guide in qualitative research and is a way of showing that no new findings or data can be found, and there is an adequate number of samples to ensure content validity (Francis et al., 2010).

Other issues of trustworthiness are transferability, dependability and conformability. To have transferability, I selected participants who are Caribbean

immigrants from various Caribbean countries and who live in the United States in addition to the other criteria I mentioned previously. Dependability, for example, is where others may check to see if I had reliable participants and how reliable was my research (Elo et al., 2014). I recorded what I did in my study, for example whom I met with and what we talked about so that I could have an audit trail of my efforts in my research. Each participant got the same research interview questions. I went over the data gathered to ensure that my interpretation of participants' responses was accurate and if any information was missing then this could be rectified. In order to have conformability where, for example, other researchers would check the accuracy of, interpretation of and recommendations for data that will be gathered (Elo et al., 2014) in order to see that I would not place any of my own biases in the findings of the study. The records on each step I took in my study would provide proof that the information obtained came from participants during the interviewing process. After I developed my coding scheme, I also used a second coder who checked to see if my coding would be able to be reproduced for reliability in my study (Campbell, Quincy, Osserman, & Pedersen, 2013).

Ethical Procedures

The participants were informed that they could refuse to participate in the study and would be able to give consent to the study if they wished to participate. This study caused no harm to participants that I know of and participants were informed that they may have stopped participating in the study at any time for any reason. If participants did not want to answer certain questions because they did not feel comfortable doing so, then they were free to skip those questions. If they felt that the topic that was covered was

sensitive to them, they could contact a free confidential support service, or they could stop.

I ensured that any work that was delegated to others were being delegated to people who were competent to perform the work based on their education, training, or experience (APA, 2017). I did not have a multiple relationship with any of the participants. That means that I only had a participant-researcher relationship with participants so that my objectivity, competence or effectiveness in performing my role as a researcher was not compromised and no participants were exploited or harmed (APA, 2017). I ensured that I respected participants' privacy and confidentiality by storing any interviewing documents, for example, questionnaires and recordings in a locked area and I used coding techniques to avoid anything that would identify my participants when others viewed my research (APA, 2017). I also kept the data on a flash drive that is protected by a password only known by me and after 5 years this flash drive will be destroyed. As per the standard requirement of the APA, raw data are expected to be kept for a minimum of 5 years (APA, 2009).

Summary

In this chapter I discussed the research design and rationale for conducting this research study. The methodology that was used was of a phenomenological and qualitative approach which was used to gather information on the understanding of Caribbean immigrants' health behavior in the United States. In this chapter I provided the criteria which was used to select participants, how data was collected and an outline of the data analysis plan that was used for this study. Issues of trustworthiness and ethical

procedures were discussed to show that steps were taken to minimize any negative effects that may arose.

In Chapter 4, I discuss the results to my data analysis from participants' responses to the research questions. I also provide a table which assisted in providing clarification for this study's findings.

Chapter 4: Results

Introduction

There is a lack of research on Caribbean immigrants' health behavior even though their population has significantly grown in the United States. Caribbean immigrants have different cultural backgrounds than U.S. Blacks and may also have different health behaviors (Archibald, 2011; Hamilton, 2014). In this study, the aim was to examine Caribbean immigrants' approach to their health behaviors in the United States. I used a qualitative, phenomenological approach that gave me the opportunity to examine each participant's health behaviors as they expressed their experiences in the United States (see Rudestam & Newton, 2015). The individual interviews were guided by one main research question and four subquestions. These five questions were further broken down into 14 interview questions that were developed to gather data from participants. Chapter 4 includes a detailed description of the pilot study, participant demographics, and the setting. In this chapter, I also provide an overview of the data collection, data analysis procedures, validity of the evidence, and the results before summarizing the chapter.

Pilot Study

I conducted the pilot study with one male participant from New York and one female participant from Maryland. Both participants met the requirements of the study: They were Caribbean Americans, had lived in the United States for at least 5 years, and were over 18 years of age. I sent the pilot study consent form via e-mail to the female pilot study participant and went over the pilot study consent form with the male pilot study participant in person. The pilot study participants were provided with a verbal and

written detailed description of the research study and how I would conduct the interview, and both participants gave their consent. The interview with the female pilot study participant was conducted over the telephone and recorded, while the interview with the male pilot study participant was conducted in person. I asked both pilot study participants the same 14 interview questions that were created for the main study. After each interview, I asked for feedback about whether the questions were easy to understand and if I should make any adjustments to the way the questions were structured. According to both pilot study participants, the 14 interview questions were clear and relevant to the research topic and they did not feel any discomfort during or after the interview.

I transcribed and typed the recorded pilot study participant interviews. I e-mailed the transcripts to my dissertation chair, Dr. Leann Stadtlander, to check the transcripts for accuracy, and it was agreed that the 14 questions were relevant to the research study.

Setting

I conducted eight interviews by telephone, and one interview face to face. The interview that was conducted face to face took place in a confidential area agreed upon by the participant.

Demographics

Nine participants met the inclusion criteria for the study. All participants were Caribbean Americans and lived in the United States for 5 years or more. The participants were between the ages of 41 and 67 years old with an average age of 53 years old. Table 1 shows the demographic information for the participants.

Table 1

Demographics of Participants

Participant	Age	Gender	Race	State
1	52	Female	African American/Black	Washington DC metro area
2	41	Female	White	Georgia
3	67	Female	African American/Black	New York
4	57	Male	African American/Black	New York
5	54	Male	African American/Black	New York
6	55	Female	African American/Black	New York
7	59	Male	African American/Black	New Jersey
8	53	Female	African American/Black	New York
9	41	Female	African American/Black	New York

Data Collection

I started the study after receiving approval from the Walden University Institutional Review Board (IRB; Approval No. 11-29-18-0186915) in November 2018 and completed the data collection in March 2019. Flyers/invitations were posted on social media as well as in churches and public places to recruit participants from these areas. I used a criterion sampling strategy in order to recruit participants (see Rudestam & Newton, 2015) who were Caribbean immigrants. The research flyer stated the criteria that the participants must meet, that they would receive a $10 Target gift card for completing the interview process, and the phone number for a free support service if the topic covered was sensitive to them.

I was contacted by participants through e-mail, social media, and the phone, and they gave consent in addition to scheduling interview times through these means. Eight interviews were conducted by phone and one was conducted in person in a confidential, public business. I first thanked the participants for agreeing to participate in the study, then assured them that their identities would be kept confidential and the findings of the study would be used to provide a better understanding of Caribbean immigrants' health behaviors.

I discussed the demographics form with all participants, and if any of the responses needed to be clarified or if a question were not answered, then the participant and I would go over it. The participants were informed that the interviews would be recorded, and they gave their consent to this. I used a digital recorder to audio record all nine interviews Participants were provided with information on the purpose of the study and how the interview process would be conducted. They were informed that their information would be stored in a locked file cabinet, and their real names would not be used in the recordings; instead, they were referred to by participant number. This step was taken to ensure their confidentiality. The participants were debriefed after the interview to minimize any stress that they may have felt.

I collected demographic information from all the participants before the start of the interviews with the main research questions and subquestions. The interview instrument comprised 14 open-ended questions that were asked in sequential order. The interviews lasted between 31 and 65 minutes depending on how much detail the participant went into and whether any of their responses needed to be clarified. If I

needed to clarify any of the interview questions, I did so, and all participants completed their interviews in one sitting.

All recordings were electronically saved and coded. I typed the transcripts for each recording and went over them to ensure their accuracy. The transcripts were stored on a USB drive in a sealed box that was kept in a locked file cabinet. I was and am the only person who had and has the key for the locked cabinet.

Data Analysis

I used a qualitative, phenomenological method for this study, and the 14 open-ended questions allowed each participant to talk about their experiences (see Rudestam & Newton, 2015). The participants expressed their health and health care experiences in the United States versus in their original country.

The data were analyzed by typing the nine transcripts into a Microsoft Word table. From there, I created codes and themes, and each question was placed in a separate file with the participant's responses for each question. The specific comments that contained the code words were placed in the table as well and code words were demarcated by bold letters.

Evidence of Trustworthiness

The trustworthiness of results is based on credibility, validity, transferability, dependability, and conformability (Elo et al., 2014). I ensured that there was credibility by recording participants' experiences as they described them. Validity was ensured by conducting interviews with enough participants until I reached saturation. I made sure of transferability by interviewing Caribbean Americans who met the study criteria.

Dependability was ensured by asking the same questions to each participant and ensuring that my interpretations of their responses were accurate. Conformability was accomplished through checking the accuracy of my interpretations of their responses and the recommendations I generated from the data gathered as well as ensuring my biases were not placed in the findings of the study.

Results

In this section, I present the results of the study that addressed the following main research question and four subquestions:

RQ: What is the shared experience of Caribbean immigrants' approach to health?

SQ1: What are the cultural influences for Caribbean immigrants' health care?

SQ2: What are the cultural influences for Caribbean immigrants' health behavior?

SQ3: How do Caribbean immigrants approach their health care?

SQ4: What do Caribbean immigrants perceive as their health care challenges?

Theme 1

To answer the main research question, I asked participants to respond to the first four interview questions about their understanding of the meaning of health, how their health has been since they came to the United States, and what they would do if they got sick. Arising out of the question about participants' meaning of health, Theme 1 was: health meant being able to function and perform well in their daily lives without major setbacks. One participant said, "Health means…being able to function and be physical, be able to perform…tasks… exercise, go to work, do things around the house and feel

good physically" (Participant 2 [P2]). Participant 3 (P3) and Participant 4 (P4) said that health meant living without disease, and P4 added "without pain and stress."

Theme 2

To the second interview question about how their health has been since they came to the United States, 6 out of the 9 participants said that their health was good. Theme 2 was that overall health was good; however, in some instances, health deteriorated. P4 said that the experience was good health, great health, and had nothing to worry about. On the other hand, Participant 6 (P6) said:

> I have developed more health issues since I've come to the USA as opposed to where I live in the West Indies. I've been diagnosed with…I've been told…I have a heart murmur. I have not been put on any medication…I still continue to have pains in my joints. I'm not on any medication for the arthritis.

Participant 7 (P7) said that he developed high blood pressure, was now diabetic, and believed it may be related to getting older. He also believed that since he is Black, he would have issues like high blood pressure and prostrate issues because those were some of the things his doctor looked at when treating him.

Theme 3

The third interview question was about how their health has improved or declined. Theme 3 was that health has declined and some of the illnesses may have been age related. However, P4 reported that he had no change in health and that he stayed the same. All other participants mentioned either serious changes or slight changes in their health. P2 said that her eyesight got worse and that she had to wear very thick glasses or

hard contact lenses until she got Lasik surgery. Now she wears a "slight prescription, cheaper glasses and soft contact lenses." She has been trying to control her rheumatoid arthritis with her diet, and she had her gall bladder taken out, so she does not experience any more pain related to that.

Theme 4

The fourth interview question concerned how they would care for their health if they got sick tomorrow. Theme 4 was that they would use home remedies like herbs or teas, and if it was serious, they would go to a doctor. P7 responded,

> It depends on…like what do you need in terms of I would see a doctor. I mean, if it was…if I had a cold I would…eat fruits like oranges. I would…take care of myself. If it were something that was…definitely more serious…I would bring it up with my doctor.

Participant 9 (P9) stated,

> If I got sick tomorrow, I would, well, it depends on the severity. If it was like chronic, but I would do regular doctor's visit. I would try not to go on standard medication. I will try a more holistic and herbal approach before I go into the regiment of pharmaceuticals…in terms of like diet or any kind of natural remedies and like, plant based rather than a commercially available medication.

P9 also said that she would probably consult with somebody about what she "could use naturally before fully investing in pharmaceuticals."

Theme 5

The fifth question asked, “before you came to the United States what did you do when you were sick.” Theme 5 was they would use natural/home remedies and/or go to the doctor if it is serious. Participant 1 responded:

> I think initially my parents, my mother would try home remedies…it was home remedies initially and then if things did not improve then we would go and see a medical doctor…again similar things like teas…herbal teas…if I had a rash on my skin we might…put lime on the rash and some kind of leaf that was found somewhere…

P2 responded:

> We did not take a lot of prescription drugs…and you know, a lot of times it was a situation where like my grandmother knew the doctor so there would be a phone call. There were not a lot of doctor visits. I don't remember sick being sick very often, but I did have measles twice, mumps once and German measles and chicken pox all before I came to the States…if one of us kids got it, all of us should get it and get it out of the way…but a lot of times if you are ill, it was treated with…it was definitely not treated with medication…we didn't really take antibiotics or anything that. Even today when I go home, you'd be hard pressed to find any kind of home medicine or even painkillers in my mom's house…a lot of it would be like ginger tea if your stomach is upset or some kind of citrus or vitamin C and if feel like you're getting a cold that kind of thing.

P7 responded that when they were sick from eating "all kinds of junk and stuff like that," after the summer vacation they would be given Senna to "clean you out and things like worm grass." P9 responded that they were given commercial drugs like Panadol or if it was cold related, they got a local herb or "a concoction rather than something over the counter," a variety of herbs boiled into a tea, Vicks or some ointments.

Theme 6

The sixth interview question sought responses about whether anyone or anything influenced how they approached their health care. Theme 6 evolved that influence came from education/knowledge and parents/family members. P3 responded:

> And I think I was influenced by my parents because…my parents were not in the habit of taking us to the hospital or to see a doctor…my father would use a thing called iodine if you got a cut.

Participant 5 (P5) responded that his influences were his grandfather and father. His grandfather lived until he was 99 and planted his own food. His father who is 84 did not take any medication and eats natural, organic food.

Theme 7

Interview question seven asked "what differences do you see between the United States culture and Caribbean (your own) culture." Theme 7 evolved that people in the United States go to the doctor and take medication more often. P3 responded:

> People here, parents here, are much more likely to take their children to the doctor or people go to the doctor, um, more readily and comparing to what I experienced…I think people more readily go to a doctor instead of first taking the

> time to see how its developing…And the Caribbean, and don't compare to when I was growing up in the Caribbean…where I was living…all these things that people have around in their yard…you had the caraille bush, sour seeds and things like that…which people might use.

P6 responded that medical attention in the United States is taken more seriously than in her country. Also, doctors in the United States give "extra attention" to patients. Participant 8 (P8) responded that in the United States, people go to the doctor regularly, more than in her own country and that there is greater access to medical professionals and health facilities are more efficient in the United States. She said that more tests and more "serious interventions" are done in the United States while in her country "there is a lot more reference back to natural things…old time remedies."

Theme 8

Interview question eight was "what do you think causes you to get sick." Theme 8 evolved that bacteria/virus, stress, exhaustion or food gets me sick. Participant 1 (P1) responded that she thought it was either bacteria or a virus that caused her to get sick and that recently stress caused her sickness. P3 responded:

> When I got sick it was the flu…most times it's when I get sick, I'm exhausted if I've been doing too much and I'm also if I'm exposed to too many bugs at the same time…like in a classroom where there's lots of children…coughing…That's how I got the flu. It was hot and there's a problem with ventilation…lack of ventilation, the air is not circulating as it should. So that how I got the flu.

P9 responded that she thought it was the amount of food and the quality of the food that was eaten. She said that according to where people lived there should be access to better quality of food like vegetables and meat and that food has the biggest impact on people getting sick.

Theme 9

The ninth interview question was about what they did when they got sick. Theme 9 evolved that they would take a break/rest, use natural remedies or go to the doctor. P3 responded:

> I put myself on bed rest first. I drink a lot of water. But according to what it is I try my home remedies because it's according to the type of illness. If it's a pain, if I hurt myself, strain, I use my heat…I use over the counter painkiller like ibuprofen or something like that.

P4 responded that he would also rest in order to give his system time to "fight whatever disease is…attacking you. Or you take some pills or…some tea to help" so that his system could fight the illness. P5 would go to the doctor and according to where he is, he would "figure out how I got it and stay away" from that area/environment.

Theme 10

Interview Question 10 asked participants to tell me how they saw Caribbean immigrants' approach to health in the United States versus their original country. Theme 10 evolved with: Caribbean immigrants trust the United States medical system more and, in the Caribbean, they use alternative remedies first. P6 responded:

> Folks are reluctant to discuss their medical and stuff. That they feel more comfortable getting their diagnosis here in the United States as opposed to getting diagnosed in Trinidad and Tobago.

P8 responded:

> I would say here in the US they would tend to go to an emergency room a lot quicker than in Trinidad...Or they would go to a physician, a doctor a lot quicker. I thin in Trinidad you may have a bit more natural, natural health practitioners than here…So, I think here people have more faith in the medical system than in the Caribbean because of the lack of the facilities and professionals and the often long delay in getting appointments.

P8 added that in the United States a lot more people have access to health insurance, so they tend to go to the doctor more often. She also responded that since drugs and pharmaceuticals are so well advertised and marketed people are more aware of the health issues so they "take advantage of" getting a certain level of health care.

Theme 11

Interview Question 11 asked "tell me about the similarities and/or differences in how you manage your health in your original country vs in the United States." Theme 11 which evolved was that the similarity was to go to the doctor and the difference was that you took care of yourself first, then go to the doctor. P3 responded: "Similarities, as I said I put myself on bed rest first…I usually get sick when I'm tired, when I've been doing too much…if it's something that's I consider very serious, then I would have to go to the doctor."

P4 responded that he goes to the doctor all the time in the United States and that in his country, they spend time letting their immune system "right it" instead of going to the doctor. P5 responded that he is careful about what he eats in the United States, that he eats natural organic food and that in his home country people pick their own fruits. P6 responded that he has a doctor for particular ailments and that in his country people have a regular family doctor.

Theme 12

Interview Question 12 asked participants about their experience with the health care system in the United States. Theme 12 which evolved was that when you have health insurance you get good health care that is affordable and when you do not accessibility is hard. P3 responded that people should have health insurance in the United States because it seems to be quite expensive as compared to her country, health care is more economical (affordable).

P9 responded:

> When I didn't have employment-based insurance it was left up to like very routine…testing and anything additional was out of pocket…I took advantage of whatever I could take advantage of but even if they told me I had issues, I believe even if it wasn't medical, I would have to wait until I got employment and got more coverage to deal with it rather than have the money to deal with it out of pocket.

P9 also responded that health care was "definitely very expensive" and that it was "highly unfair" that an individual has a higher cost than what the insurance companies pay.

Theme 13

Interview Question 13 asked about the challenges they experienced in their health and accessing health care while living in the United States. Theme 13 evolved that there were no major or no challenges. P1 responded:

> I have not had any major challenges accessing health care in the United States…I've been pretty lucky. I've worked in hospitals. I've managed clinical group practices…several of my friends are medical doctors…I've really had no major issues over the years in accessing health care for either me or my daughter while I've been living in the United States.

P4 responded that he had no challenge, however, it takes longer to get an appointment and people could go to the emergency room if they had a serious illness. P6 responded that she feels comfortable and that every time she goes to the doctor, she gets relief from her symptoms.

Theme 14

Interview Question 14 asked participants what they thought could improve the health care system for Caribbean immigrants in the United States. Theme 14 evolved that more education about health care should be given to Caribbean immigrants. P4 responded:

> They need to do more advertising, more grassroots…they need to kind of find a way to explain people thing in their own language because a bunch of people that's here, even if they don't speak English…they are not able to tell the doctor all that happening to them. So, at that time people get frustrated and they just

> don't want to go to the doctor for any little thing…hiring people from the same culture, like have so many people that cultural competency.

P8 responded that there should be access to information, organization groups and Caribbean American health professionals should do outreach in communities and there should be a database of Caribbean American health professionals. She also said that Caribbean immigrants would be more trusting and proactive in taking care of their health if they had (health professionals) who had similar accents and (cultural) backgrounds to them.

Summary

The purpose of this study was to examine Caribbean immigrants' approach to their health behavior in the United States. In Chapter 4, I showed how the data was collected, managed and analyzed. The nine participants said by word of mouth and by signing the Informed Consent form that they understood the Informed Consent before the interview started. Their interview responses explained their experiences and health behaviors in the United States and their home country. A qualitative phenomenological study method was used, and steps were taken to ensure that the data from the responses were interpreted in a manner in which participants' health behaviors were captured (Rudestam & Newton, 2015).

In response to RQ, most participants mentioned that health meant they were able to function well in their daily lives. Some of them had more health issues since being in the United States. Most of them said that they used natural home remedies to take care of illnesses, however, if the illness was serious, they would go to the doctor for treatment.

In response to SQ1, most participants used home remedies like herbs or teas before they took commercial medication when they got sick. Their family members, in particular their parents or grandparents influenced how they approach their health care. In response to SQ2, most participants believed that in the United States, people go to the doctor and take medication more often than in their Caribbean countries. They believed that viruses, stress and sometimes the kind of food they eat caused them to get sick. In order to recover from their illness, they would rest, use natural remedies or go to the doctor if the illness turned out to be serious.

For SQ3, most participants believed that Caribbean immigrants trust the health care system in the United States while in the Caribbean they used alternative remedies first before going to a doctor. There was not much similarity except that when they felt it necessary, they would go to the doctor. The differences were that first, they would rest themselves and take natural remedies, hoping that could cure them before they sought out a doctor.

The responses to SQ4 resulted in participants stating that it was important to have health insurance in order to get adequate care in the United States, otherwise it would be expensive, and they may not be able to get all the care that they may need. Participants had no major to no challenges in their health and accessing health care while being in the United States. Participants mentioned that the health care system could be improved for Caribbean immigrants by having culturally competent health professionals, providing more health education and more accessibility to information from and about Caribbean American health professionals. In Chapter 5 I document the interpretation of the findings

of the research, the limitations, the recommendations, the social change that may occur and the conclusion.

Chapter 5: Discussion, Conclusions and Recommendations

Introduction

The purpose of this study was to explore Caribbean immigrants' approaches to their health behaviors in the United States. I used a qualitative, phenomenological method to examine the participants' health behaviors and show whether acculturation plays a role in their new environment (see Rudestam & Newton, 2015). This method allowed me to gather information on participants' experiences in the United States and their birth countries as well as how their health and health behaviors have changed since they came to the United States.

There has been a significant increase in the Caribbean population in the United States from approximately 3 million in 2000 to approximately 4 million in 2014 (Zong & Batalova, 2016). However, there has not been research on Caribbean immigrants' health behaviors even though the population continues to increase, having increased by 26% to approximately 3.7 million in 2010 and again by about 18% to 4 million in 2014 (Zong & Batalova, 2016). While there are over 4 million Caribbean immigrants residing in the United States, there are over 1 million living in New York State (U.S. Census Bureau, 2017; U.S. Department of Commerce, 2014). According to Hamilton (2014), it is not clear whether health behavior is affected by immigrants' specific culture or other issues affecting immigrants' behavior. However, previous research has suggested that the health of immigrants and their descendants is negatively affected as they follow the social and cultural norms of the United States (Lacey, 2015). Since a better understanding of

Caribbean immigrants' health approaches is needed, I conducted this study to address the issue.

The following research question and four subquestions guided this study exploring Caribbean Americans' health behaviors:

RQ: What is the shared experience of Caribbean immigrants' approach to health?

SQ1: What are the cultural influences for Caribbean immigrants' health care?

SQ2: What are the cultural influences for Caribbean immigrants' health behavior?

SQ3: How do Caribbean immigrants approach their health care?

SQ4: What do Caribbean immigrants perceive as their health care challenges?

These questions were addressed through asking Caribbean immigrants 14 interview questions and the various themes that emerged from their responses.

The key findings for the main research question were that most participants said that the meaning of health to them was that they were able to function well in their daily lives. While some of them developed more health issues since they migrated to the United States, most of the participants used natural home remedies to take care of their illnesses. However, if their illnesses turned out to be serious, they would then go to their doctor to get treatment. King (2012) found that Caribbean immigrants to the United States had an increase in chronic diseases compared to nonimmigrants, and one of the reasons is that Caribbean Americans engaged in unhealthy eating behavior. According to Lacey et al. (2015), this is due to immigrants following the social and cultural norms of the United States.

The key findings for SQ1 were that when most participants got sick, they first used home remedies, like herbs or teas, before they used pharmaceuticals, and their family members influenced how they approached their health care. This is consistent with Brathwaite and Lemonde's (2017) findings that Caribbean immigrants used herbal medicines, traditional foods (e.g., fish broth and provisions to strengthen them), and folk medicines to improve their health and spiritual healing.

The key findings for SQ2 were that most participants stated that most people in the United States take medication and go to the doctor more than they did in their own countries. They also stated that viruses, stress, and some food caused them to get ill. They recovered from their illnesses by resting, using natural remedies, or going to the doctor when the illness is serious. According to Brathwaite and Lemonde (2017), Caribbean immigrants may have concerns about following the advice of health professionals in the United States because it is different from what they are accustomed to following. However, as they stay in the United States, their health behaviors and overall health may be influenced by their environment, what they see on the television, and the demands of their lives (Brathwaite & Lemonde, 2017; Lacey et al., 2015).

The main findings for SQ3 were that Caribbean immigrants trust the health care system in the United States, and when in the Caribbean, they preferred to use alternative remedies before going to their doctor. This is inconsistent with the findings of Brathwaite and Lemonde (2017) who reported that Caribbean immigrants in the United States would be wary about following the health advice of their health professionals in the United States because this advice would not be consistent with what they are accustomed to

following. Participants did not see much similarity in how they managed their health except that they would go to the doctor. However, the differences in how they managed their health were that they would rest and take natural remedies before going to the doctor.

The key findings concerning SQ4 were that participants believed health insurance was important in order to get adequate health care in the United States; otherwise, obtaining health care would be too expensive and those without insurance may not get appropriate care. They did not have any major health or health care challenges while in the United States. The participants said that an improved health care system for Caribbean immigrants means that there would be culturally competent health professionals, there would be more health education provided to immigrants, and there would be more information from and about Caribbean American health professionals. According to Rhodes et al. (2015), some immigrants may avoid getting health care services because of their fear of the immigration enforcement policies, so they stay ill even if they were able to get health care services to get better. According to Viruell-Fuentes et al. (2012), some immigrants may not have proper or adequate access to health care for specific treatments for diseases like hypertension or cancer. Immigrant policies may negatively affect immigrants' health and well-being where immigrants may feel that they are being discriminated against by health care workers (Viruell-Fuentes et al., 2012). When health professionals understand Caribbean immigrants' health beliefs and practices, these medical professionals are provided with valuable information on how these factors influence immigrants' health and how they manage their illnesses

(Brathwaite & Lemonde, 2017). This information can help health professionals create specific interventions for Caribbean immigrants (Brathwaite & Lemonde, 2017).

Acculturation Theory

The acculturation theory (Park, 1914) was the theoretical foundation used in this study. According to this theory, health behavior can be influenced by three stages: contact, accommodation, and assimilation (Padilla & Perez, 2003). I also included the areas of social and cultural identity and biculturalism in this foundation since over the years the definition of acculturation has expanded to include these factors and Caribbean Americans have experienced these in their environments (see Schwartz et al., 2006). Concerning social identity, the findings of this study showed that Caribbean Americans hold onto their ideas, preferences, and fears as they nurture their uniqueness (see Schwartz et al., 2006) by maintaining their cultural health behavior of using natural remedies first before going to a doctor. Caribbean Americans hold onto their cultural identity by having similar attitudes, beliefs, and behaviors to other Caribbean immigrants when their health behavior is concerned (Schwartz et al., 2006). The participants continue to follow what they learned from their family members as they were growing up in their home countries and having the same behaviors and understanding of what health means while living in the United States. Some of the Caribbean American participants were also able to engage in biculturalism, in which they adopted the values and practices of their former and host countries (see Schwartz et al., 2006) by using natural home remedies while also understanding the significance of going to see a health professional when an illness is too serious to handle on their own.

Another aspect of the acculturation theory is that as immigrants stay in the United States longer, they may adopt unhealthy cultural changes while adopting the lifestyles of the Western culture (e.g., eating unhealthy foods like processed foods that are high in fat; Ro, 2014). While some participants mentioned they may eat unhealthy foods and have more stress while being in the United States, they tended to counterbalance that lifestyle by getting better quality foods, managing stress better, and getting adequate rest as needed.

Aligning with the acculturation theory used as the theoretical foundation for this study, the participants showed that the main aspect of the theory that reflected on their behavior was more towards the stage where they first held onto their former cultural behavior of using natural alternatives. However, if they thought their illness could not be managed by them through rest and natural remedies, then they would go to the hospital or see their doctor.

Interpretation of the Findings

Caribbean immigrants tend to follow the health behavior of their Caribbean culture, which they learn mainly from their family members and continue to practice as they navigate their lifestyles in the United States. They believe that illnesses could be treated with natural home remedies; however, if the illnesses turned out to be serious, then they would seek out a doctor.

The results of the current study were consistent with King's (2012) findings concerning Caribbean immigrants in the United States experiencing an increase in diseases because of unhealthy eating behaviors. When Caribbean immigrants follow the

social and cultural norms of the United States and experience an increase in life stresses, their health is negatively affected, resulting in an increase in illnesses (Lacey et al., 2015).

The results of the present study were also consistent with those of Brathwaite and Lemonde (2017) who reported that Caribbean immigrants in the United States are accustomed to using natural, alternative methods to improve their health and would be wary about following the health advice of their health professionals in the United States because it would not be consistent with what they are accustomed to following. The results of the present study showed that as Caribbean immigrants stay in the United States, they tended to "go back to their roots" and seek out natural, herbal remedies to take care of their ailments before they visited a doctor. This finding was similar to Consedine et al. (2014) who found that if Caribbean immigrants believe that the U.S. culture is significantly different from their original culture, then it is harder for them to acculturate.

Limitations

The participants in the present study showed that even when Caribbean immigrants came from different Caribbean countries and lived in different parts of the United States, they tended to have similar health behaviors. One limitation to the research study was that I only interviewed English-speaking participants, so I am not sure if participants of another language would react differently where their health behaviors are concerned since migrating to the United States. For example, Hispanic- or Portuguese-

speaking, Caribbean immigrants may have the same health behaviors or may look at their health in different ways than English-speaking Caribbean immigrants do.

Another limitation was that as I was recruiting potential participants, there were a number of individuals hesitant to participate in a research study because they were guarded about sharing information that they considered to be private. There is no way of knowing whether their responses would have been different than the people who participated in the study.

Recommendations

One recommendation for future research is to conduct research on non-English-speaking participants and explore how acculturation affects their health and health behaviors. This line of research will help health professionals better understand their needs of and may influence health policies that affect Caribbean immigrants. Another recommendation for future research is to study what limitations health professionals have concerning serving Caribbean immigrants and what would help them to improve their services to Caribbean immigrants.

Implications

The findings of this study bring greater awareness of the needs of Caribbean Americans. The results of this study can be used to help health professionals better understand how Caribbean Americans think about their health, health behaviors, and what they may need as well as how their health professionals can better serve them. Health professionals should be more aware of Caribbean immigrants' health beliefs and how they manage their illnesses (i.e., their health practices) so that health professionals

can tailor health treatments or preventative methods to treat, prevent, and/or minimize the occurrence of diseases (e.g., hypertension or diabetes).

Conclusion

I conducted this study to explore Caribbean immigrants' approaches to their health behavior in the United States. The qualitative, phenomenological method enabled me to examine the participants' health behaviors and show whether acculturation played a role in their new environment (see Rudestam & Newton, 2015). Caribbean immigrants tended to follow the cultural health behaviors that were learned from family members as they were growing up in their countries of origin, which shows that their culture still had a significant impact on their lives even though they may have other influences in their new environment in the United States.

Caribbean immigrants may be better served if health professionals are more culturally sensitive and/or if access to information on the availability of health professionals from their own culture was readily available. Since Caribbean immigrants tend to use natural herbal remedies, health professionals may want to research natural remedies that may have fewer side effects and may help with the health and well-being of their patients. This may also lead to looking into health policies that could positively affect Caribbean immigrants in U.S. communities. I would like this research to start a conversation concerning how to improve the lives of Caribbean immigrants in the United States through having access to health care services that can be tailored to them and the use of alternative medicines/remedies so that Caribbean immigrants can benefit from having a better and healthier life in the United States.

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Appendix: Interview Questions

Main Question: What is the shared experience of Caribbean immigrants' approach to health?	1. Tell me what health means to you. 2. Tell me about your health since you came to the United States. 3. Tell me how your health has improved or declined. 4. If you got sick tomorrow, how would you care for your health?
Subquestion: What are the cultural influences for Caribbean immigrants' health care?	5. Before you came to the United States, what did you do when you were sick? 6. Does anyone or anything influence how you approach your health care?
Subquestion: What are the cultural influences for Caribbean immigrants' health behavior?	7. What differences do you see between the United States culture and Caribbean (your own) culture? 8. What do you think causes you to get sick? 9. What do you do when you get sick?
Subquestion: How do Caribbean immigrants approach their health care?	10. Tell me about how you see Caribbean immigrants' approach to health in the

	United States vs their original country? 11. Tell me about the similarities and/or differences in how you manage your health in your original country vs in the United States?
Subquestion: What do Caribbean immigrants perceive as their health care challenges?	12. Tell me about your experience with the health care system in the United States? 13. What challenges have you experienced in your health and accessing health care while living in the United States? 14. What do you think could improve health care system for Caribbean immigrants in the United States?