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SOCIAL WORK PRACTICE IN HEALTH CARE: AN ETHNIC SENSITIVE APPROACH

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ABSTRACT

The relationship between ethnicity and modes of response to illness has been well documented. One example is stoicism as contrasted with volatile behavior in response to pain of different groups. Another is increasing awareness of the fact that non-traditional healers (e.g., espiritistas, cuaranderos) are used extensively by members of various ethnic groups.

Insufficient attention has been paid to how such knowledge can be incorporated in social work practice.

This paper reviews prevailing social work interventive procedures and skills and suggests needed adaptations if social work practice is to be more sensitive and responsive to different health behaviors and beliefs of various ethnic groups.

Consideration is given to various views of illness causation, response, cure and death. In this context the potential for varying modes of cooperation with non-traditional healers is explored.

Introduction

There is a vast literature which describes and analyzes the relationship between ethnicity and modes of response to health and illness. Less attention has been paid to how such knowledge can be used to guide social workers in the planning and delivery of social work services in health care.

There are extensive variations in health beliefs and practices. These revolve around (1) views about the cause of illness; (2) the efficacy of varying curing

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practices; (3) the types of individuals and resources that are considered appropriate healers; (4) accepted responses to pain; (5) the degree to which the manifestation of particular symptoms or syndromes are viewed as "legitimate" or stigmatizing and shameful; and (6) the response to illness expected from the family, neighborhood networks and the community. Some beliefs and practices are evident in subtle variations in response to pain and readiness to comply with medical regimen. Others represent dramatic departures from western healing practices and include recourse to folk healers.

This paper reviews some of the major health beliefs and practices of different ethnic and cultural groups and proposes intensification and adaptation in prevailing social work interventive procedures and skills designed to enhance sensitivity to these differences.

Major Terms and Concepts

Much of the social work literature on health and illness behavior is focused on the beliefs, practices and concerns of those groups usually considered to be ethnic minorities. Unlike much of that work, this paper deals with a range of groups, recognizing major differences between them. The following concepts and definitions inform the perspective presented here.

Ethnic Groups

It has been proposed (Shibutani and Kwan, 1965) that ethnic groups consist of those who conceive of themselves as being alike by virtue of their common ancestry.

Others (e.g., Greeley, 1974) view an ethnic group as a collectivity based on common origin. Such groups usually share a common past, a common present and the assumption of a common and shared future. A common language, religion, and in many cases, common physical features characterize many ethnic groups.

Minority Groups

Minority groups have been defined as ". . . the under-privileged in a system of ethnic stratification and people of low standing--people who receive unequal treatment and who therefore come to regard themselves as objects of discrimination" (Shibutani and Kwan, 1965).

Ethclass

The point at which social class and ethnic group membership intersect has been characterized as ethclass. Gordon (1964) has used this concept to explain the role that social class membership plays in defining the basic conditions of life at the same time as it seeks to account for the differences between groups at the same social class level. These differences are often explained by ethnic group membership.

Ethnic Reality

Elsewhere we have suggested (Devore and Schlesinger, 1981) that the intersect of ethnicity and social class generates identifiable dispositions and behaviors. We characterize these dispositions and the behaviors which flow from them as the ethnic reality or ethclass in action. Included are dispositions on such matters as appropriate child rearing practices, proper care for the aged, and health and illness behavior.

Variations in Health Beliefs and Practices

The variations in response to health and illness are traced to deeply ingrained beliefs about (1) nature; (2) the supernatural; and (3) the role of individuals vis-a-vis nature, other human beings and the Gods. Characteristic views about whether people are controlled by or master nature translate into prescriptions for response to illness, and explanations for its cause. These overriding cultural themes and belief systems, together with a group's unique history with migration and involvement in the mainstream society shape many responses to illness.

Contemporary western societies are characterized by strong reliance on science, technology and the conviction that nature can be mastered (Parsons, 1958; Mechanic, 1978). The massive technological advances of the past one hundred years are powerful testimony to the strength of those beliefs. From this perspective, religion on the one hand and science and medicine on the other represent different domains of thought and action (Freidson, 1970).

Non-western or traditional perspectives tend to implicate fate, nature, the Gods, the spirits or fellow human beings as the cause of illness. People are viewed as passive recipients of diverse forces (Martinez, 1978; Garrison, 1977; Fields, 1976).

Many tribal cultures make no distinction between religion and medicine. Healing experiences are considered an integral part of community life. Harmony--of people with nature, with each other and with the Gods--is the desired state. Disease states are viewed as indicative of underlying disharmony and may be a reflection of witchcraft, spirits, animal contamination and disordered human relationships (Coulehan, 1980). For many Mexican Americans, illness is subject to God's will and a consequence of having sinned (Martinez, 1978).

In this world view, strategies designed to minimize discomfort and stress variously call upon nature, the spirits, witchcraft and modern medicine. Some humans are thought to have supernatural power to heal and have been chosen for this role. These include the espiritista, the curandero and the singer (Garrison, 1977; Martinez, 1978; Coulehan, 1980; Abad and Boyce, 1979).

Ethnographic study of a Black community suggests that a viable system of folk medicine exists for many Blacks. Many elements of this system are believed to be shared by some Mexican Americans, Puerto Ricans, southern whites, Pennsylvania

Dutch and Kansas farmers. Those who adhere to this belief system are largely of working or underclass status and poorly educated. The beliefs are derived from a composite of classical medicine of an earlier day, European folklore, some African traits, modern scientific medicine, fundamentalist Christianity and the Voodoo religion of the West Indies. According to this perspective the world is a dangerous place. People are subject to attack from external sources and must be wary of nature and God. Illness is one of many undesirable events in the same category as poverty and unemployment. The notion of disharmony is also of importance (Snow, 1974).

Numerous investigations have suggested that the health beliefs and practices of American Jews are in major accord with the objectives and methods of modern medicine. They make extensive use of physicians, are more likely to use psychiatric care than most other groups and have great concern about the meaning of symptoms (Suchman, 1964; Greenblum, 1974). Response to pain is volatile and concern is focused on the implication of these symptoms for the future (Zborowski, 1952). The Jewish people's extensive concern with health has been explained in terms of "the sense of precariousness and fear concerning survival related to centuries of dispersal and persecution" (Howe, 1975).

Italians are also said to be volatile in response to pain. Their concerns are expressed more in terms of the immediate discomfort experienced (Zborowski, 1952). Other Mediterranean culture groups (e.g., Greeks) have been shown to have greater worry about illness than those of Irish or British origin (Pilowsky and Spence, 1977

Slovaks, not unlike "Old Americans" tend to be stoic in the face of pain (Stein, 1976; Zborowski, 1952). Illness is viewed as a form of weakness, and medical care is to be put off as long as possible (Stein, 1976).

The relationship between ethnic group membership and the specific manifestations of psychiatric pathology has been investigated by Opler and Singer (1956). Studying a group of schizophrenic patients in a New York psychiatric hospital they found that basic cultural themes concerning aggression, sexuality and the relative dominance of the mother or father were reflected in both the content and etiology of schizophrenic disorders of Irish and Italian men.

The fact that particular syndromes are characteristically found among some groups has been frequently noted. An example is the ataque, experienced by some Puerto Ricans and Chicanos on the mainland. Though it can take different forms, behavior such as sudden unprovoked tearing off of clothing in public, twitching, screaming and falling into a semi-conscious state is not uncommon. Many view the ataque as a culturally recognized and legitimate cry for help when people are experiencing stress. Ataques are often attributed to the works of the spirits and espiritistas are believed to have the power to exorcise these (Garrison, 1977; Abad and Boyce, 1979).

Ethnic dispositions to death vary as do those revolving about health and illness. For many American Indians death is a part of life. Many can visualize

themselves as performers in the "Dance of Death." No matter whether tribal burial customs call for people to be buried in sleeping, sitting or fetal positions, life is to be lived to the fullest and death accepted as a natural conclusion (Kalish and Reynolds, 1976).

The reciprocal obligations which are an intrinsic part of Japanese family and community life often prevent the dying from encouraging family members to spend time at the deathbed. Such attendance is thought to inconvenience family members. The response of a Sansei (third generation Japanese) terminally ill individual reveals this disposition: "I wouldn't want my family to know. They would worry too much. They would be super nice. I would feel guilty putting a burden on them" (Kalish and Reynolds, 1976). The self-effacing stance which some associate with Japanese Americans is also revealed in the views on death and dying. Some express the view that no one is so important that his/her death would cause suffering to others. Hence some Japanese Americans may hold the view that the potential grief experienced by family and friends is not sufficient reason to hold on to life.

Investigation of the funeral customs of Black Americans (Devore,1979) suggests that spirituals such as "Soon I will be done with the trouble of dis' world," "Up above my head I hear angels in the air" or "Swing low sweet chariot, coming for to carry me home" give a Black perspective whereby many view death as release of oppression by the mainstream.

This brief review has merely touched on the range and diversity of health beliefs and practices.

Dispositions to Help Seeking

Experience with prevailing health care systems, coupled with ethnic dispositions generate a number of characteristic approaches to the use of health and welfar services.

As many as 35 percent of Puerto Rican and Mexican Americans are said to use both folk healers and western health systems simultaneously or at varying points in their lives. Use of the former tends to be associated with problems involving or triggered by emotional trauma and family problems (Garrison, 1977; Martinez, 1978). Folk healers usually do not deal with those somatic complaints which they know to be beyond their purview. Members of many groups, including Asians, seek psychiatric care reluctantly (President's Commission on Mental Health, 1978). Asians were found to be the last to hospitalize their seriously psychiatrically impaired family members when compared to the patterns of other groups (Lin and Lin, 1978). Admission of difficulty may mean that one has shamed the family and the community.

Many American Indians consider the kind of dialogue in which social workers and their clients engage as signs of "interference." Such interference is viewed most negatively. For these reasons, many prevailing social work modalities are not in accord with the perspective of many American Indians (Goodtracks, 1973).

There are many groups for whom there is less demarcation between patient and healer than immersion in the rational, western health care delivery system would suggest. Some (Giordano, 1977; Fandetti and Gelfand, 1977; Krause, 1978) point out that "extended family is seen as the front-line resource for intensive advice on emotional problems" (Fandetti and Gelfand, 1977). This assertion is based largely on review of the feelings and dispositions of several white ethnic groups, including Slovaks, Italians, Poles and Jews.

The reluctance of many groups to institutionalize their elderly, retarded or mentally disturbed members has been observed. This is true for many Blacks, Puerto Ricans and some segments of the working class (Mercer, 1965; Lowy, 1979; Ghali, 1977).

The Effect of Variations in Health Beliefs and Practices

It is clear that many traditional and ethnically based beliefs and practices can and do contribute to the comfort and well being of those who adhere to them. Herbal teas can serve to reduce agitation (Delgado, 1979); the espiritista is usually a trusted member of the community who is skillful in drawing on the potential supports of family and important others when emotional and familial crises generate ataques, bouts of depression or other emotional difficulties. The intensive focus on health as a mechanism of coping with the fact of an oppressive past and as a means of assuring future survival is associated with protective infant care practices and long standing low rates of infant mortality among Jews (Anderson, 1958).

For many groups, the shame associated with exposure of emotional difficulties reduces the likelihood that competent psychiatric care will be sought. Truly delusional ideation can be mistaken for a culturally based belief in spirit possession (Podell and Campos, 1979). The folk belief system described by Snow contains such misinformation; if followed faulty beliefs about menstruation and proper diet following pregnancy can interfere with use of contraception and adequate post partum diets (Snow, 1974; Snow and Johnson, 1977).

Further, many of the people who adhere to these beliefs and practices confront a variety of difficulties in their encounters with the mainstream health care system. These include ignorance of their existence, taunting and authoritarian demands that they be abandoned, inadequate funding to allow those who seek community care to plan for such care and failure to utilize knowledge concerning these dispositions in a manner which enhances health care delivery. Language frequently poses inordinate barriers.

Many others whose health beliefs correspond more closely with those of western health professionals still behave in ways which are not consonant with the views of caretakers. The volatile, emotive patient is often viewed as a nuisance who makes excessive demands and is perceived as a hypochondriac. Stoic patients, though admired for their capacity to endure suffering may pose problems for those trying

to make a diagnosis or arrange proper convalescent care following an illness. The stoic may not evince the proper cry of pain associated with making a differential diagnosis and is a nuisance to the dentist who prefers that patients sit quietly anesthetized. The volatile patient may be viewed as too dependent and ready to assume the sick role; the stoic may well be characterized as resistive or as inappropriately denying his or her illness.

Surely, social workers who want to be responsive and sensitive to this diversity have a great deal to learn and do.

Proposed Adaptations in Social Work Interventions

Attention to (1) the ethnic and class roots of illness behavior, (2) the disporportionate prevalence and incidence of health problems found among many minority groups and (3) to the real and perceived barriers in health care delivery experienced by many of these groups highlights the need for simultaneous attention to micro and macro tasks as they are identified by individuals or members of various groups, by the "ethnic reality" of the group served and by professional assessment.

No single paper can encompass the range of issues--whether at a micro or macro level--which must be addressed if sensitivity to ethnic based health behaviors and health needs is to be enhanced.

We therefore limit our discussion to our perspective on (1) the importance of knowledge of the organizational and community context in which service is rendered; (2) adaptations in a number of those interventive procedures which are commonly used as health care social workers encounter individuals and groups for the prime purpose of rendering direct services and (3) selective interventive actions at the community and organizational level. Some case vignettes are presented in order to highlight the dispositions reviewed above, the type of client response these evoke and the proposed adaptations in practitioner activity.

The Organizational and Community Context

Health care social workers are variously located in general or psychiatric hospitals, outpatient clinics, mental health services, senior citizens' outreach centers, American Indian reservations and specialized settings such as those serving the developmentally disabled, departments of health, and health planning agencies. Each of these types of organizations is extremely complex and frequently characterized by a high degree of formalization and bureaucratization. For the most part these services are located in communities which have a distinct character--often containing population groups with particular needs for services.

It is an essential component of ethnic sensitive practice that social workers familiarize themselves with the ethnic distribution of the populations served, those residing in the communities in which they are located, and the particular needs of

various groups. The possible lack of fit between the mode in which service delivery in the health sector is organized and the dispositions of the groups using those services is crucial.

Our review has pointed to the fact that many people are wary of the rational, technologically oriented system of care. Many are particularly loathe to couch emotional problems in psychiatric terms and view mental health facilities as stigmatizing. The fact that so many groups make extensive use of traditional and community based healers makes it essential that workers be alert to this possibility. Analogously, workers must make it their business to know whether other members of the health team are aware of these needs and to play an educational role where there are gaps in sensitivity or knowledge.

In dealing with this kind of material in the classroom it has come to our attention that many health care facilities, including their social work components, have limited knowledge of these issues. We consider knowledge of and working with the larger organizational and community context an essential first step in ethnic sensitive health care practice.*

The Physical Setting, Privacy and Body Language

Health care settings are usually hectic, confusing and fast paced. For the most part those using the services are experiencing pain, discomfort and fear of loss. Many are perhaps experiencing the major crisis with which they have ever been confronted. They usually come seeking relief from pain or severe emotional upset. Few define their problems in terms which call for a social worker.

Social workers have a particular obligation to reach out quickly with awareness of the fear, confusion and pain which is involved. Those who tend to perceive most crises in physical terms may be wary of the social worker who suggests that they may have "emotional" difficulties. Others, whose very being is threatened by the fact that circumstances have brought them to the point where illness must be acknowledged, may find their dignity further eroded by the implication that social services are needed.

For these and other reasons health care social workers must pay particular attention to how they initiate encounters and to setting the stage for the encounter.

Determining when not to wear the white coat, when it is particularly important to draw the curtain at the bedside, how to phrase the basis for social work intervention, and when it is important or not to include members of the family in major deliberations are all issues which are in large measure related to the ethnic dispositions of those being served.

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* Not too long ago we assigned health students the task of developing a "profile" of the communities where their facilities were located. They were to use diverse data sources including interviews with hospital personnel. One student was advised by a hospital administrator that the instructors were outdated in their thinking, by still focusing on issues relevant in the sixties.

Considerable attention has been paid to the skills and techniques involved in "launching the interaction process" (Middleman and Goldberg, 1974). The importance of setting a comfortable "stage" is stressed, as is the need for privacy. It is assumed that a comfortable, open, relaxed posture and appropriate eye contact will put people at ease (Egan, 1975). Part of the initial encounter involves "tuning in" defined as "development of the workers' preparatory empathy" (Shulman, 1979). These are basic considerations. Yet there are situations where the generic approaches may be counterproductive unless the particular orientations of any group are taken into account. Important is the fact that so many health settings make it extremely difficult to assure the kind of privacy which is viewed as important. The following vignettes are illustrative.

Mary Kato

Mary Kato, a 15 year old American-born Japanese girl, daughter of immigrants, is referred to the local mental health center. She has been withdrawn, has begun to truant and her school work, formerly excellent, is deteriorating. She has on occasion run away from home.

In planning the intake interview, Ms. Jones, the social worker decides to see the youngster and her parents separately, believing that adolescents are more comfortable in communicating their problems when not in the presence of their parents.

Ms. Jones' efforts to learn what is troubling the youngster are unproductive. Mary sits quietly, her head averted, and answers questions with a simple yes or no. The parents appear similarly reluctant to engage in discussion. They say that they have come because they have been told they should. However, they can manage Mary now. In response to questions about the nature of their marriage and their relationship with their children they say that everything is all right.

When the worker shifts attention to the school difficulty and asks whether some tutoring to help her "catch up" with school work might be helpful, Mr. and Mrs. K. agree and begin to ask very specific questions about how this might be arranged.

Mrs. Slavolta

Mrs. Slavolta, a 35 year old American-Polish mother of two children under 10 is admitted to the hospital with severe gastrointestinal distress. Following diagnosis of a duodenal ulcer the doctors recommend that she spend two weeks at home at rest, essentially relieved of her child care responsibilities. Her husband works long hours. She lives near relatives.

> Upon visiting Mrs. S. at her bedside in the hospital room which she shares with another patient it is the social worker's impression that Mrs. S. is in pain as evidenced by periodic grimacing as she places her hands on her abdomen. When the social worker introduces herself within earshot of the other patient, Mrs. S. barely acknowledges her until she draws the curtain.
>
> Sitting at as much distance from the bed as the setting allows the worker indicates why she is there. Mrs. S. denies she is in pain, says "I'll manage, though not everybody could. Besides honey, I don't need help from them welfare agencies."

As our review has indicated, the Kato family and Mrs. Slavolta are both members of ethnic groups which place great value on "doing for themselves" and "caring for their own." For many Asians, the suggestion that matters of emotional turmoil be considered outside the immediate family is most difficult for the very fact of such difficulty shames the family (Toupin, 1980). The family group is often viewed to be more important than any individual within it. Eye contact, especially with someone in authority, is considered disrespectful. Mary Kato's problem is the family's problem and initial separation may have been most painful and alien. On the other hand there is more comfort in dealing with concrete problems, and the authority of the clinic is likely to be respected. The shift--from early focus on the presumed emotional problems to the suggestion for tutoring--helps all involved to begin to deal with one of the issues--the decline in school work. While the information presented does not permit the inference that there is no major pathology present, neither does the girl's and family's reluctance to face the worker squarely or openly. The behavior can well be tentatively viewed as a culturally syntonic response to the situation. For many Asians, the pain of self disclosure involved in the therapeutic encounter may be more stressful than the difficulties which triggered the encounter.

Slovaks pride themselves in being strong, not running to doctors and not giving in to illness. Help is grudgingly accepted and work the essence of life. The hospital is anathema to many (Stein, 1976).

To the extent that Mrs. S. shares these feelings the social worker's effort to initiate conversation in earshot of the neighbor may be particularly distressing. With people who have these kinds of perceptions, adherence to tenets of privacy and non verbal clues which indicate understanding of their suffering without forcing verbal acknowledgment of dependence is particularly important. Where there are alternatives to help from formally organized agencies--such as those potentially available from relatives or neighbors--these should be suggested. A stranger in the home to care for the children may strike a particularly discordant note.

The Staging and Phasing of Various Facets of the Interventive Process

Increasing attention has been paid to assuring that work with people proceeds on the basis of problems in the terms they define them. Important in this connection is the view that worker and client develop a contract about why they are meeting, how they will proceed and what can hopefully be gained (Devore and Schlesinger, 1981). And yet many people, particularly those seen by health care social workers are captive clients who have limited choice about being involved or the nature of the involvement. Consider the following examples.

The Browns

The Browns are an American Indian family living in an urban center. They are patients of a neighborhood health center in which the social worker routinely sees all new families.

There are multiple problems. Mr. Brown has a persistent cough which is being investigated. He is unemployed, smokes heavily and is suspected of being an alcoholic. Mrs. Brown, pregnant with their sixth child, looks haggard. The school age children come to school tired and seemingly hungry. The school has reason to think that the children are neglected. It is believed they are frequently left unattended.

Mr. Green, the social worker, tries to elicit a history of family relationships, to find out whether there is a drinking problem and to get a picture of how they handle their children. Neither parents nor children look directly at the worker as he is talking to them. When the worker asks about leaving the children alone they are impassive though seemingly fearful.

When the worker shifts his focus and asks whether they know about the food stamp program they readily enter into discussion and ask a number of questions designed to find out how they could obtain them.

Mrs. Bernstein

Mrs. Bernstein, a 70 year old Jewish widow, is hospitalized because of a heart attack. She lives alone. She will need to spend two to three weeks in the hospital. Following this she will need some help in caring for her daily needs. Two grown sons live in a nearby city with their families. They visit occasionally.

Mrs. Bernstein is voluble, friendly, but worried. She readily discusses her symptoms, her family and her past life with the social worker, the doctors, the nurses and her roommate. She would like to go back to her own home or live with one of her sons. "They're good boys. They'll take care of me."

But it turns out that neither of her sons can take her in, nor do they have the funds to pay for care in a home for the aged. Now, Mrs. B. becomes despondent and speaks to the worker in whispered tones, checking to see that the curtain is drawn when the worker visits.

The life situation in which the Browns and Mrs. Bernstein find themselves gives them little room to maneuver or to set the terms of the contract. The Browns are likely fearful that their children will be removed. They know that this is a fate that befalls many American Indian families (Dial, 1978). The idea of talking to the worker about their family problems is alien to them. The clan or the tribe is the place for that. But they live in the city now and it is difficult to go back and to find the kind of support they once enjoyed. However, help which will allow them to get more food makes sense. They will contract for that. To engage them around their other problems will take time. Perhaps, if the worker continued to demonstrate an interest and is able to provide much needed concrete help they will come to trust him. Their basic stance now is that advice or questions about the children is frightening, disrespectful and constitutes interference which is anathema to them.

Mrs. Bernstein, once friendly and voluble, has begun to withdraw. Doing the "right thing"--caring for her children, going to the right doctors--has yielded minimal rewards. She is old and sick. Her ability to contract with the worker is constrained. For the hospital will not allow her to occupy a bed until she is well enough to take care of herself. She complains more and more as she struggles with her reality. Cherished values are no longer serving her. But Mrs. Bernstein has talked a lot about how she used to cook and go to meetings of the Jewish women's organization and to the temple. Can the worker draw on these aspects of her proud heritage to regain self respect and as a way of helping her to make some difficult decisions? Can she go to a Jewish home for the aged? Is there a Jewish organization which can be helped to make plans for people like Mrs. Bernstein? Her sons must have some guilt. Perhaps they can become involved in some community enterprise or counseling processes which addresses the needs of the younger generation caught between the demands of two worlds.

These few case examples clearly do not exhaust the range of adaptations required. They were presented in order to highlight some of the specific issues which surfaces as well as to suggest some general principles which should be followed in our encounters with clients.

These include: (1) an intellectual stance which recognizes the importance of ethnic related health behaviors and an emotional stance which permits workers to adapt to these in accord with clients' major ethnic dispositions; (2) recognition of the reluctance of members of many ethnic groups to rapidly engage in consideration of emotionally laden matters; (3) respect for the healing power of strong beliefs and the potential for help which inher in the family, community networks, the churches, and other groups such as benevolent associations. Perhaps most importantly

behavior which derives from major belief systems must not be erroneously stigmatized or labeled, for much of that behavior reflects coping responses which have withstood the test of time.

Macro-Interventions

The social worker who is sensitive to these issues has an additional and ongoing obligation. That involves efforts to adapt and modify the context in which health care is rendered, as well as those elements of the community and social policy which impact on health. Such efforts can be grouped into a number of areas including: (1) efforts to effect health legislation; (2) development of mechanisms designed to legitimate those traditional healing practices which serve a health maintaining and caring function; (3) development of and cooperation with indigenous family and community networks; and (4) efforts to change the administrative practices of health care institutions in order to generate more comfortable, ethnic sensitive environments.

We touch briefly on the last three points. The inclusion of traditional healers as part of the health care team has been proposed by many members of the groups to which reference has been made. This theme is evident in the task panel reports of various ethnic groups submitted to the President's Commission on Mental Health (1978). Others have suggested that "culture specialists," people able to interpret the cultural meanings of behaviors manifest in "crisis" settings be employed as an integral part of such service systems (Podell and Campos, 1979). It is our contention that if social work does not play such a role it will essentially fault on its commitment to the populations it serves.

Attention to administrative practices can have a major impact. These include efforts to adapt service time schedules to those who do not adhere to western time tenets, inclusion of personnel who are members of and speak the language of the groups served, and participation of consumers in decision making.

Conclusion

Our review has suggested that ethnic sensitive health care practice involves knowledge of and sensitivity to health beliefs and practices of various groups. Prevailing practice modalities can and must be modified to take account of these differences.

Attention to diverse health beliefs and practices highlights the need for simultaneous attention to service delivery and system change.

We close this discussion by review of a case situation which suggests how practice can be enhanced when micro and level tasks coupled with sensitivity to the ethnic reality are brought to bear.

A Mexican American woman accustomed to delivering her babies at home, surrounded by family and friends, suffers greatly when placed in the Anglo maternity ward. The sounds are unfamiliar to her and the strangers do not speak her language. She is denied privacy when she is placed in the labor room with other women. Wrapped in a towel she gets up searching for familiar faces and more familiar sounds. Physical force may be used to return her to bed. She may be termed an uncooperative, unappreciative patient. (Cited from Devore and Schlesinger, 1981).

To date, insufficient attention has been paid to the possibility of adapting hospital procedures to meet the health care dispositions of a Mexican-American community. A variety of actions are called for in this situation: (1) understandin of ethnic related health behaviors call attention to the ethnic reality and suggests the possibility that this woman's attempt to flee from the delivery room is likely not pathological; (2) the woman needs immediate attention to evert further crisis; (3) consideration of alternatives to the delivery room procedures, so alien to many women like her, need to be explored. "Birthing centers" where family members can be involved in the delivery could represent an accommodation between traditional and western delivery practices.

All of these considerations focus on the need to develop strategies which generate a partnership between social work, other health care professionals, those healers respected and recognized by their communities and the consumers of services. Such a partnership, if entered with knowledge and respect for the ethnic reality can minimize the sense of alienation which so often serves as a barrier to service utilization.

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