Challenges and Pitfalls in the Evaluation and Treatment of Haitian Immigrants and Descendants in the United States

Jean-Claude Dutès[1]

Abstract: *This article addresses some of the challenges confronting mental health professionals working with Haitians and persons of Haitian descents in the United States of America. The different of barriers to treatment, as well suggestions to address them, are discussed.*

Key words: *barriers, bias, challenges, culture, language.*

Résumé (Défis et embûches dans l'évaluation et le traitement des immigrants et descendants haïtiens aux États-Unis): *Cet article aborde certains défis auxquels les professionnels en santé mentale sont confrontés à l'égard des Haïtiens et des personnes de descendance haïtienne aux États-Unis. Les auteurs discutent des obstacles au traitement et présentent certaines suggestions pour y remédier.*

Mots clés: *obstacles, préjugés, défis, culture, langue*

Introduction

Immigration disrupts everything in a person's life. For adults, it requires a reconceptualization of the self, and a willingness to adopt new ways of thinking and acting that create new sets of feelings and engender a new and different psychological being. It is a dynamic process that leads to a new personal and collective culture for which nothing can be

1. Ph. D., Licensed Psychologist/Clinical Neuropsychologist.

taken for granted. Thus, the task of working with a population in cultural flux like any immigrant group is analogous to walking on quicksand, with very little solid footing. That is what we have been doing in a mental health center working with immigrant children and their families in a community in South Central Florida. We are not presenting empirical research but our observations and thoughts about the challenges we have experienced and some of the concerns that we have.

Social and economic context

The foreign-born immigrant population in America has been growing steadily and quickly since 1990, with one million immigrants per year bringing the percentage of immigrants to 13% (APA, 2012). While early immigrants from early 1900's tended to be of European origins, the new wave starting in the 1960's contributed to a greater racial and cultural diversification of American society, with most of the immigrants from the last third of the 20th century, coming from Asia, Latin America and Africa (APA, 2012). Of that group, over one million are from Haiti, or children of Haitian immigrants, who migrated due to economic hardships and/or political turmoil and violence (Hawkins, 2016; Pierre et al., 2010). While most of the Haitian immigrants came from Haiti, many come from other countries in the regions such as the Dominican Republic, Bahamas, the French Islands, France, countries in Africa and Canada. Forming a diversified group, they range from highly educated persons with advanced degrees to those with little or no formal education. Based on US census data, 78% of persons of Haitian ancestry who were 25 years old or older reported having a high school diploma or a higher degree (Schultz and Batalova, 2017). As a group, they work more than other immigrants, with 71% of those age 16 and older working compared to 66% of foreign born and 62% of US born individuals (Schultz and Batalova, 2017). Earning more than other immigrants from the Caribbean, with a median income at $47,200 a year, they earn less than native born Americans who have a median income of $51,500 (Schultz and Batalova, 2017). Represented in various occupations, Shultz and Batolova (2017) report that 38% of Haitian immigrants are in service occupations, 23% in management, 17% in sales and 17% in production, transportation and material moving occupations, with a poverty rate of 18%. While 49% and 30% have health insurance from private and public sources, respectively, 21 % have no coverage at all. Strongly connected to family members and relatives still in Haiti, Haitian immigrants in the US sent $1.3 billion through formal channels to Haiti in 2015, more than the total

remittances from Haitian immigrants in other countries (Shultz and Batalova, 2017).

Haitian immigrants and mental health risk factors

Haitian immigrants in the United States and their descendants have difficulties meeting mental health needs, despite being at risk for psychosocial adjustment difficulties. Family separation, intergenerational conflicts, employment instability and racism (APA, 2012) are among the factors affecting all immigrant groups. In addition, our clients have reported histories of domestic violence and sexual abuse, harsh disciplinary procedures, overcrowded homes and multiple jobs, as well as the burden of supporting two set of families, one in the US and one in Haiti, with frequent stress causing phone calls from relatives in Haiti asking for assistance. With parents working many hours, often holding more than one job, children are often left unsupervised or are required to oversee younger ones, contributing to delinquency, behavior problems at school and academic underachievement. Various researchers have reported findings indicating that Haitian immigrants suffer with or at risk for a number of mental health conditions such as depression (Fawsi et al, 2009); Nicolas et al. 2007), post-traumatic stress disorder (Belizaire and Fuentes, 2011), academic underperformance (Howard, 2016), and many Haitian immigrant communities have noted an increase in suicides.

To meet mental health needs, access to treatment services and being able to continue in treatment until the initial problem is resolved, or significantly ameliorated, is required. However, access to mental health services and retention are undermined by many factors that limit access to services and prevent many clients from staying in treatment until the issues that precipitated their seeking services are resolved. These barriers tend to be diverse and varied and to affect all immigrant populations to varying degrees. The APA presidential task force on immigration (2012) grouped them into the following: Social-Cultural, Contextual-Structural and Clinical Procedural barriers. Below the author reports on his experience as the director and psychologist providing services both for pay and mostly free of charge to Haitian immigrants and their descendants.

Contextual structural barriers

Contextual-Structural barriers refer to the unavailability of, or lack of access to, appropriate and culturally sensitive mental health services in immigrant languages, a shortage of qualified mental health workers

for an ethnic group and lack of knowledge of existing mental health services and resources (APA, 2012). As these obstacles are removed, however, as in our case, providing culturally sensitive mental health services in the language of the clients by service providers knowledgeable of the immigrant and host culture, others become more prominent. Many potential clients decry the cost of mental health services. Those without insurance coverage usually indicate that they cannot afford the service, even when the fee is significantly discounted.

For those with insurance, some have difficulties paying the co-pays, the portion of the cost of service that is not covered by their insurance. The problem here pertains mostly to being able to sustain the payment over time, causing many to discontinue treatment prematurely. Many service seekers, and not just Haitians, do not have an adequate understanding of what their insurance covers, usually thinking that it covers more of the cost of services than it does in reality. In the United States, private companies and all public agencies cover the majority of payment for health services.

With a greater appreciation of the potential barriers to services, some public agencies offer free mental health services. In these cases, the challenges often pertain to problems with transportation to and from the service site. Clients often report transportation difficulties due to problems with their automobile. While public transportation is available, it is usually impractical due to time constraints for persons who are trying to squeeze in a session between jobs. In our area, a short distance of a few miles that could be covered in 10 to 15 minutes by private transportation can take up to an hour when using public transportation. In response to that problem, services are provided in schools, at homes or at a mutually convenient place with adequate consideration for confidentiality needs. Providing services in the home and at a mutually convenient place, however, has been difficult at times, putting confidentiality at risk and placing a burden on practitioners to locate a suitable and mutually convenient place to hold sessions. Therapists have held sessions on front porches of homes, in parks and sometimes in fast food restaurants.

Work schedules further restrict potential service seekers from accessing services. To meet basic needs and financial obligations many potential clients work on a full-time basis, at least 40 hours a week, with many working overtime or holding a second job, in positions that provide little or no scheduling flexibilities. In addition, for many parents, lack of childcare is a major problem as they cannot afford to pay for it while they travel to and from treatment.

Social cultural barriers

These barriers pertain to the difference in the manner that symptoms are viewed, expressed and explained between mental health providers and clients. It has been observed that Haitians tend to view mental health problems from a religious-magical perspective (Jean-Jacques, 2018; Pierre et al. 2010), with recourse to mental health professionals, when it occurs, as a last resort. Our experiences are consistent with those observations.

Our center has worked with children whose parents believe they are under magic spells that is preventing them from learning in school but were persuaded to bring them to treatment, although this did not dissuade them from continuing to seek the reversal of the spells from traditional means. We have provided services to children whose parents disagree about psychological treatment, with one parent wanting it and the other resisting it because he/she does not believe in it. In some of these cases, we have learned through treatment that what was presented as a culturally acceptable explanation was a cover for desires for control associated with that parent own psychological issues. We have also worked with a case where the client was fully engaged in therapy learning to manage the stress associated with a severe neurological condition that was being exacerbated by empathic family stress (Nicolas et al., 2011), while his family insisted that he pursues traditional magical and herbal treatment. We learned about another case where the parents refused to allow an adult child to take psychiatric medication insisting that they take the client to Haiti for treatment. The treating clinic and the family reached a compromise whereby they agree to bring the family's "Ougan," or Vodou priest to the states to treat the client in return for their agreement to allow the client to take the medicine if the treatment did not work. The traditional treatment was ineffective, and the parent allowed the person to take the medication, which worked.

Of significant importance is the fear that psychologists could read minds and would engage in mind control. For some others, the counseling and psychotherapy process seems too simple: they do not believe that words, conversations can be curative. In cases when referrals were the results of an investigation into accusations of child abuse of any kind, there is usually strong mistrust of mental health professionals. Their conception of parental authority and responsibility for raising children tends to clash with the prevalent societal views in the US that interventions should be in what is in the best interest of the children. In those cases, mental professionals are perceived as the "enemy" and part

of a system that is diluting parental authority and intent on breaking up their families. We have also met with clients who declined to continue in treatment because it threatens their self-image and out of concerns as to how they would be perceived by their community.

Except for a few cases involving parents who sought services for their children after hearing a radio program on mental health, most of our clients, more than one hundred and fifty over a three-year period, were children referred for services due to behavior problems by their schools or the juvenile judicial system. Of note, very few were referred by their priests or pastors, or those they refer did not follow through. This was notable as we work very closely with some of the churches in the community, doing presentations on mental health and conducting parenting classes, and both priests and ministers have been very receptive to our reaching out effort.

With many clients now able to access free services and to engage in mental health treatment, the lack of knowledge about available services and the need for education about psychological treatment to eliminate distortions are becoming more of an issue than absence of services.

Clinical cultural barriers

According to the APA (2012), these barriers pertain to lack of culturally sensitive and relevant services, clinicians' bias, and communication bias related to language differences and cultural nuances. With increasing availability of mental health services, clinical cultural barriers are becoming more prevalent. As Jean-Jacques (2018) have indicated the training of mental health professionals do not prepare them to work within the cultural world view of most Haitians in Haiti. This is the same in the United States, although over the last thirty years, great effort has been, and continues to be made, to sensitize and train students to provide services in the diverse environment that American society has become. However, to have grown up in a Haitian home and to be able to speak Kreyol and/or French is not a guarantee that you understand the world view of most Haitians due to family bias inherent in the socialization process. On many occasions, listening to mental health professionals in US attributing certain behaviors or tendencies to Haitian culture, I often wonder whether they are referring to family instead of Haitian culture, given the variations related to regions in Haiti and nuances of culture related to language and education level. Underscoring this point, Menos (2005) argues that "therapists working with Haitians should avoid making assumptions. Because of the many classes, religious, and other subcultures in Haitian society, therapists should be open to asking

many questions about emotional dynamics, religious beliefs and other aspects of family life (p. 136).

While most Haitian immigrants and their descendants have at least some degree of fluency in Haitian Kreyol, their fluency and depth of mastery, however, is variable. Because of the different countries of origin prior to entering the US, the Haitian Kreyol spoken by most Haitian immigrants reflect the influence of the language spoken in the countries where they came from. Even among Haitians who come from Haiti, their spoken language reflects the effects of formal education and that illiteracy. In our area, where most of the Haitian immigrants are from the Artibonite and Northern part of Haiti, their Kreyol is different from that of Haitians who grew up in New York, or in Canada. Being able to engage in everyday interactions in Kreyol does not means that one has mastery of the emotional vocabulary of that language and is able to wield it as expertly as needed to facilitate understanding and communicate the empathy that is essential for trust building and effective interventions.

The old Haitian adage "Kreyol pale, Kreyol Konprann" is not tenable. In this area, I think that more work is needed in that therapist need to deepen their knowledge and understanding of the language spoken by their clients, so they can adapt and switch to the language register that is appropriate for each client. One of the reasons that some Haitian clients have given for dropping out of therapy with a Kreyol speaking Haitian therapist is that they did not understand what the therapist was saying.

Another area where growth is needed is the willingness to explore spiritual issues and the accuracy of a client's age, especially when conducting evaluations. While many therapists are aware of the influence of Vodou in Haitian thinking, very few know how to address it sensitively and appropriately in therapy. For many, it is a distasteful topic that makes them uncomfortable. After discussing this topic with many mental health professionals, I came away thinking that for them, to inquire about it and/or explore it in therapy is akin to condoning it. Interestingly, the culturally competent American therapist approach is to inquire and probe into life experiences and to find ways to be effective with each client, one at a time, as was reflected in the anecdote we shared earlier. In our experience, we have found that when we have addressed the issue in a non-judgmental manner as part of an exploration of stress, that includes spiritual stress, it had a liberating effect on the client and deepened the therapeutic relationship.

When doing assessments, especially psychological evaluations and assessment for psychotropic medications, whether the client's age has

ever been adjusted, may provide valuable information likely to produce valid results and more effective pharmacological psychiatric interventions. We have learned from our practice that some immigrants, not just Haitians, have had their age adjusted in their home country or lowered that of their children for various reasons.

With respect to psychological evaluations, great caution is required in the interpretation of test results when the normative sample is culturally dissimilar from the examinee. Performance in general, especially first time results suggestive of impaired ability, should not be a basis for making a diagnosis, but serve as a baseline for future assessments where learning and development may be inferred. In assessing clients, an ecological approach (APA, 2012), with information coming from various sources about the functional ability of the client, is more likely to provide a valid picture of that person's functioning than test findings.

Pitfalls

In response to the need for mental health services, many agencies in the US are providing such services free of charge, with ethnic and language matching becoming more common. Availability is less of a barrier. Lack of awareness of such services, misconceptions about mental health, language inadequacy and mental health professionals' bias have moved to the forefront. To avoid the pitfall inherent in ethnic and language matching is the recognition that being Haitian and speaking Kreyol are not good substitute for the sensitivity, tact, open mindedness and empathy that underlie effective clinical interventions (Corey, 2013; Menos, 2005). Knowledge about Haitian emotional language, their terms for expressing distress and happiness within and across subcultures, is necessary for effective clinical interventions and adequate retention of clients. Of importance here is the recognition that being of the Haitian culture and speaking Kreyol are insufficient for making a therapist an effective practitioner when working with Haitian clients. The challenge resides in mental health practitioners' willingness to keep an open mind (Menos, 2005), familiarize themselves with the manner in which Haitians communicate their emotional distress, their idioms of distress, (Hunter et al., 2012; Kaiser et al., 2014), and the approach (Schwartz et al, 2014; Nicolas et al, 2006) they use in seeking assistance for personal adjustment difficulties confronting them or their children. Having such knowledge increases the potential for more effective clinical interventions, as these would take into consideration relevant contextual elements and associated underlying issues motivating the desire for mental health services.

Another pitfall pertains to therapists being overconfident that their training has rendered them culturally competent to work with Haitians and their descendants without extending themselves to broaden their knowledge base and question their attitudes. The challenge in this case is being open to looking within themselves toward identifying possible personal bias, questioning the limitations of their training and examining how these may be affecting their work (Corey, 2013). This means that to increase their effectiveness, they must be willing to extend their education, broaden their knowledge base and deepen their understanding of the cultural nuances they are apt to encounter in their work with Haitians and persons of Haitian descents (Schwartz et al, 2014; Nicolas et al, 2006).

Therapists' creative response to structural and contextual barriers has the potential for being problematic. While flexibility is part of the solution, too much of it may put fundamental principles of mental health services in jeopardy. Of these two come to mind: confidentiality and professional boundaries (APA Code of Ethics, 2017). While being flexible, therapists cannot abdicate their responsibility for maintaining confidentiality regardless of locations nor allow the familiarity that can come from meeting in places other than the office to blur professional boundaries.

In psychological assessments, the pitfall lies in the complacent acceptance of test findings without regards to their limitations for the client in question. To minimize such misuse, an ecological approach is suggested in evaluating test findings, and we recommend using first test results as a baseline for evaluating future assessment findings.

Concluding comments

American society, where many Haitian immigrants and their descendants live, is becoming more culturally diversified. With this has come increased awareness of the mental health needs and barriers that prevented or limited access of the more recent ethnic groups in America from getting needed mental health services. There are 1,1 million Haitians and their descendants living in America. Over the last ten years, mental health services targeting Haitians have increased as have the pool of Haitian mental health professionals. While availability is less of a problem, lack of awareness of available services and misperceptions as what mental health professionals do continue to be serious issues, pointing to the need for more education. But more important now is the need for Haitian mental health professionals to focus on themselves in an examination for potential bias inherent in their social conditioning and professional training in

order to adapt their professional expertise to the mental health needs of the Haitian population. While we applaud the flexibility used in circumventing access related issues pertaining to locations, transportation and scheduling times, we are nevertheless concerned about potential erosion of confidentiality and blurring of professional boundaries. With respect to psychological assessment, we argue for an ecological approach as the best way to minimize diagnostic errors.

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