

INFORMATION TO USERS

This manuscript has been reproduced from the microfilm master. UMI films the text directly from the original or copy submitted. Thus, some thesis and dissertation copies are in typewriter face, while others may be from any type of computer printer.

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleedthrough, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps.

Photographs included in the original manuscript have been reproduced xerographically in this copy. Higher quality 6" x 9" black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.

ProQuest Information and Learning
300 North Zeeb Road, Ann Arbor, MI 48106-1346 USA
800-521-0600

UMI[®]



A

**CULTURAL DIVERSITY IN HEALTH AND MENTAL HEALTH:
THE CASE OF HAITIANS LIVING IN NEW YORK CITY**

by

MARIE J. MITH-JOSEPH

A dissertation submitted to the Graduate Faculty in Sociology
in partial fulfillment of the requirements for the degree
of Doctor of Philosophy, The City University of
New York

2001

UMI Number: 3008852

Copyright 2001 by
Mith-Joseph, Marie Joelle

All rights reserved.

UMI[®]

UMI Microform 3008852

Copyright 2001 by Bell & Howell Information and Learning Company.

All rights reserved. This microform edition is protected against
unauthorized copying under Title 17, United States Code.

Bell & Howell Information and Learning Company
300 North Zeeb Road
P.O. Box 1346
Ann Arbor, MI 48106-1346

© 2001

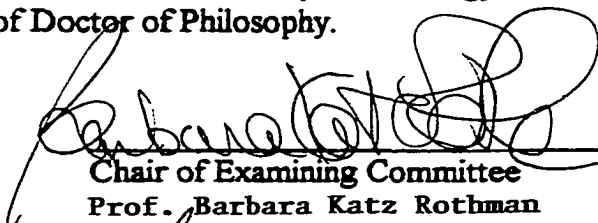
MARIE J. MITH-JOSEPH

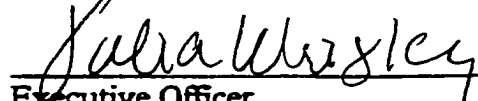
All Rights Reserved

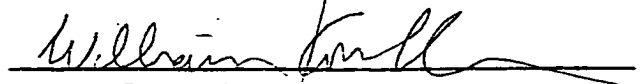
This manuscript has been read and accepted for the Graduate Faculty in Sociology in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

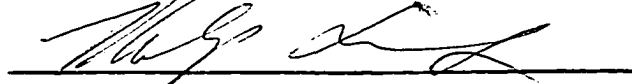
4/5/01
Date

4/5/01
Date


Chair of Examining Committee
Prof. Barbara Katz Rothman


Executive Officer
Prof. Julia Wrigley


Prof. William Kornblum


Prof. Philip Kasinitz

Supervisory Committee

THE CITY UNIVERSITY OF NEW YORK

/uw.

ABSTRACT**CULTURAL DIVERSITY IN HEALTH AND MENTAL HEALTH:
THE CASE OF HAITIANS LIVING IN NEW YORK CITY**

by

Marie J. Mith-Joseph

Advisor: Professor Barbara Katz Rothman

This study was focused towards uncovering possible explanations for differences noted in the doctor-patient relationship involving Haitian patients and white American medical and mental health care providers in New York City. Some Haitians have reported their interactions with white providers were at times degrading. The roots of this negativism was explored. Another component of this study was to use the case of Haitians to further support the inclusion of cultural sensitivity in health care.

Qualitative methodologies were utilized: interviews and participant observation. Three small samples were interviewed about their experiences in this interaction: white American providers, Haitian patients, and Haitian providers. Data gathered were supplemented with literature information.

Some of the white providers interviewed acknowledged the possible existence of biases among their colleagues, and advocated sensitivity training in their education. They also reported difficulties providing health care while responding to stresses imposed by the health care system.

The Haitian patients reported observing other groups treated more positively and felt Haitians were looked upon with disdain and perceived as Black, poor and ignorant.

Haitian providers recognized difficulties white providers may experience providing care to Haitians who are very attached to their culture. However, they also seemed to believe there is a lack of respect for Haitians due to the historically poor image of Haitians in our society and this is displayed in some of the interactions between white providers and Haitian patients.

The results of this study suggest the negative experiences some Haitians have had when interacting with white providers is likely related to the providers' own biases about Haitians, which also appear to interfere in how providers perceive and treat Haitian patients.

The study's results have ramifications for other groups as well. What appears to be implied in this study is an increase likelihood that the image society has of a group can permeate to different institutions in that society, e.g., health care, and have adverse effects on that group. Cultural sensitivity training for providers is also indicated.

ACKNOWLEDGEMENTS

This venture is dedicated to my native country, Haiti, and to my many Haitian compatriots for whom I have developed a deeper understanding during the course of this study.

I am indebted to my beloved parents, my mother Marie Therese and my deceased father Beliard, who instilled in me the thirst for knowledge and educational growth. I thank my mother for her endless support and for believing in me.

I am also grateful to my husband Stan for his words of encouragement and for his assistance. Special thanks go to my beloved grandmother Mammie Rose for her love, her prayers, and her words of wisdom. Thanks to my brothers, Ronald and Richard, my sister Marline, Uncle Eric, family and friends for their support.

Much thanks and appreciation to my dissertation committee members: Barbara Katz Rothman, William Kornblum, and Philip Kasinitz for their graciously shared expertise and guidance. I am particularly grateful to Barbara Katz Rothman for her dedication and for being with me from the inception of this project to the end. Special thanks to Avrama Gingold for her editing expertise and for her always welcomed sense of humor.

I thank my Haitian and American friends and colleagues for their support, for assisting me in recruiting the participants interviewed for this project, for assisting with Creole translation, and for their stimulating discussions.

I am especially thankful to the participants interviewed for this study, the American and Haitian providers as well as the Haitian patients. Their willingness to be interviewed on an issue so delicate and sensitive was greatly appreciated.

Minette and Sidney

TABLE OF CONTENTS

ABSTRACT	iv
ACKNOWLEDGEMENTS	vi
Chapter	
I. INTRODUCTION	1
II. ISSUES IN THE LITERATURE ON HEALTH AND ILLNESS BEHAVIOR	14
The Expanded Definition of Health and What is Illness Behavior	14
Parsons's "Sick Role"	17
Sociocultural Factors in Illness Behavior	21
III. OVERVIEW OF FOCUS POPULATION	26
History	26
The Island of Hispaniola and Slavery	26
The Revolution and the New Nation	28
The United States Marine Occupation	29
The Post-Occupation Era and Thereafter	33
Race, Language and Status	33
Family Life and Gender Roles	36
Religion	39
Education	41
Economy	43
Health	44
The Haitian Migration and Life in New York City	44
IV. METHODS	51
The Study	51
Qualitative Research Approach	52
The Sample	55
Haitian Patients	57
Recruitment of Haitian Patients	57
Criteria for Inclusion in the Study	59

Characteristics of the Haitian Patients	61
Occupation and Income of the Haitian Patients	61
Medical Coverage	62
Haitian Medical and Mental Health Providers	62
White American Medical and Mental Health Providers	64
Procedures and Data Collection Instruments	66
The Referral of Haitian Patients	67
The Referral of American and Haitian Providers	69
Difficulties Encountered During the Research	69
The Interviews	71
Participant Observation	75
Data Analysis	78
Data Recordings and Coding Systems	80
V. FINDINGS	82
Illness Behavior of Haitians Living in New York City	82
Intraethnic Variations	82
<i>"Deye Morne Gen Morne"</i>	
(Behind mountains are mountains)	84
Hidden Beliefs and Practices	88
The Hot, the Cold and the <i>Gaz</i>	92
Vocabularies of Distress	97
Symptoms and the Decision for Treatment	99
Haitians' Utilization of the American Medical System	102
The Socioeconomic Factor	102
Choosing a Provider	104
The Haitian Expectation	111
Provider-Patient Relationship	113
The Intrinsically Problematic Relationship	113
<i>We are Seen as Black, Poor and Ignorant:</i>	
The American Provider and the Haitian Patient	117
<i>We Are Regular People with Biases.</i>	
<i>We Were Only Trained to Practice Medicine:</i>	
The Voices of the White American Providers	126
<i>They Speak Our Tongue: The Haitian Patient</i>	
and the Haitian Provider	133
The Haitian Providers: They Come with <i>"Baggages"</i>	134
The Haitian Providers: The General Lack of Respect for Haitians	141

VI. SUMMARY AND CONCLUSIONS	146
APPENDICES	156
A. Cultural Diversity in Mental Health Workshop	157
B. Workshop: Haitians and Health/Mental Health	158
BIBLIOGRAPHY	159

Chapter I

INTRODUCTION

The notion of cultural sensitivity has received increased attention over the past few decades as the role of cultural differences in effectively communicating with the diverse populations of a multi-cultural society has become more apparent. True, many in the United States have opposed what might be termed the cultural sensitivity movement, possibly perceiving it as a threat to the status quo or recognizing it as one more indication of tolerance for those in our society who come from different ethnicities and cultures. Nonetheless, many others believe that given the current racial and ethnic composition of the United States, we cannot afford to resist the movement towards greater sensitivity to cultural differences.

The new recognition of the world as a global marketplace has also meant recognizing the challenges inherent in interacting with the many diverse societies, cultures, and groups in that marketplace. As the institution of medicine in the United States has taken on more of the coloring of a business institution, so too has concern about “reaching out” to various racial and ethnic groups as potential consumers, i.e., patients. In New York City, many medical and mental health clinics are identified on the basis of the language spoken by staff members, which in turn suggests which people are most likely to be comfortable as clients of that clinic. Awareness of cultural diversity also becomes an important component in staff training. Even some

governmental accrediting bodies responsible for monitoring medical and mental health establishments are now making such training a requirement.

At the same time as awareness of the role of cultural diversity in health and mental health has grown, this often creates discomfort among medical and mental health providers whose training has been focused on the biological aspects of illness with only minimal importance given to the sociocultural factors involved in illness and in health. This discomfort is still present, despite decades of research indicating the need to incorporate sociocultural variables into the provision of physical and mental health care (Zborowski, 1952, 1969; Tseng & McDermott, 1981; Gaw, 1982; Marsella & White, 1982; Ponterotto, Casas, Suzuki, & Alexander, 1995; Pedersen, Draguns, Lonner, & Trimble, 1996).

Ethnic groups as well as social classes differ in their perceptions of what constitutes illness and health, and what is defined as normal or abnormal. Groups also differ in their definitions of what is appropriate treatment for a given illness. The health beliefs of a group will affect not only its members' utilization of orthodox medical care, but also the criteria used to maintain and define health. For example, some ethnic groups do not acknowledge mental illness at all as an illness, or mental illness may be minimized and defined as a condition not requiring professional intervention (Gaw, 1982; Marsella & White, 1982; Pedersen et al., 1996). A mental illness such as depression assumes different meanings in different cultures. As with other psychiatric conditions, how depression is manifested is in large part a function of culture. Marsella and White (1982) have noted that the symptoms of depression (e.g., depressed mood, devaluation of self) commonly seen in western societies are often absent in non-western

societies. In Asian societies, for example, physical problems such as headaches, body aches, and dizziness are more commonly seen in the expression of depression.

Differences in symptom manifestation pose serious challenges for health and mental health providers. These challenges have been resisted for a long time, because confronting them requires self-evaluation and evaluation of biases held on the part of the practitioner, as well as changes in attitude and behavior. It also necessitates respecting others' beliefs about health and illness, beliefs which may not coincide with the provider's western trained views. *Respecting* the views of others does not mean agreeing with those views. What is important is the awareness and understanding of the interplay of sociocultural variables in health and mental health. Harwood (1981) regards ethnic differences between patients and medical providers as an important practice concern in treatment situations. He further contends that if providers are to perform in the most "effective and efficient" manner, they must be cognizant of their patients' culturally based illness beliefs and expectations.

Dialogue generated as the result of such interaction has the potential for producing positive effects in the relationship between patient and provider. It also can promote a nurturing atmosphere in which the patient can feel understood and accepted by the provider, feel safe and secure enough to share full details of symptoms and illness as perceived by the patient, and share aspects of the patient's culture with the provider. This in turn gives the provider an opportunity to understand the patient's ailment better and to know the patient at a more complete level than merely as a "presenting case." Positive overall relationships between providers and patients have

been known to improve communication between providers and patients, and increase cooperation by and treatment compliance in patients.

I have often observed such sensitive interaction between white American doctors and non-Haitian ethnic groups. If such interactions generally produce situations benefitting both provider and patient, in which the increase in patient cooperation makes the provider's work easier, why then is it not induced more in the relationship between physicians and Haitian patients. As a Haitian, I am well aware of idiosyncracies of Haitian culture that may require effort on the part of others to understand. I do not at all believe these peculiarities are in any way utterly unlike those of other cultures. Thus, I have often wondered whether there exist unknown factors operating against the production of a fertile terrain that would allow for a more positive provider-patient relationship between Haitian patients and white American providers.

As a Haitian social work supervisor and a trained psychotherapist who has been working in a New York City hospital and at a community mental health clinic for more than fifteen years, I have become progressively more conscious of certain particularities in the interactions between the Haitian patient and the white American provider. What I observed in these interactions was not often apparent with other ethnic groups.

Because of the nature of the interactions I observed between the Haitian patient and the white American provider, I often asked myself: What is it about Haitians as a group that gives a different "flavor" to the usual doctor-patient relationship? Certainly some of the culturally derived dynamic present in the interactions between Haitian patients and white American providers were also observable with other ethnic groups, nevertheless there was that something, a certain *je ne sais quoi*, that seemed at times to

manifest itself in those interactions involving Haitians, and was absent in interactions between white American providers and representatives of other ethnic groups, even other people of color.

Hence, this study grew out of my determination to uncover what that “something” was. Defining and describing that “something” is the question this study addresses. What is that “something?” Is it historically and/or politically rooted? Is it associated with American society’s longstanding perception of Haitians as primitive? If so, does this come into play during the interactions between the Haitian patient and the white American health care provider?

In the present study, I use the term *provider* to identify the American and Haitian physicians (Mds) and psychologists (PhDs) interviewed. Reference to the “doctor-patient” relationship refers to the patient’s relationship with physician or psychologist.

The delicate and debatable nature of the issues in this study has seemingly led to a lack of interest in addressing them, even though many individuals within and outside the New York Haitian community have indicated they are aware of the issues explored in this study. I have had non-Haitian as well as Haitian health care professionals and patients comment to me that “some white doctors are not as sympathetic to Haitians as to other people.” My Haitian compatriots appear more apt to address issues over which they feel they can exert control. Otherwise, resignation is the attitude displayed, frequently accompanied by comments to the effect that “when you live in a country that’s not yours, you have to accept things.” This attitude of resigned acceptance has been one of my motivations to conduct this study.

Looking at Haitians as a group and comparing them to other ethnic and nationality groups as I tried to decide what might be the origin of that *je ne sais quoi* existing in the relationship between the Haitian patient and the white American provider, I consistently found myself thinking of the poor image American society has of Haiti and of Haitians. As a Haitian who lives in New York City, I have often heard other Haitians complain that all conversations with Americans about Haiti seem always to be reduced to voodoo, poverty, the “boat people,” and the Duvalier dictatorship.

It concerns me that our society has chosen to focus only on the negatives about Haiti and Haitians, and to give little if any attention to the positives. The resilience of Haiti, from the slave history and revolt, and gaining independence and becoming the first black republic in the western hemisphere is seldom mentioned. This resilience is still seen in the achievements of the many Haitians in New York and throughout the world who have overcome barriers and difficulties to succeed in their new homes. Likewise, Haitian culture is rarely evaluated for its richness. Haitian art and literature have gained worldwide fame, yet these aspects of Haitian culture are not publicized by the mass media to the same extent negative aspects are. Thus American society is provided with only a negative and stereotypic image of Haiti and Haitians.

Although a handful of social scientists have addressed the unfairness of Haiti's poor image, their writings have not had the same effect as the negative view of Haiti presented by numerous members of the mass media, which by definition the general public finds more accessible than scholarly writings. Mintz (1984), Ferguson (1987), and Lawless (1992) are among the social scientists who have directed their attention to this issue.

The negative image of Haiti is not a recent phenomenon, and dates back at least to 1804 when Haiti gained its independence and became the world's first black republic. The white powers of the world found the idea of black self-determination very difficult to accept. Haiti was isolated, made an outcast, and left to fail. Everything bad and evil was associated with the former colony the French had called "the pearl of the Antilles" because of its wealth and advanced standing compared to the other Caribbean islands (Ferguson, 1987; Fick, 1990). Lawless (1992) notes that the post-independence period was plagued by racist accounts of the Haitian revolution. He further indicates that:

. . . favorable accounts of the Haitian Revolution are difficult to find as more and more groups depended on advancing their own nefarious interests through denigrating the black struggle for freedom and Haiti's subsequent struggle for survival in a hostile white world (Lawless, 1992:47).

Haiti's blackness and its African ancestry were linked to savagery and Haitians were castigated as cannibals and barbarians (Ferguson, 1987; Lawless, 1992).

Over the past century, Haiti's image has further deteriorated as the result of several other factors, including the much publicized and misunderstood nature of one of Haiti's religions, *voodoo*, wrongly connecting it with witchcraft, black magic, and sorcery; the torturous dictatorship of the Duvalier regime; and the media-named "boat people." Perhaps the most damaging and stigmatizing crisis in labeling occurred in the 1980s, when the United States Center for Disease Control (CDC) labeled Haitians as being high risk for contracting the Acquired Immune Deficiency Syndrome (AIDS). The CDC initially placed Haitians on its list of high risk populations, but subsequently

withdrew them from the list after much protest from Haitians and their supporters.

Lawless (1992) poignantly remarks that:

. . . almost all that anyone hears about Haiti is filtered through various attempts throughout recent history to put Haiti back “in its place” as black, backward, dangerous and savage (Lawless, 1992:51).

As previously noted, to date very little research has addressed the issue of the longstanding poor image of Haitians. Although this study does not directly focus on the image of Haitians, it does attempt to connect the image to the quality of the relationship between the Haitian patient and the white American health care provider. This study also further supports the need for the inclusion of sensitivity to cultural diversity in the provision of health and mental health services. The research participants are a sample of Haitians, but the issues and concerns addressed have ramifications for other groups and are applicable to situations other than health care.

The significance of Haitians as a noteworthy group in New York City rests on their increased presence in the community. It is estimated that half a million Haitians live in the New York City area (NYC Dept. of City Planning, 1996). Between 1990-1994, Haitians were among the ten largest immigrant groups in the city (NYC Dept. of City Planning, 1996). As the Haitian population in the city grows, so too will its demands for health care, and the probability of Haitians coming in contact with white American health care providers increases. Thus, uncovering an element that has negatively affected this contact may benefit both the providers and the patients, as positive doctor-patient relationships may lead to more cooperative and compliant patients, less frustration for the health care provider, improved quality of care, and possibly more cost effective care.

Patients who stop going to a doctor because of that doctor's "behaviors and attitudes" may wait until their illness is at a chronic state and receive care in a hospital emergency room. This is costly to society overall (especially if the individual is uninsured) and places additional stress on an already overburdened health care system. It must also be noted that for some ethnic groups, such as the Haitians, making the decision to seek health care from a physician is sometimes an emotional and financial sacrifice. The emotional sacrifice may have a greater meaning for those whose health care belief system is unorthodox and geared toward the use of alternative medicine. The fact that the individual makes it even once to a doctor's office is indicative of the individual seeing at least some value in this contact. Thus, promoting positive experiences for the patient is desirable as that first contact may be the decisive factor in determining whether the patient will continue to seek professional care.

Another element involved in supporting the promotion of positive doctor-patient interaction with Haitians is what I refer to as "basic human emotions and feelings." Consider the possible resentment that may develop when Haitian patients consistently observe other ethnic groups being treated by white American providers in a way they have not enjoyed. The Haitian patient may internally pose questions such as: "What's wrong with me? Why wasn't the doctor as nice and respectful to me? These feelings left unresolved can be detrimental to society as a whole, to a world where people of varied races and ethnicities must live together and work together. These feelings can indeed spillover to other aspects of individual life.

Both Haitian and non-Haitian health care providers have witnessed the differential treatment accorded to Haitians and non-Haitians by white American health

care providers. What are Haitian health care providers to make of the behavior of their colleagues toward their compatriots? How does this affect their relationships with their white colleagues, and do they believe the white provider's perception of Haitians applies to them? These are important questions, although not directly addressed in this study, and are in the forefront of some of the comments made by Haitian providers.

In attempting to answer the research question, it became necessary for me to observe and analyze the doctor-patient dyad, that is, the white American health care provider and the Haitian patient. A qualitative methodology, inspired by symbolic interaction, was used. The two main methods employed were the interview and participant observation. Interviews with both members of the dyad were essential, and semi-structured in-depth face-to-face taped and untaped interviews were conducted on a small sample of Haitians and white American health care providers. Although all racial and ethnic groups are represented in the community of health care providers in New York City, for purposes of this study, I interviewed American providers from the dominant group, i.e., those not identified as "people of color." It is their relationship with Haitians that is the central concern of this study. Although the sample of Haitian patients was small, it comprised a variety of socioeconomic levels, occupations, genders, and ages so it approximated a representative sample of the Haitian-American community in New York City. The morbidity rate of the sample was similar to that of the general population of Haitians in the city.

In interviewing the white American providers, I sought information about their experiences in providing health care to Haitians. Interviews with Haitian patients primarily addressed their experiences in seeking health care from white American

providers. In both cases, I was particularly interested in how the interviewees perceived the doctor-patient relationship.

A small sample of Haitian-American health providers was also interviewed. The aim was to obtain information about their perspective on the relationship between their white American professional peers and Haitian patients. The Haitian providers are at the distinct advantage of sharing a common cultural heritage with the Haitian patients while at the same time sharing, for the most part, a common scientific knowledge base with their professional colleagues and peers.

Participant observation occurred during my normal daily work at my two places of employment: a New York City hospital outpatient clinic and a community mental health clinic. In addition, I had informal, untaped discussions with other health care professionals, such as nurses, nurse practitioners, physician assistants, dieticians, and social workers.

Interviews with the health care providers were held at the hospitals, community clinics, and in private offices where they practiced, and a few at their homes. The Haitian patients interviewed were all New York City residents and represented a cross-section of socioeconomic levels. None were employed in a health care setting, nor were any of their household members. Although some of the doctors and patients did comment on issues relating to inpatient hospital care, the study emphasized outpatient medical and mental health care, that is, the doctor-patient relationship at hospital clinics, community clinics, and in private offices. In addition, the data were supplemented with information garnered from a comprehensive literature search, as

well as by reflections on my many hours of critical discussions with Haitian and other New York City residents, some of whom were working in the health care fields.

Three main areas were addressed. First, I explored the illness behavior of Haitians living in New York City in the attempt to determine how Haitian culture and world view affect the way Haitians respond to illness. Second, I explored the utilization of the orthodox medical and mental health system by Haitians. Finally, I looked at the provider-patient relationship, where the suggested explanation of the research question might be found. There I investigated the experiences, both positive and negative, of Haitians with white American providers, and included input from Haitian providers.

Chapter II looks at issues in the professional literature dealing with health and illness behavior, including sociocultural factors that help determine just how illness and appropriate behavior for the ill are defined. Chapter III provides an overview of the focus population, together with background on Haitian history and culture. This affords the reader the opportunity to better understand Haitians as an ethnic group and to understand the significance of the question this study attempts to answer. Chapter IV discusses the methods used in the research, and describes the characteristics of the patients and the health providers, both white American and Haitian, interviewed. Chapter V, Findings, is divided into three main areas: the illness behavior of New York Haitians, how they utilize the American medical system, and the provider-patient relationship. Finally, in Chapter VI, I summarize the findings and suggest some of their implications for health care of Haitians and other ethnic and nationality groups.

General characteristics of Haitians as a group are discussed in this study. This should not be taken to suggest that the Haitian community is monolithic in either values

or personality characteristics. Whether in Haiti, the United States, or elsewhere, intragroup variations in values, attitudes, behaviors, and lifestyles are very much present. These are discussed under findings.

The objective of this research is not to criticize or critique white American health care providers. Neither is it my intention to suggest that the negative experiences are representative of the experiences, views, and attitudes of all Haitians, nor those of all New York City's white American and Haitian health care providers. Many Haitian respondents reported having very positive experiences with white American providers and likewise, there are white American providers who claim that Haitians are among "their best patients," and who were interested and indeed fascinated in learning about Haitian culture from their patients.

The actual interviews with white American and Haitian health care providers as well as those with the Haitian patients were extensive. Although the sample size may be relatively small, the data obtained were sufficient to point to some disturbing issues regarding the delivery of medical and mental health care to Haitians in New York City. They additionally suggest not merely a possible answer to the research question but also a means of alleviating a problematic situation.

Chapter II

ISSUES IN THE LITERATURE ON HEALTH AND ILLNESS BEHAVIOR

Expanded Definition of Health and Illness Behavior

The customary definition of health often uses the medical model, defining *health* as the absence of disease or medical condition. More recently, the World Health Organization (WHO) has developed an expanded definition of health now used frequently in the literature. Health is defined not only in terms of its medical aspects but also in terms of the individual's own perception of his or her overall well-being. Thus health is defined as "a state of complete physical, mental and social well-being" (Goldacre, 1996; Kindig, 1997; Tarlov, 1996).

This conception of health is useful as a structural mechanism from which to work in devising policies directed toward attaining health improvement. It embraces the realization that social factors, such as socioeconomic status, and societal ills, such as deprivations, inequalities, and instabilities, all affect individual health outcomes. Kindig (1997) and Tarlov (1996) both suggest that the above factors predispose individuals to certain diseases or medical conditions. Both also pointed out that although research has supported the general argument of the effect of social factors on medical conditions, the specific mechanisms by which this apparent conversion process occurs has yet to be determined. The basic tenet of Kindig and Tarlov's argument is

that in attempting to improve the health of a society's population, policies to be implemented should address not only physical and mental health issues, but also issues that will increase the overall well-being of that population, such as adequate housing, employment, and education.

The traditional Western medical model of treating illness and distress has focused on observed physical and biological changes. Differences in response to illness were seen primarily as the result of severity of distress associated with the illness, individual pain thresholds, and other personal psychological characteristics. Anthropologists, however, have long advocated the inclusion of cultural variables in the study of illness and illness behavior. Sociologists later joined them in recognizing the significance of sociocultural factors in health and illness. Over the past decades, numerous researchers in the two disciplines have investigated the sociocultural dynamics affecting health and illness behavior (Parsons, 1951; Zborowski, 1952, 1969; Zola, 1983a, 1983b, 1983c, 1983d; McKinlay, 1972, 1990; Mechanic, 1978, 1982; Twaddle, 1979; Mishler, Amarasingham, Hauser, Liem, Osherson, & Waxler, 1981; Helman, 1984; Laguerre, 1984). Health and illness behavior have come to be understood as social phenomena, directly affected by factors such as race, ethnicity, culture, and socioeconomic status.

Having historically enjoyed professional autonomy and great power, the medical profession has, for the most part, been successful in resisting the incorporation of sociocultural elements into the management of people treated. This applies to both providers who treat physical illnesses and to those who treat mental illness. Recently,

however, many governing organizations have recognized the importance of sociocultural factors in health and mental health, and are requiring sensitivity training in this area for health care providers. Psychiatry's previous omission of sociocultural variables in its treatment of mental illness has been criticized from both within and outside the profession (Marsella & White, 1982; Tzeng & McDermott, 1981; Mishler et al., 1981; Fish, 1996; Pedersen, Draguns, Lonner, & Trimble, 1996).

Illness is described by Helman (1984) as:

the subjective response of the patient, and of those around him, to his being unwell; particularly how he, and they interpret the origin and significance of this event; how it effects [*sic.*] his behavior, and his relationship with other people; and the various steps he takes to remedy the situation. It not only includes his experience of ill-health, but also the meaning he gives to that experience (pp. 68-69).

Thus the patient's perception of how he or she feels and the perception of those in his or her environment are crucial in this definition of illness.

According to Mechanic (1978), illness behavior "refers to any behavior relevant to any condition that causes or might usefully cause an individual to concern himself with his symptoms and to seek help" (pp. 249-250). As is the case with any behavior, illness behavior is culturally and socially learned, and differs among individuals and groups. Variations exist in the way illness is perceived, and in the way symptoms are interpreted and acted upon. A condition may be defined by one group as an illness or sickness warranting immediate care, and not recognized as such by another group. Differences in illness behavior are observed across culture, ethnicity, and socioeconomic status. These factors involved in illness behavior have been extensively

addressed in the literature (Jones & Jones, 1973; Mechanic, 1982; McKinlay, 1972, 1990; Twaddle, 1979).

Parsons's "Sick Role"

Sociology's involvement in the study of health and illness behavior has produced a unique perspective from which to view the ill individual. Among the notable contributions to the study of illness is Talcott Parsons's (1951) formulation of the "sick role." Parsons conceptualized illness as being not only a medical problem, but also a problem containing social factors. Thus illness was to be regarded as both a medical and a sociological problem.

Parsons contends sickness is analogous to social deviance. Parsons is implying that both social deviance and sickness represent a deviation from normality. A behavior is characterized as deviant when it is compared to a particular standard set by society. Likewise, illness is also measured against a societal standard, whether illness is self-diagnosed by the individual or diagnosed by a medical provider. Both illness and social deviance take on different meanings based on the culture of the society in which they occur. What may be considered illness or deviant behavior in one culture or society may not be so defined in another. Thus the culture within which the illness or deviant behavior takes place becomes an important variable, not only in the way in which deviation from normality is defined, but also in dictating the way these deviant behaviors are to be dealt with by the members of that culture.

According to Parsons, the sick role is “an institutionalized role which shares certain characteristics with that of criminality but also involves certain very important differences” (Parsons, 1951: 312). The Parsonian formulation of the sick role comprises four expectations vis-à-vis the sick individual. The first is exemption from normal role responsibilities. This requires that the exemption be legitimized by others, most specifically by a physician, who serves as a quasi-gatekeeper. The other expectations are that the sick individual cannot be held responsible for his or her condition; that the state of being sick is not desired by the sick individual; and that the sick individual is expected to seek out and cooperate with technical, competent help, namely a physician (Parsons, 1951). Thus, the Parsonian formulation suggests that the privileges and exemptions associated with the sick status are limited and conditional.

However, it appears to me that Parsons's formulation of the sick role should be regarded more as a Weberian *ideal type* (Weber, 1958), that is, as an analytical tool accentuating significant aspects of illness behavior. The sick role expectations are more normative than description, definitions of what “ought” to be expected from the ill individual, and which may not occur and may not necessarily apply to all individuals. The sick role as described by Parsons is not enacted by many in our culturally heterogeneous society. Nonetheless, as an ideal type, the Parsonian sick role can serve as a framework against which to analyze observed variations in illness behavior.

Although Parsons's model has been praised in the medical sociology literature, at the same time it has been controversial. Critics such as Freidson (1972) and Robinson (1971) have generally questioned its usefulness and limitations. They contend

that the sick role may not be applicable to certain medical conditions—such as pregnancy, mental illness, mental retardation—or to chronic conditions and incurable illnesses.

Freidson (1972), a well known critic of the Parsonian model, contends that in the above noted conditions, particularly in chronic illnesses, recovery may not be possible and hence the expectation of recovery in Parsons's formulation is irrelevant. Thus, Freidson suggests, Parsons's sick role is more applicable to acute illnesses. Freidson also criticizes the importance Parsons places on the physician as the legitimizer of sickness. He emphasizes that many individuals who are ill do not always consult professionals, but may engage in self-treatment, possibly including consultation with non-professionals.

Consultation with a professional as a condition for being granted "sick status" is likewise of concern to me. Many individuals from various ethnic groups, as well as people from the lower socioeconomic strata, may not always seek professional medical assistance when ill (Kosa & Zola, 1975).

This issue is quite pertinent to Haitians, the target group of this study. The majority of Haitians living in New York City are in the lower socioeconomic strata. Being defined as sick and adopting the sick role is not an option for many, as they lack the resources to be exempted from their normal obligations. That is, they cannot afford to be sick. They may have more immediate needs to meet, such as purchasing food and paying rent, and they may not have the financial resources to pay for medical treatment. Their situation is not unlike that of non-Haitians in the lower socioeconomic

strata of our society. The relationship between health and socioeconomic status is well documented in the sociological literature (Kosa & Zola, 1975; Mechanic, 1978; Twaddle, 1979; McKinlay, 1990; Kindig, 1997).

In addition, many Haitians, due to a world view that perceives illness as being caused either by natural or supernatural forces, do not always seek professional assistance when ill. For some, seeking professional help is undesirable as it may conflict with beliefs about the nature of their illness. Many usually self-diagnose and treat their own illnesses, or may solicit the assistance of others in the community, i.e., family and friends (not necessarily medical professionals) as well as folk healers. Lay individuals as well as folk healers and medical professionals comprise what Kleinman (1980) has noted as "sectors of health care." According to Kleinman (1980), in any society, these different sectors are utilized by individuals when they are ill.

Within the Haitian culture, the sick individual, whether self- or other-diagnosed, may be granted the status of sick by those within his or her environment, and be exempted from certain duties as seen appropriate by the culture, irrespective of medical opinion. Within the Haitian culture, there are cases when an individual may be defined as "sick" by others (nonprofessionals) in the community and yet not be deemed such by a medical professional. For example, a woman who is pregnant is considered to be in an "abnormal" state and is expected to adhere to exemptions as defined by the community. Parsons's (1951) incorporation of the community in defining the sick individual can be appreciated here.

Although individual differences exist, Haitians in general have similar beliefs about health and illness. The Haitian community, along with its strong cultural tradition, has enormous influence over individual members; it is sometimes considered "one big community" where everyone seems to know each other. It is this familiarity which paradoxically can be a source of pressure to individuals within the community, a situation analogous to Emile Durkheim's conception of society's pressure on and power over the individual (Durkheim, 1965).

Sociocultural Factors in Illness Behavior

Cultural and ethnic differences have been noted in the degree to which different groups respond to Parsons's sick role and to illness in general (Mechanic, 1978; Twaddle, 1979; Zborowski, 1969). In an exploration of the relationship between ethnicity and the sick role, Twaddle (1979) observed that some ethnic groups were more accepting of the sick role than were others. For example, he noted that Catholic Italians were more rejecting of the sick role than were Protestants and Jews, the Jews being the most accepting. While I concur with Twaddle's study, I would venture to add that under the rubric of ethnicity, there is an issue of "expectation" which may play a role in the acceptance of the sick role. For example, if an individual is from an ethnic group in which it is "ethnically and culturally expected" for the individual to assume the sick role for a particular ailment, the individual may comply with the cultural or group expectations so as not to disappoint members of that individual's culture or ethnic group. In some cultures a variety of rituals are performed when one suffers from

a particular ailment. Accepting and playing the sick role allows members of that culture to “fulfill” their duties toward the ill individual, while at the same time reinforcing the individual’s membership in and identification with the group. One can only speculate on the amount of pressure implicitly as well as explicitly placed upon the sick individual to accept the sick role.

Twaddle also contended that the Protestants and Jews in his study were more achievement oriented and were of higher socioeconomic status than the Italian Catholics. He suggests that those who are of higher socioeconomic strata are more likely than those of lower strata to see themselves as sick and deserving of sick role status. The previously cited connection between illness behavior and socioeconomic status is thus again supported. However, I question whether the issue is whether or not lower socioeconomic status individuals *define* themselves as sick. They well may define themselves as sick, but due to circumstances and lack of resources are unable to assume and act out the sick role. Thus, it may be that the individual’s circumstances may be of more importance in determining acceptance or rejection of the sick role or sick status, rather than the individual’s actual perception and will.

In Twaddle's (1979) study, Jews were reported to seek medical care earlier, report more trivial conditions as being sick, and expect exemption from normal responsibilities. The Protestants and Italian Catholics were less likely to define themselves as sick, saw their symptoms as being less disabling and thus not justifying exemption from normal obligations. This study illustrates that health concerns are associated with ethnicity and that groups vary in their perceptions of illness and health.

The interplay of culture and ethnicity in illness behavior has been supported by similar studies done by Zborowski (1969), Zola (1983a), and Nader and Maretzki (1973).

Twaddle (1979) also noted that illness patterns tend to be influenced by ethnicity and culture. Dietary habits and other social behaviors can lead to the prevalence of certain maladies in a group. For example, the pervasiveness of hypertension among African-Americans in the United States has been directly linked to their high consumption of salt and fat. Hypertension is a particular concern for Haitians, many of whom are unaware they have the condition or may not fully understand the potential consequences of this condition if it is not kept under control through strict adherence to diet and sometimes medication.

According to Haitian medical providers and the literature (Laguerre, 1984; Charles, 1986), Haitians in general tend to minimize the severity of most illness symptoms. Economic conditions, as previously noted, may play a role in this, concurring with Twaddle's 1979 study. Those symptoms that are acted upon and perceived to require intervention are, in general, those defined as such by the culture. In addition, some conditions are more culture specific, appearing only in certain cultures, having distinct meaning to that group as well as their own culturally derived treatment modalities.

Tseng and McDermott (1981) have discussed the importance of recognizing and respecting culture specific conditions. They advocate the need to expand the scope of the western psychiatric classification system to accommodate mental illnesses that are peculiar to certain cultures. These conditions are often deemed to be "unclassifiable"

because they do not fit into the western psychiatric classification. Tseng and McDermott argue that such practice suggests that individuals are expected to follow certain patterns of behavior, thus allowing no room for cultural variations. I am particularly concerned about this issue, as the lack of awareness and acceptance of cultural variations in psychiatry has undoubtedly led to serious errors in diagnosing conditions. This concern is voiced by many in the literature (Lebra, 1976; Wright, 1982; Marsella & White, 1982; Charles, 1986; Fish, 1996).

In studies conducted by Tseng & McDermott (1981), culture specific emotional and mental illnesses were noted in various cultures around the world (e.g., Chinese, Australian, Latino). Tseng and McDermott note that in societies where culture specific conditions exist, treatment mechanisms are usually in place to treat those conditions.

Physical and emotional culture specific conditions are quite common within the Haitian culture. For example, the emotional condition known as *Kèm sote* (my heart startled) is common among Haitians. This condition is usually brought about as a result of sudden surprise or fear. Some of the symptoms include rapid heartbeat, trembling, hyperventilation, and, in extreme cases, incontinence. A typical treatment for this condition is a teaspoon of molasses or a cup of strong black coffee without sugar. If available, a cup of a herbal tea known as *vèvenn* is also used.

Awareness and understanding of cultural factors in matters of health and illness is of the utmost importance, if individual needs are to be met properly. Another example within the same area of culture specific conditions is the Haitian phenomenon known as *gaz* (gas). For many Haitians, having gas can be disabling to the individual.

Gas is generally known as a pain that can occur in various parts of the body, and can travel from one site to another (Laguerre, 1984). Treatment for *gaz* is sought immediately, albeit not always via traditional medical intervention. Self treatment usually includes changes in one's diet, such as avoiding foods believed to cause gas and increasing intake of those foods believed to relieve gas, such as plantains.

This gas "ailment" can be confusing to non-Haitians. Haitian medical providers, knowing of this gas phenomenon within the Haitian culture, have learned to focus on the investigation of specific illnesses that may have symptom manifestations similar to the presentation of the *gaz* location. The health provider must also be mindful that Haitians generally tend to experience difficulty describing their symptoms. They tend to tell the medical provider what they *believe* to be wrong with themselves, rather than to describe specific symptoms, and often will blame discomforts on *gaz*. According to Laguerre (1984), what medical providers hear from Haitian patients may not always represent felt symptoms, but may very well be symptoms of the perceived illness. This issue of *gaz* will be discussed further in a later chapter, as it is of great significance to most Haitians, across socioeconomic levels.

The significance of symptom definition and its relationship to culture has been explored by Zola (1983d), Mechanic (1982), and others. It should be taken into consideration whenever medical evaluations of individuals are made.

Chapter III

OVERVIEW OF FOCUS POPULATION

History

The Island of Hispaniola and Slavery

The Republic of Haiti is located in the western third of the Caribbean island of Hispaniola, lying 56 miles southeast of Cuba and 621 miles from Florida. (The Dominican Republic occupies the eastern two-thirds of the island.) Haiti is mountainous and is approximately 10,714 square miles, roughly the size of the state of Maryland (Lawless, 1992; Turner, 2000).

In 1492, Christopher Columbus landed on the northern coast of the island of Ayti (present day Haiti), then inhabited by the Taino Arawak Indians. Within fifty years approximately half a million Arawak had been eliminated through diseases and from abuses by the Spaniards (Leyburn, 1966; Ferguson, 1987). The Spaniards named their new-found territory *Hispaniola* and began to bring African slaves to work on sugar plantations and cattle ranches. As the island economy began to falter over time, Spain began to divert its interest to Mexico and Peru with their gold and silver mines. French and British settlers subsequently occupied the island. The French, more numerous than the British, occupied the western part of the island, the remaining Spaniards staying in the eastern end (Ferguson, 1987)..

In 1697 the Treaty of Ryswick divided the island of Hispaniola. Spain ceded the western part of the island to the French, and it became the French colony of Saint Domingue. The eastern part of the island (Santo Domingo) remained under Spanish control (Nicholls, 1979; Ferguson, 1987). The French controlled Saint Domingue for approximately one century. During that time the French colony became the world's most prosperous colony. The riches of the colony were, however, based on a slave economy. Slaves were brought to the island from Africa to be free labor to work on plantations, producing sugar, indigo, coffee, and cocoa. Sugar was the main export of the colony, which at that time exported more sugar than all of the British Caribbean colonies. In the latter part of the eighteenth century, the wealth of Saint Dominique was proverbial, and the French accordingly called it "the pearl of the Antilles." Wealth poured into the colony itself and into France.

The wealthy white planters created for themselves a miniature version of France, surrounding themselves with opulence and domestic servants (slaves). They and other wealthy white Frenchmen were known as *les grands blancs* (Ferguson, 1987; Fick, 1990). (Interestingly, "grands blancs" is still used by Haitians to refer to any Haitians who live in opulence.) The slave society comprised not only white planters and black slaves, but also a middle group, the *mulattoes*. The mulattoes who were the offspring of white masters and black female slaves were afforded more privileges than the black slaves. The *affranchis*, that is, people of color who were free, were predominantly mulattoes. Many of them were wealthy property owners in their own

right, some even owning plantations and slaves (Nicholls, 1979; Price-Mars, 1983; Fick, 1990).

While the mulattoes had a more elevated standing than the black slaves, because they were not “pure white” they did not have the same political rights as the *grands blanc* (the rich whites) and tended to be unwelcome in the milieu of the colony’s elite. Their lack of acceptance by the rich whites resulted in ambivalent feelings by the mulattoes toward both whites and blacks. The mulattoes shared racial ancestry with the whites, and had similar economic interests and many similar values. At the same time, rejection by the whites forced the mulattoes to confront the African ancestry they shared with the black slaves, whom the society defined as inferior. This conflicted identification is part and parcel of the deepest roots of the color contention that existed among Haitians then, and, although to a significantly less degree today, continues to exist.

The Revolution and the New Nation

In 1791, the slaves revolted against their French masters. The revolt was led by a former slave, Toussaint L’Ouverture, a major figure in Haitian history. Eventually L’Ouverture was captured by French troops led by Napoleon Bonaparte, and thrust into prison where he later died. The struggle for freedom continued under the leadership of Jean Jacques Dessalines, Henri Christophe, and Alexandre Petion (Leyburn, 1966).

After thirteen years of turmoil and battles, the slaves and former slaves prevailed, and defeated Napoleon’s troops. On January 1, 1804, Dessalines proclaimed independence from France. Haiti thus became the world’s first black republic and the

second oldest independent nation in the western hemisphere. The French name of Saint Dominique was annulled and the new state returned to its original Arawak Indian name of Ayti (Haiti), “to emphasize the break with the French” (James, 1989: 370).

France refused to recognize Haiti as a nation, and other countries, including the United States, followed the French lead. Nicholls (1979) notes this attitude was widely blamed on prejudice against the Haitian “black nation.” Haiti was isolated and left alone without allies or support. This isolation is often believed to be a contributing factor in the country’s continuing poverty. France finally recognized Haiti’s independence in 1825; the United States did not recognize it until 1862. From 1822 to 1844, Haiti occupied the Spanish-speaking eastern portion of the island (Santo Domingo). In 1844, Santo Domingo established its independence and renamed itself the Dominican Republic, retaining Santo Domingo as the name of its capital city (Nicholls, 1979; Morse, 1988).

The United States Marine Occupation.

After Haiti gained independence in 1804, the country experienced a succession of political instability, economic and social turmoil, and governmental leaders. In 1915, the United States sent the Marines to Haiti in order to protect its “economic and strategic interests” there and to prevent further European intervention in Haiti, particularly as Germany had begun to control much of the country’s economic activity. (Nicholls, 1979; Ferguson, 1987; Laguerre, 1993). From 1915 to 1934, the United States controlled much of the country’s political and economic life. America supported Haitian presidents who were believed willing to cooperate with the American

administration and to defend American interests there. The Americans were supported by many of the elite of Haiti, who welcomed the intervention of the United States to help stabilize the economy and to shield them from the effects of the economic turmoil that had preceded the occupation. The elites, mostly mulattoes, were also able to play a greater role in politics and to aspire to the presidency.

During the American hegemony, Haiti's infrastructure was developed, roads and bridges built, and utilities such as telephone and electrical systems were installed. These improvements benefitted the Haitians, but were done for the benefit of the Americans and other investors. American presence in Haiti facilitated foreign investments, especially by American companies. At the same time, contempt for Americans began to develop as accusations of unfairness, racism, and mistreatment began to emerge against the Americans. Many Haitian peasants were made to engage in a system of forced labor known as the *corvée*, which resulted in the rebellion of 1918 wherein many Haitians were killed by American troops. Anti-American sentiment and Haitian pride and solidarity heightened among all Haitians, including the mulattoes. Discontent with the United States occupation became pervasive, and after several strikes, demonstrations, and much disturbance, in 1934 President Roosevelt ordered American troops to vacate Haiti.

The Post-Occupation Era and Thereafter

The years after the United States occupation, 1934 to 1957, made up a period of adjustment, restructuring, and instability, marked by a succession of Presidents and a growing military force that progressively became more and more directly involved in

national politics. In 1957, François Duvalier was elected President of Haiti. His initial appeal to the Haitian populace stemmed from his proclamation that he would redirect the seat of power from an elite predominantly mulatto to a new black middle class more sympathetic to the peasants and lower classes (Nicholls, 1979).

In 1964, Duvalier, known as “Papa Doc,” declared himself president for life, and remained in complete control of the country until his death in 1971. Before he died, Duvalier declared his 19-year-old son, Jean Claude Duvalier (“Baby Doc”) was to be his successor and president for life (Nicholls, 1979; Ferguson, 1987; Morse, 1988).

The Duvalier dictatorial regime was plagued by corruption, intimidation, suffering, and terror. The elder Duvalier created his own militia, the *Tontons Macoutes*, personal informants used to control the Haitian people, who were given “license to bully, extort and murder” (Ferguson, 1987:40). The enormous political, social and economic instability, devastation, and misery of the people eventually led to an exodus of Haitians to other countries. Many peasants went to Haiti’s neighbor, the Dominican Republic, where they were mistreated and endured forced labor. (Haitians have a history of mistreatment in the Dominican Republic: in 1937, thirty-five thousand Haitians were killed there [Lawless, 1992].) Anti-Haitian sentiment is quite strong in the Dominican Republic, and Lawless (1992) contends that Dominicans see Haitians as inferior, calling them “primitive, dirty and practitioners of voodoo” (Lawless, 1992:139-140). Mintz and Price (1985) have noted that “Haitians are viewed

by Dominicans not only as blacker people but also as culturally inferior” (Mintz & Price, 1985:65).

During the Duvalier regime, the United States was a popular destination for many Haitian emigres, especially the states of New York and Florida. Florida, closest to Haiti and having a similar warm climate, is the port to which many Haitians who flee the country head. In order to escape the torture, widespread killings, and poverty to which they were subjected in Haiti, many Haitians risked their lives on small, poorly constructed boats (whereby they were labelled “boat people” by the media).

The horrible conditions at home led the people to rebel. In 1986, Jean-Claude Duvalier was forced to leave the country (transported to France on a United States aircraft). Although later denouncing the enormities of the Duvalier regime, the United States has been criticized for having previously supported it (Ferguson, 1987; Dupuy, 1997).

In 1987, a new constitution was ratified by a referendum. This constitution calls for two legislative chambers, an 83-member Chamber of Deputies, a 27-member Senate, and an executive president elected for one five-year term. The president may run for another term, but only after a five-year interval (Turner, 2000). Dupuy (1997) noted:

The 1987 Constitution was the most progressive Haiti had ever known. Calling for the creation of a parliamentary democracy, the Constitution barred former close collaborators of the Duvalier regime from running for or holding public office for a period of ten years. Going beyond the traditional liberal provisions, the Constitution embodied several social democratic principles and articles. It called for a thorough agrarian reform, and it declared that health care, housing, education, food, and social security were fundamental human rights, in addition to those of

personal liberty, freedom of thought and freedom of political association. In yet another significant acknowledgement of the historical exclusion of the majority of creole-speaking Haitians, the constitution declared Creole as an official language of the educated and propertied classes" (Dupuy, 1997: 54-55).

The post-Duvalier period saw several attempts to establish a true democracy in Haiti. A succession of short-lived presidents furthered the country's instability. In December of 1990, a Catholic priest, Jean-bertrand Aristide, was elected Haiti's forty-fourth President. Only seven months later, he was overthrown by a military coup (Laguette, 1993; Dupuy, 1997). Three years later, in 1994, with the backing of the United Nations Security Council, the United States President Clinton sent American troops into Haiti and reinstated Aristide as President to complete his terms (Dupuy, 1997). Aristide was succeeded by Renee Preval, reportedly his handpicked successor. In February 2001, Aristide was again inaugurated as President of Haiti. His electoral victory was contested by the opposition, reportedly claiming the election had been plagued by fraud.

Race, Language, and Status

Haitians are mainly descendants of the African slaves who had been brought to the island in the 1600s by the Spaniards and the French. The estimated population is 7.8 million (Turner, 2000), approximately 90% of whom are of African descent. The remaining Haitians are of mixed African-Caucasian ancestry (mulattoes). There are also some Haitians with mixed Indian features, said to be possibly from the mixture of the original Arawaks who had once settled in Haiti and the Africans. In addition, the population included a very small percentage of European whites and others of varied

races and ethnicities, such as Arabs (Palestinians, Lebanese, and Syrians for the most part), some of whom are also found in other Caribbean countries such as Jamaica, Trinidad, and the Dominican Republic (Leyburn, 1966; Rodman, 1973; Nicholls, 1979, 1985; James, 1984; Laguerre, 1984; Mintz, 1984; Dayan, 1995).

Prior to the 1987 Constitution, French was Haiti's official language. The present constitution recognizes both French and Creole (*Kreyol*) as the two official languages. There have been debates and misunderstanding of what Creole (*Kreyol*) is. Some call it a French dialect, others refer to it as a blend of French, Spanish, English, Dutch, and African words. Still others call it a "Franco-African patois." The Creole spoken by Haitians has also been called "Haitian Creole" (Lawless, 1992:84-92).

Although until comparatively recently French alone was the official language of Haiti, only a small percentage of the population, usually the elite and the educated, actually speak it. The "language of the people" as it is often called has always been Creole (*Kreyol*). Thus, almost all Haitians can speak Creole, but not all are able to speak French.

The persistent use of French in all official matters was criticized as self-serving for the elite, and as an exclusionary mechanism to restrict the majority of Haitians—the peasants and the lower classes, who usually speak only Creole—from participating in the affairs of the country. Among Haitians, the ability to speak French has always been associated with educational level, social class, and economic status.

In the past, the Haitian population was essentially divided into two classes: a dominant ruling class consisting mainly of light-skinned individuals, and the peasants,

mainly dark-skinned. With the emergence of a middle class and an educated elite, societal division in today's Haiti is measured not only by skin tone but even more so by educational level, achieved wealth, and family background. Mintz (1984) noted:

However much weight one assigns color differences within Haiti, the fact remains that those differences express themselves primarily in terms of class and do not normally transcend class considerations. In other words, the line that divides Haitians most is *not* a color line (Mintz, 1984:30).

The relationship between color and class in Haiti is rooted in its history.

However, other factors are included in the relationship, and make this configuration difficult for outsiders to understand. Trouillot (1990) views color prejudice in Haiti as more "complex" and different from western color prejudice. He further notes that:

Haitian "color" categories refer to many more aspects of phenotype than skin color alone . . . color never operates alone . . . color categories embraces characteristics that go far beyond the perceived phenotype into [the] field of social relations. . . . these can include income, social origin, level of formal education, customary behavior, ties of kinship or marriage and other characteristics . . . Haitian color categories refer not only to skin color and other somatic features, but to a large range of sociocultural attributes that do not have a somatic referent (Trouillot, 1990:112-113).

Although skin color may be used as an initial divisive tool, other aspects of the individual may also be considered. For example, not all dark-skinned Haitians are perceived and treated the same. A rich, educated dark-skinned Haitian will likely be accorded privileges not available to another, less educated individual whose skin tone may not be as dark as the other's.

Family Life and Gender Roles

In the past, much of the population of Haiti lived in small homes on farms. The entire family contributed to the work on the farm. The Haitian peasant woman was involved with buying and selling agricultural goods as well as caring for her family. The peasant man was mainly responsible for the farm, the family's primary source of subsistence. He would assist other peasants in need to plant and harvest crops; the same service was rendered back to him when he had the need.

Although more and more peasants have left their farms to live in the cities, the peasantry remains the largest percentage of the total Haitian population. Most peasants own their own land, although the plots are generally small. The urban lower class consists mostly of those who once lived in the rural areas and now live a life strikingly different from those of the middle and upper classes. They live in crowded areas in small living quarters often under poor sanitary conditions.

By way of contrast, the homes of the middle and upper classes are larger and filled with modern amenities. Some of the more lavish homes of the upper class boast swimming pools, exotic gardens, and luxurious furnishings. Servants assist with household activities and taking care of children.

The Haitian family tends to be *matricentric* or mother-oriented. It encompasses an extended family system, consisting of not only the nuclear family of parents and their minor children, but can also include in its orbit grandparents, aunts, uncles, cousins, and other, more distant, relatives and friends. The family is expected to care for all its members, including elderly parents and extended relatives. Many Haitians are

involved in *plasaj*, similar to common-law marriage in the United States. In such unions, the couples live together as husbands and wives bringing up their families of children, and are little different from unions where the couple is officially married.

Although *plasaj* occurs in all socioeconomic classes, it is more common among the lower than among the higher classes. The prestige and status associated with legal marriage is still expected among the middle and upper classes. Reasons often suggested for the prevalence of *plasaj* among the lower classes include the sheer cost of a marriage ceremony: license, priest, outfit, and reception. In addition, the woman in a *plasaj* relationship finds it easier to obtain assistance in time of need if she is not legally bound to one man who is normatively required to care for her and her children. The man has more freedom to do as he wishes if he is not legally bound to one woman (Leyburn, 1966; Nicholls, 1985).

Traditionally, the Haitian male is expected to provide for his family and to control all family decision making. The woman's responsibilities generally consist of caring for the household and the children. However, change has occurred. Women now have more power in family decisions, and they are also participating more in the family's economic life as they work outside the home and run their own businesses. This change is particularly relevant to women in the middle and upper classes, who in the past were mostly housewives. Among the peasant class, this is not a new phenomenon. Peasant women have always played an active role in the labor force. To an even greater extent than women from other Caribbean nations, the peasant women

of Haiti have played an instrumental role in the country's economy since independence and the abolishment of slavery (Mintz, 1984; Nicholls, 1985).

The family life of the lower classes is greatly different from that of the upper classes. Children in peasant and the lower classes play an important role in the family labor force and providing family subsistence. Peasant children are needed to work on the family farms and assist the family in all areas, including the selling of goods to help support the family. These children are also active in helping to care for younger siblings.

Children of the middle and upper classes are not expected to participate in the family's economic life as providers. Often cared for by servants, they are expected to attend school, do well, and participate in social and recreational activities with relatives and social class peers. Some Haitian girls are trained in homemaking skills such as cooking and sewing, and supervising a household. Haitian parents are generally loving, caring, and rather overprotective of their children. Nonetheless, Haitian upbringing is known to be severe, with strict disciplinary rules and punishments. Children are seldom given the opportunity to be "heard."

Haitians in general are very attached to their culture which is strongly influenced by their African past. Mintz (1984) noted:

The role of the African past in Haiti's culture remains highly significant, but that past is rarely perceived consciously as such. That is, unlike most Afro-Caribbean peoples, Haitians are at *home with their own culture*; the ideological overtones that accompany being black, of African origin, with glorious revolutionary past and rather somber present, only reveal themselves fully in Haiti to those who are not Haitian (Mintz, 1984:300-301).

The Haitian peasantry and those of the lower classes tend to be more accepting and more attuned to traditional Haitian identity and culture than those from the higher classes. Many from the middle and upper classes have incorporated aspects of French customs into their own lives, perceiving them as more sophisticated and prestigious than traditional Haitian customs. Price-Mars (1983) has criticized the Haitian elites for their detachment from the native Haitian culture, their African past, and for their imitation of the French, “wanting so much to be seen as French.”

Religion

Haitians practice a variety of religious faiths, but the country’s official religion is Roman Catholicism. Approximately 90% of Haitians are Catholic; the remaining 10% belong to various Protestant denominations and sects, such as Baptist, Methodist, and Jehovah’s Witness (Bibb & Casimir, 1996; Turner, 2000). The Catholic Church has played an active role in Haiti since the days of slavery, when the religion of Catholicism was imposed upon the slaves by their masters, as a rationale to justifying the institution of slavery as “an exercise in redeeming souls” (Ferguson, 1987:3). The Catholic Church has a history of condemning the practice of voodoo, the religion practiced by the slaves and still practiced by many Haitians. In addition, until fairly recently, the Church allegedly aligned itself with the interests of the mulatto elites, thus further perpetuating Haiti’s color division between the mulatto elite and the black lower classes.

In addition to the religions mentioned, many Haitians also practice Voodooism. The word Voodoo (*Vodun*) is a West African word meaning “God” or “Spirit.”

Voodoo is a set of beliefs and practices that claim to deal with life and death and the forces that control men's activities (Courlander, 1960; Leyburn, 1966; Price-Mars, 1983; Laguerre, 1984; Hurston, 1990). Voodoo is not to be confused with black magic, which is forbidden to genuine Voodoo worshippers. The voodoo ceremony involves a variety of rituals, trances, songs and dances wherein appeal is made to spirits (*loua*). The *loua* is believed to protect from evil, bring good fortune, and provide indication for illness or misfortune. In return, individuals and families engage in rituals, including "feeding" the spirits with food and drinks, and making gift offerings to the spirits. The ceremony is led by a priest (*houngan*) and takes place in a "temple" (Courlander, 1960).

As noted by Laguerre (1984), Haitians often use Voodoo as both a religion and a medical system. The voodoo priests (*houngans*) are well regarded among many Haitians, and are often sought after for treatment of an illness. Lawless (1992) noted that many voodoo rituals are also seen as healing rites and have become part of a folk medical system used frequently by those living in rural areas.

Despite the official negative attitude of the Catholic Church toward Voodoo, many Haitians practice both religions simultaneously. Decades ago, Courlander (1960) made a comment which likely is equally valid today: "Many a Haitian who participates in rites of vodoun on Saturday worships in a Catholic Chapel [*sic.*] on Sunday" (Courlander, 1960:6).

The voodoo religion was noted to have played a role in the slave rebellion. Not only did voodoo provide a venue wherein the slaves could maintain their cultural identity and a connection with their African past, but the religion served to help maintain cohesion among the slaves, despite often diverse tribal backgrounds (Nicholls, 1985; Ferguson, 1987). Among Haitians, voodoo practitioners are generally believed to be peasants and others from the lower classes. Nevertheless, while publicly denouncing the practice of voodoo, many Haitians of the middle and upper classes have been known to practice voodoo privately. At least in public, many upper class Haitians castigate voodoo as being primitive and unsophisticated. They also often assert that the reputation the practice of voodoo causes the country is a shameful one, and that it acts to inhibit efforts for progress. Unfortunately, misunderstandings of the religion have led to negative opinions of its practice. Price-Mars (1983) took umbrage at those who have criticized the practice of voodoo as something bad. He noted similarities between Voodoo and Catholicism, and implied that the negative image of voodoo was connected to the fact that it is a religion practiced mostly by peasants, and that it is a true reflection of the “religious sentiments of th Haitian peasant.”

Education

Education in Haiti is free and is supposed to be compulsory at the primary level. However, many children of poor and peasant families do not go to school. Their families are unable to afford the related expenses of clothing, books, and transportation. In addition, many of these children are active contributors to family

subsistence, and are needed to work on the farm, selling goods, and engaging in other activities to help support the family.

The literacy rate in Haiti in 1995 was estimated to be 45.8%, 48.3% among males and 43.4% among females (Turner, 2000). Although the literacy rate has risen over the past several years, illiteracy remains one of the country's foremost social problems. In addition to the reasons mentioned above for not attending school, Haiti suffers a shortage of teachers, particularly in those areas where they are most needed. Low pay and undesirable living conditions have hindered efforts to provide teachers to help fight illiteracy.

Approximately 20% of Haitian schoolchildren go to secular state schools; the remaining 80% are served by private and religious schools (Turner, 2000). Some of the private and religious schools are subsidized by the government, and as the schools which generally educate the urban middle and upper classes, they perform an important role in molding the country. The state schools are usually attended by students from the lower socioeconomic classes.

Until fairly recently, instruction was predominantly in French. After much debate, Creole (*Kreyol*) has been approved by the government as a second language of instruction. Nonetheless, most of the private schools continue to instruct in French while most of the state schools teach in Creole. Some private schools have compromised with the government by agreeing to provide at least one course in the Creole language to their students. The French system of schooling is followed in Haiti, and is based on three levels of education: primary, secondary, and university levels.

Economy

Haiti's political instability has had a direct effect on its economy. Haiti is one of the poorest countries in the world and has the lowest per capita income in the western hemisphere. The unemployment rate in 1998 was reported to be approximately 60% (Turner, 2000).

Haiti's economy is primarily agrarian. As noted by Dupuy (1997), in 1985, approximately 70% of the population was employed in agriculture. Since then the percentage has drastically declined due to factors such as soil erosion, poor irrigation practices, and lack of funds. The economy was further damaged when the country's political instability led to the closing of many foreign plants in the 1980s, and the consequent loss of jobs by the Haitians working in them. The domestic manufacturing sector has also suffered a decrease in production as a result of difficulties in obtaining the necessary raw materials. The tourism industry which once flourished in Haiti has declined drastically and is now almost non-existent. This decline can be attributed to the interaction of two factors, the deteriorating political climate of the country and the previous false allegation that Haitians are high risk for AIDS (Acquired Immune Deficiency Syndrome). In addition to owners and employees of hotels and restaurants and other tourist-oriented businesses, self-employed artisans and street vendors who relied on tourists to purchase their goods suffer from the decline of tourism.

Health

Health care is another of Haiti's critical problems, and there is a drastic shortage of health care providers. In a country of more than 7 million inhabitants, in 1994 it was estimated that there were only 641 physicians, 95 dentists, 2,725 nurses, and 50 hospitals (Turner, 2000). Moreover, health services are most available in the capital area and in the cities. The rural areas, where health care is greatly needed, are poorly served.

Malnutrition is prevalent. The infant mortality rate is high: 92 per 1,000 live births in 1997, and a life expectancy of 51.3 years for males and 56.2 years for females (Turner, 2000). The country's political instability and dire poverty have only exacerbated the poor health conditions.

Socioeconomic class dictates the type of health care, if any, that one receives in Haiti. Those in the upper socioeconomic levels usually have access to modern health services; some even travel to Florida or New York City for medical treatment. The majority rely on the sparse availability of services, services which if not provided gratis they cannot afford to obtain. However, most Haitians are heavily invested in the use of alternative remedies for their ailments. This will be discussed further in a later section of this study.

The Haitian Migration and Life in New York City

For more than seventy years, Haitians have been emigrating in search of better educational and economic conditions and in search of political freedom. In addition to the United States, Haitians have also migrated to France and Canada. In the United

States, a sizable influx of Haitians began settling in the New York City area in the late 1950s at the beginning of the Duvalier regime (Mintz, 1984; Sutton & Chaney, 1987; Lawless, 1992; Basch, Shiller, & Blanc, 1995). The years that followed saw considerable increase in the immigration rate of Haitians to the United States, France, and Canada.

Although many came in search of educational and economic opportunities, a greater number came for political freedom. Indeed, the United States has been the destination for most Haitians who left Haiti. During the period 1990-1994, Haitians were among the top twenty immigrant groups to enter the United States and among the top ten immigrant groups to come to New York City. Currently, New York City has the largest concentration of Haitians of any city in the United States (NYC Dept. of City Planning, 1996; Statistical Abstract of the United States, 1995). Initially, many immigrant Haitians saw themselves in a transient state and planned to return to Haiti once the country achieved political stability. Over the years, with continued political instability and continued poverty, the hope of “returning home” has been shattered for many. Within the Haitian community in New York City, one seldom hears discussion about returning to Haiti. In fact, comments such as, “Our country is finished” and “We have to resign ourselves to staying where we are,” are far more common.

In addition to New York City, many Haitians have settled in Florida and smaller numbers in other states such as New Jersey, Massachusetts, and Illinois. The sensational media coverage of the travels of the “boat people” of Haiti to Florida in the 1970s brought Haitians “notoriety,” albeit quite negative and degrading. Many of the

“boat people” risk their lives in poorly built boats to escape the political terrorism and poverty in Haiti. Unfortunately, many drown at sea and never make it to the Florida shore. Others are intercepted at sea and returned to Haiti by the United States government, which has refused to grant the Haitians the political asylum granted to many others, such as the Cubans who have fled to Florida. Schaefer (1995), noting that while the United States has generally been receptive to accepting refugees from other nations, some are “more welcomed” than others, reflected on the different treatment the Haitian refugees received in Florida compared to the treatment afforded the Cubans. Lawless (1992) noted an interesting study on the “boat people” of which few Americans were aware. He pointed to the fact that many of the “boat people” detained in Florida were not as:

penniless, illiterate, unskilled and human wrecks described in the American press . . . many worked in semi-skilled trades in Haiti, such as tailoring, carpentry and auto mechanics (Lawless, 1992:7).

The estimated 500,000 Haitians living in the New York City area are concentrated mainly in Brooklyn, Manhattan, and Queens, with Brooklyn the most heavily populated of the three boroughs (NYC Dept. of City Planning, 1996). In the New York metropolitan area, enclaves of Haitians can also be found in Nassau and Suffolk counties on Long Island, and in Rockland County.

The Haitian population in New York City spans the socioeconomic spectrum, comprising professionals such as doctors, lawyers, and engineers, and middle and lower classes. However, the majority of Haitians in New York City are in the lower socioeconomic strata (NYC Dept. of City Planning, 1996; Basch et al., 1995). A fairly

high percentage Haitians living in New York City are employed as workers in factories, as home attendants, as domestic workers, and as taxi drivers. Haitians have a reputation as hardworking people motivated to better themselves economically.

Some of the Haitian immigrants had professional and vocational careers in Haiti and have not been able to transfer their skills and credentials in order to obtain employment in their fields. Some of these individuals, many relatively advanced in age, have been placed in a position where they must accept employment outside of their specialized skills in order to support themselves and their families. These individuals often hold positions in the lower socioeconomic strata which they believe to be below their expectations. This is quite damaging to their self-esteem, and often leads to depression and withdrawal from the community. This has been observed in my practice as a health care professional and has also been noted in the literature (Laguerre, 1984; Charles, 1986; Basch et al., 1995).

Some Haitians have been able to start their own small businesses, catering mainly to the Haitian community. They have stores, restaurants, barber shops, beauty parlors, auto repair shops, and real estate and insurance offices. A growing number of Haitians in New York City have furthered their educations, in the desire to acquire more marketable skills, and obtain higher paying jobs so they may move up the socioeconomic ladder and provide their children with the opportunities they did not have. In New York City alone, Haitians were among the immigrant groups whose share of professional specialties and technical positions has shown substantial increase over the past several years (NYC Dept. of City Planning, 1996). In addition to Haitian

doctors, lawyers, etc., who have private practices, according to Basch et al. (1995), many other Haitians are employed in white collar jobs in both private industry and the public sector. While this does not at all diminish the fact that most Haitians living in New York City are in the lower socioeconomic strata, it does suggest at the least a small trend toward upward mobility.

Like other ethnic communities in New York City, the Haitians have their distinctive characteristics, and take great pride in their cultural traditions. Haitians have contributed both culturally and economically to the New York City community and the United States at large. Haiti's cultural richness, its cuisine, music, and arts have been shared with the people of New York and the nation, whether it be Haitian art that has received worldwide recognition and been exhibited in major galleries in New York City and elsewhere, or the work of young Haitian writers such as the acclaimed Edwidge Danticat.

Although Haitian family life in New York City differs the life most Haitians were accustomed to in Haiti, many Haitians do retain fundamental Haitian customs, beliefs, and values. Some have successfully integrated aspects of American culture into their own Haitian culture. Likewise at the same time, many Haitians continue to hold onto areas they perceive to be part of their traditional social lifestyle of "class differentiation." Sutton and Chaney (1987) note:

Many Haitians in the United States continue to operate within the same social categories they have transferred from Haiti . . . the traditional class system, as they define it, based on education, wealth, color and family name still provides the ideological and behavioral frame of reference for them; United States society does not. Thus, they attempt to recreate Haiti on foreign soil (Sutton & Chaney, 1987:211).

For many Haitian men and women, life in New York City has meant experiencing major role changes, as women become more independent, contribute to family finances, and participate in family decision making. At the same time, men are faced with situations in which they must assist with childrearing and with household chores, responsibilities to which they were not exposed in Haiti. This transformation has indeed created conflict between Haitian men and women, and both are forced to adjust to new role demands (Charles, 1986; Sutton & Chaney, 1987; Kasinitz, 1992; Bibb & Casimir, 1996).

Haitians living in New York City confront many of the problems other immigrant groups face, such as immigration status, employment, housing, language barriers, and access to services, such as adequate medical care, the concern of this study. Haitians generally tend to be “pride conscious,” and often find it difficult to request and accept assistance, especially from “outsiders” and government agencies, for to do so is to admit to personal inadequacy, to inability to care for oneself.

Many Haitians hold more than one job as additional income is needed not only to maintain themselves and their immediate families living in New York City, but also to support relatives left in Haiti. Many also have inadequate housing and live in overcrowded premises. Many households consist of members from more than one family as well as friends. Without this arrangement, families are often unable to pay the exorbitant rents in New York City. Occasionally, several families will join forces to purchase a house together. Although the living arrangement may be done for economic

reasons, it functions to solidify the family system and replicate the extended family lifestyle of Haiti.

Chapter IV

METHODS

The Study

This study developed out of my awareness of the importance of cultural factors to issues of physical and mental health, coupled with my concerns about differences which I had observed in the medical treatment of Haitians. Specifically, I had wanted to better understand some of the dynamics at work in the relationships between Haitian-Americans seeking medical care in New York City and white American health care providers.

As a Haitian-American social work supervisor and a trained psychotherapist who has been working in a New York City hospital and at a community mental health center for more than fifteen years, I began to notice certain idiosyncratic particularities in the interaction between the Haitian patient and the white American provider. What I observed in these interactions was not as readily evident with other ethnic groups.

I often questioned what it was about Haitians as a group that gave a different “flavor” to the usual doctor-patient relationship. Although some of the culturally defined dynamics I observed in the interaction between Haitian patient and white American medical provider were visible with other minorities and ethnically diverse groups, nevertheless there was that *je ne sais quoi* that seemed at times to exist in interactions involving Haitians. As a result of my own personal and professional

experience and observation, I became ever more determined to uncover what that “something” was and if it were historically and politically rooted. I began to question if it were associated with the longstanding perception of Haitians as primitive, and if so, whether it comes into play during the negotiation process that arise between patient and health care provider.

Perhaps because of the sensitive and debatable nature of the issues of this study, there has been a lack of interest in addressing them. Even within the New York Haitian community, where many have expressed an awareness of those issues, there appears to be a deliberate avoidance of seriously exploring the origin of the issues in question. Instead, what is more commonly observed is a certain amount of resignation, frequently expressed by comments such as, “when you live in a country as a guest, you have to accept certain things.”

Qualitative Research Approach

In attempting to uncover whatever it is that seems to exist in the interaction between the Haitian patient and the white American health care provider, I decided to closely observe and analyze the doctor-patient dyad. To do so, it was necessary to interview a sample of the players involved in the dyad, namely white American health care providers and Haitian-American patients. I realized it would be beneficial also to obtain input from the perspective of the Haitian-American health care providers, who are in the distinctive position of sharing a common cultural heritage with the Haitian patients while at the same time being colleagues of the white American health care

providers and sharing with them a common professional and technical heritage and rules of practice.

Thus, in addition to the knowledge obtained from my own personal and professional experiences, I interviewed a small sample of white American health care providers practicing in New York City and Haitian patients living in that city. From the former, I sought to obtain information about the providers' experiences in providing health care to New York's Haitians. From the latter, I wanted to find out what they experienced in seeking health care from white American health care providers.

The nature of this research is conducive to the use of the qualitative methodologies inspired by the symbolic interactionist approach in sociology. Using these methods permits access to rich research data that goes beyond simple enumeration of physical activities. Thus, rather than merely enumerating the frequency with which Haitian Americans look to white American providers for their health care, I would obtain information about the *experiential* nature of the dyadic experience from both the Haitian patients and the white American and Haitian providers of health care.

The two main methods used in this study were interviews and participant observation. Intensive interviewing affords the opportunity to better capture the personal experiences of the research participants, what I have called above the experiential aspect of those experiences. Participant observation provides further detailed data and adds depth to an understanding of the issues being explored. The combined use of participant observation and interviews not only enriched the data but also assisted in achieving that degree of objectivity which might otherwise be

compromised when participant observation alone is used as a method of inquiry (Wax, 1971; Howard, 1985).

The research protocol for this study included semi-structured in-depth face-to-face taped and untaped interviews, telephone interviews, and more informal interviews. Detailed notes were taken during all interviews. These notes not only contained reports of what was said, but also my own reflections on the interview content.

Semi-structured interviews were deemed more beneficial than structured ones for the purpose of this study. The degree they were structured, in that all participants were asked the same or similar questions in much the same order, facilitated attaining specific information on questions to be asked all interviewees, and the degree to which there was a lack of strict structure afforded the interviewees the opportunity to share their feelings, experiences, and concerns during the course of the interview. This also provided the interviewees the chance to introduce issues of which I, the researcher, had not been aware. Additionally, it provided a venue in which I could explore with the interviewees various issues more fulsomely than would otherwise have been possible.

A few informal, untaped interviews were also conducted with non-physician health care professionals such as nurses, nurse practitioners, physician assistants, dietitians, and social workers. They were of varied races and ethnicity, including white Americans, African-Americans, Latinos, and Asians as well as Haitian-Americans. The informality of these interviews seemed less threatening than the more formal interviews, which contributed to a certain level of spontaneity and openness for them to share their feelings.

During my initial planning of this research, I contemplated using a white American assistant to conduct interviews with the white American health providers. The decision to use such an assistant was based on a desire to promote an atmosphere during the interviewing process that would enhance rapport with the interviewee and would be conducive to openness and honesty on the part of the providers. I feared that I, as a Haitian-American researcher studying a sensitive issue affecting Haitians, might be provided with less than honest information.

The woman who served briefly as my assistant was a master's level social worker employed in a health care setting in New York City. She was completely introduced to the study and was very knowledgeable about the issues with which this study is concerned. However, she was able to conduct only one interview and then, due to personal obligations, was forced to relocate away from the city. As it became very difficult to find another suitable assistant, all subsequent interviews were conducted by me. Following the assistant's only interview with a white American provider, the provider was kind enough to allow me to have an informal interview and discussion with him.

The Sample

Before recruiting participants for the study, I obtained clearance to conduct my interviews from the CUNY Graduate School Human Subject Committee.

The sample comprised 27 Haitian patients, 10 white American medical and mental health providers and 11 Haitian medical and mental health providers. Several factors were influential in determining sample size. During preliminary work for the

research, it became obvious that interviewing Haitians would be a difficult task. As a group, Haitians tend to be skeptical of participating in situations where information is requested of them. As a Haitian, I was quite aware of this historically rooted skepticism and was also cautioned of this by Haitians in the New York community. To compound the situation, like many other groups, a substantial percentage of Haitians work very long hours while caring for their families. Thus, although I was prepared to be very flexible in scheduling interviews, I realized that time constraints would be just as much a problem for the Haitian patient participants as for the medical providers.

Nevertheless, the Haitians interviewed come from a variety of occupations, ages, income levels, and education levels, sufficient to approximate a representative sample of the Haitian-American community in New York City. The representativeness of the sample is confirmed by consultations with various individual leaders of the Haitian community as well as data obtained from the New York City Department of City Planning (1996).

Likewise, the demanding schedules of the Haitian and white American health care providers made scheduling appointments an arduous and delicate task. I was also faced with the reluctance of some providers to participate in the study of what they considered subject matter of a sensitive nature. These factors certainly impeded efforts to increase the size of the sample of providers. Nevertheless, the sample is a fairly good mixture of medical and mental health providers from various specialties. Finally, and most importantly, although the sample size is small, analysis of the data collected

will be of heuristic value and can assist in ultimately understanding the core issues of the study.

Haitian Patients

Recruitment of Haitian Patients

Haitian patient participants in the study were recruited by referrals, direct solicitation, and by posting flyers in places and areas in New York City highly frequented by Haitians. These included professional offices, community centers, various agencies servicing Haitians, churches, supermarkets, local Haitian stores, restaurants, beauty parlors, barber shops, and Haitian clubs and organizations. In addition, I increased my presence in neighborhoods known to have a high concentration of Haitians resident there, such as Crown Heights and the East Flatbush sections of Brooklyn, Cambria Heights in Queens, and the Upper West Side in Manhattan. While in these neighborhoods, I patronized local Haitian stores and businesses, interacted with the people, and listened to their concerns. A few of the study's participants came from these contacts.

In addition, I told some members of the Haitian community about my research project, gave them flyers about the study, and encouraged them to refer interested parties to me. The flyers contained brief information about the study, including the criteria for participation, a telephone number for contacting the researcher, and notice of compensation in the form of a raffle. I also placed a note in the flyer that the researcher was Haitian, in the hope this would assist in appealing to the community. I

also felt that perhaps participants would feel more comfortable sharing their feelings with someone who shares their heritage.

I was not the only one who solicited participants, or distributed flyers and postings. Relatives, friends, and colleagues all helped with these tasks. In some facilities flyers could not be posted or distributed, due to objections on the part of the owners. Although no direct reason was given for their objections, from conversations with some of the owners I suspect that they feared permitting the distribution or posting of flyers might be construed as their approval of the study.

I was surprised by the attitude of some of the facility owners, as before even developing the flyers I had mailed formal letters to these facilities, telling them of my research project. Letters were all followed by telephone calls, and in a few cases interviews with the facility owner. A sample flyer was sent to the facility owners before setting a time for posting and/or distribution.

Distributing and posting flyers indeed developed into an unexpected experience. Some facility owners were quite responsive vis-à-vis the research project, felt the area needed to be explored, and complimented me for undertaking such a study. They accepted the distribution and posting of flyers in their facilities (some approving in writing) and offered an open invitation to come to their facilities to distribute more flyers, or even to send flyers to them for distribution. On the other hand, some facility owners were quite pessimistic about the study and refused to permit flyers to be posted or distributed in their facilities. A common theme was, "things will never change, and as black visitors in a white country, Haitians have to accept things as they are." Other

facility owners were more subtle in their refusals: they would ask me to mail them the flyers (in some instances I personally hand-delivered them) with the understanding that the facility owners would do the posting and distributing of the flyers themselves. During follow-up telephone calls, I was informed either that the flyers had never been received or that they had been misplaced.

Criteria for Inclusion in the Study

The criteria for participation in the study was that individuals be between the ages of 25 and 70, have lived in New York City for at least five years, and possess basic communication skills in English. The age range is fairly representative of the majority of Haitians living in the city. Individuals of varying educational and socioeconomic statuses were welcome. However, as I proceeded with interviewing Haitian patients, I particularly attended to gender, age, educational and socioeconomic status, as I wanted the sample to be representative of Haitians living in New York City. Further, those demographic variables have all been well documented in the medical sociology literature as important factors in health and illness behavior (Kosa & Zola, 1975; Mechanic, 1978; McKinlay, 1990).

Requiring at least a five year residency in New York City serves a critical purpose. The expectation is that during the five year period most, although not necessarily all, individuals would have acquired at least some basic English skills. The ability to communicate in English was used to eliminate or at the least minimize the language barrier variable so often a concern of American providers.

Other criteria for participation in the study included having been born in Haiti and spent at least some childhood years there. This was to ensure a certain degree of life exposure to Haiti and to the Haitian health belief system, which might well have an impact on the individual's own health practices.

Individuals who were employed in the health care field or who had a household member working in that field could not participate in the study. Such individuals were likely to demonstrate illness behaviors somewhat different than the Haitian without possibly sympathetic ties to the field. Those themselves employed in a health care field or who have close ties to someone in that field would be more likely (although not always) to subscribe to western views of health and illness than would those who have minimal contact with the field or with those working in the health care system. Regular contact with the orthodox western medical system may induce behaviors manufactured and approved of by the system, behaviors which may well differ from the more traditional cultural healing practices and illness behavior of the majority of Haitians.

This particular criterion created an unexpected difficulty in recruiting Haitian patients for the study. Many Haitians living in New York City do work in the health care field at socioeconomic and status levels that include home health aide, nurse's aide, nurse, support and maintenance staff at health care facilities such as hospitals, laboratory technician, dietician, and physician. Those who do not work in the health care field are likely to have a household member who does. This probability is greater than might otherwise be expected, given the extended family composition and structure of many Haitian households.

Characteristics of the Haitian Patients

The Haitian patient participants consisted of 27 individuals, 14 women and 13 men. Their ages ranged from 30 to 70, with the majority between 40 and 59 years of age. Fourteen of the participants were married, 2 live in common-law relationships, 4 are single, 3 are divorced, 2 are separated, and 2 are widowed. Most of the participants have children, and some have their children living with them.

With the exception of one participant who had been living in New York City only 9 years, all of the others had been residents for well over 10 years. Approximately 50% of the participants reported residing in New York City for more than 20 years. The participants live in four of the city's five boroughs, Brooklyn, Queens, Manhattan, and The Bronx. None live in Staten Island, a borough known to have few Haitians.

Occupation and income of the Haitian patients. Nineteen of the 27 participants are employed outside the home, 3 are self-employed, 3 are retired and receiving Social Security benefits, and one is on Disability and receiving benefits. One participant described himself as "officially unemployed," and admits he does odd jobs as a handyman to support himself. With regard to occupation, 7 participants hold professional degrees and are employed in their profession, such as law, engineering, accounting, education, and company management. The remaining participants who are employed are engaged in a combination of vocational trades, semi-skilled and unskilled labor, including factory and domestic work. The three who are self-employed are a barber, a beautician, and a taxicab driver. Total household income ranged from

\$10,000 per year to well over \$50,000 per year. Approximately 50% of the participants have annual household incomes of more than \$50,000.

Medical coverage. Eighteen of the 27 Haitian patients had commercial medical coverage either through their own employers or through their spouse's employment. One participant was on Medicaid and 3 had Medicare coverage. Five participants had no medical coverage at all.

The majority of the participants receive medical and mental health care at the offices of private providers. A few use hospital and community clinics, including Health Maintenance Organizations (HMO) such as HIP. These participants are in no way more ill than the general Haitian population in New York City.

Haitian Medical and Mental Health Providers

Eleven Haitian medical and mental health providers, men and women practicing in the various boroughs of New York City, were interviewed. Originally, only 10 providers had agreed to be interviewed, but an additional provider, initially reluctant to be interviewed, unexpectedly made himself available for interview.

In interviewing these providers, my goal was to learn their views on treating Haitians in New York City, and to explore some of their concerns. I was also interested in discovering whether they shared concerns with the Haitian patients as well as with their white American counterparts. I was particularly interested in their perception of the doctor-patient relationship between white American providers and Haitian patients.

Criteria for inclusion in the study were that the provider had been born in Haiti and received at least some formal education in Haiti. In addition, they were to hold professional degrees (the M.D. or Ph.D.), to be actively engaged in the practice of physical or mental health, be licensed to practice in New York State, and have some experience treating Haitians in New York City. The Haitian providers interviewed for this study came from recommendations and from my own contacts. I had requested the assistance of relatives, friends, and colleagues in recruiting participants for the study.

The 8 men and 3 women providers interviewed ranged in age from the middle 40s to the late 50s, with one over the age of 60. All are physicians, with earned M.D. degrees, and are involved in various specialties and practice settings. Three are mental health providers (psychiatrists). The others comprise 2 internal medicine physicians, 2 obstetric/gynecologists, 1 urologist, 1 pediatric/adolescent medicine physician, 1 orthopedic surgeon and 1 anesthesiologist.

I had hoped to interview more mental health providers, but this was impossible due to the small pool of practicing Haitian mental health providers available in New York City. In the United States, there are many mental health providers who are not physicians, such as psychologists, clinical social workers, and psychiatric nurses. They are uncommon in Haiti and among Haitians. Very few people in Haiti pursue careers in mental health, and of those who attend medical school only a few choose psychiatry as a specialty. Mental health traditionally was not well accepted and valued in Haiti. Although some changes have been noted, mental health is still not a career of choice for most Haitians.

The medical and mental health providers interviewed practice in a variety of settings: private practice, and hospital and community clinics. Approximately 80% of the physicians combine a private practice with a hospital practice, and 20% work only in community clinics and hospitals. They have been practicing medicine an average of more than 20 years, and most serve a clientele that consists of approximately 50% Haitians.

White American Medical and Mental Health Providers

Medical and mental health providers in New York City come from all racial and ethnic groups. For purposes of this study, I interviewed only providers from the dominant white group, who are not identified as people of color. The doctor-patient relationship that exist between this specific group of providers and their Haitian patients is one of the areas of concern in this study.

Ten white American medical and mental health providers were interviewed for this study. As with the Haitian providers, some were recommended to me by colleagues, friends, and relatives, and others were from my own contacts and affiliations. To participate in this study, like the Haitian providers, the American providers were required to have an advanced professional degree (M.D. or Ph.D.). They were also required to be licensed and practicing in New York City.

Providers who had received most of their medical training in the United States were preferred to those trained elsewhere. Not only can this maximize the similarity of training, but it also takes into account the strong possibility that professionals who had had previous contact with non-Americans, minority groups, or people of color, might

be more sensitized to issues of concern to foreign born patients and minority group members, which in turn might affect the provider's professional behavior towards such people. Finally, participant providers were required to have had experience in providing services to Haitians and other ethnic groups in the city.

The providers interviewed consisted of 7 men and 3 women. Their ages ranged from the mid-40s to the late 50s, with one provider over 60 years old. Five providers were primarily medical providers: 2 obstetric/gynecologists, 1 gynecologist-urologist, 1 internal medicine physician, and 1 internal medicine-cardiologist. Unlike the Haitian providers, there were 5 mental health providers: two psychiatrists (M.D.s) and 3 psychologists with Ph.D.s.

The physicians and psychologists practice in the various boroughs of New York City. Approximately 90% of the providers are engaged in private practice as well as either hospital or community clinic practice. Only 10% do not have private practices and work only at either a hospital or a clinic. They have been in practice an average of fifteen years.

Although all providers attested to having had a "fairly decent" amount of experience treating Haitians, they found it difficult to approximate the percentage of their patient population that is Haitian. They were better able to approximate the overall percentage of their practice that consists of minorities (including Haitians); this was an average of 60%. All were able to report specific details of some of their experiences treating Haitians.

Procedures and Data Collection Instruments

The majority of data from this study were collected over a period of one year from January 1998 through December 1998. However, some data were also collected prior to and subsequent to 1998. This is especially the case for data collected by participant observation, which has been more of a continuous practice. As noted above, during the period of data collection, I increased my presence in heavily populated Haitian neighborhoods. Because Haitians in general in one way or another try to maintain a certain connection with their Haitian culture, frequenting Haitian places such as restaurants, clubs, stores, churches, etc., gave me the opportunity to make contact with a fairly good cross-section of the Haitian community of New York City.

I also visited several hospitals, medical offices, and clinics in New York City, both Haitian and non-Haitian establishments. My visits were generally to observe the activities occurring in these places, with a focus on doctor-patient interactions. In some instances, my visits were scheduled. In others, my presence was the result of going to the facility either to obtain services for myself or to visit or to accompany someone. One of my most memorable interviews with a white American medical provider occurred at a popular private hospital during a fairly busy time of day. The provider I was interviewing, a department director, introduced me to a number of key individuals and told them about my study. However, the hospital was so busy that I doubt if my presence had any effect on the staff's behavior or on the way business was conducted. This was a good learning experience for me, much different from my experience as a professional working at another hospital.

The Referral of Haitian Patients

The approval obtained from the Graduate Center Human Subject Committee came with a time limit to complete the interviews. The process of making contact with Haitian patients and the providers presented its own challenges.

Most of the patient participants, whether referred to me or who became aware of the study through the flyers, had to be telephoned. Even those interested individuals who had noticed the flyers at a facility or had been given flyers would not call me themselves. They preferred to give their names and telephone numbers to either a staff member in the facility where the flyer had been seen or to the person who had given them the flyers. I, along with other Haitians who were assisting me in the recruitment process, understood that this phenomenon was “typical of Haitians.” The common explanation is that, “Haitians are very proud people. If you need their help, you should take the first step to contact them.” This is especially true for something like a study that is not considered an emergency, and does not directly involve the individual’s welfare.

Thus, except for participants gathered via my own solicitation, referred participants were all contacted via telephone and were provided details of the study. The participants were screened for appropriateness and that they met the criteria for participation, and were informed of their rights should they choose to participate. They were made aware of the consent they were to sign, and of the free raffle they would be eligible to enter as a reward for participating in the study. Entering the raffle was optional, as I am aware that some people, due to personal or religious beliefs, do not

participate in raffles. The raffle prizes were not disclosed to the participants during the recruitment process.

Some individuals initially expressed reservations about participating in the study, echoing familiar comments such as, “Haitians are black immigrants; they don’t rate and why should the white folks change their behavior towards them?” They would ask me to call them back in “a couple of weeks,” which often extended to even longer periods of time.

For the most part, once someone had finally agreed to participate in the study and an interview date and time were scheduled, participants were generally compliant in keeping their appointments. To increase compliance, participants were offered their choice of place to hold the interview as well as date and time. Most participants preferred to be interviewed in their homes.

Most of the patient participants appreciated the raffle held after all interviews were completed. They complimented me for undertaking “something good,” and told me a raffle was unnecessary. They were more interested in obtaining my business card for future contact for assistance. Once while soliciting participants in a popular Haitian neighborhood, I found myself surrounded by people seeking my assistance with problems they or a relative or a friend were having in negotiating the health care and social service systems. Through follow-up contacts and referrals, I was able to provide them with the requested services.

The Referral of American and Haitian Providers

Contacting the providers interviewed for this study required an enormous amount of follow-up telephone calls, patience, and flexibility. Providers recommended to me as well as those from my own contacts were mailed letters introducing them to the study. I also included telephone numbers where I could be reached for questions and to set up interviews. Very few providers telephoned me. Those who did not respond to my letter were telephoned by me. To actually speak with a provider required several telephone calls, as the providers were often busy and unavailable.

Most of the providers who were recommended to me had been briefed on the subject matter of the study by the people who did the recommending, and thus to some extent they had agreed to be contacted for the interview. Others requested time to “think” about participating in the study. I had great difficulty recruiting providers, especially white American providers. Some who initially had agreed to be interviewed later declined, sometimes citing the sensitive nature of the research project and the use of recording devices. One white American asked, “Am I going to hear my voice on television one day?”

Difficulties Encountered During the Research

The major difficulty I encountered during the research process was the reluctance of participants to be interviewed and to allow the interviews to be recorded. There appears to be a pervasive atmosphere of fear of recording devices in our society. This was noted with all participants, especially with the white American providers. During initial interviews, I noted that the participants in general were much more

verbal, spontaneous and open, and provided somewhat richer details during the informal, untaped discussions that preceded and followed the interviews. It became necessary for me to give participants the option of not having any audio recording device used.

With the exception of two initial interviews, one with a white American woman physician who welcomed the use of a recorder, all of the other providers (both Haitian and white American) opted for me not to use any recording devices during the interviews. However, they were willing to give me extra time so that extensive notes could be taken. The physician who permitted me to use a tape recorder appeared quite comfortable during the interview. She was talkative, and commented that the use of a recording device was not a concern to her as the information she was giving me during the interview “was facts and [her] opinions as [she] viewed things.”

The Haitian patient participants all agreed to the use of a recording device and note taking once they were made fully aware of the purposes of the study. However, I did note that discussions (unrecorded) after the interviews usually provided additional data. Participants, both patients and providers, were offered their choice of interview location. The majority of Haitian providers and patients preferred to be interviewed in their homes. Others preferred their places of work. One Haitian patient asked that she be interviewed in my car, which was done.

Scheduling interviews with medical providers presented the greatest challenge. Appointments were often scheduled weeks in advance, only to be rescheduled, some several times. The utmost flexibility and patience were needed in attempting to

interview the medical providers. This entailed being available 7 days a week, day and night. It also required that I travel to whatever site requested for the interviews, whether it be the provider's home, office, or hospital. Some providers, although they work in one of the boroughs of New York City, have their residences in the outer suburbs.

For all that I recognized the realities of the busy schedules of health care providers, at times I felt an underlying resistance was operating to produce the constant rescheduling of appointments. After many unsuccessful attempts at scheduling firm interview times and dates, and against my wishes, it became necessary for me to interview two white providers over the telephone. This was at their request, as both felt their busy schedules would not allow for a face-to-face interview. All these obstacles certainly interfered with attempts to expand the sample size of providers.

However, ironically, those providers interviewed over the telephone were even more revealing of their feelings about the central issue of the study than providers interviewed face to face. The telephone interviewees were candid about their views on treating certain patients, and of the "system" in which they are required to practice.

The Interviews

The semi-structured interview format was quite valuable for this research, as it complemented the data I had collected via participant observation. The questionnaires for the interviews were designed specifically for this study and consisted of open-ended questions generally used as a guide to elicit information from the interviewees.

Generally, the questionnaires asked for information about: (1) the personal experiences

of Haitian patients in seeking and receiving medical and mental health care from white American providers; (2) the professional experiences of white American medical and mental health providers in servicing Haitians and other minority and ethnic groups in New York City; and (3) the professional experiences of Haitian medical and mental health providers in servicing Haitians and non-Haitians.

The Haitian patients were not asked about their health status, and from the onset were encouraged to keep such information confidential from the interviewer.

Nonetheless, despite repeated reminders throughout the interviews, some people did volunteer particulars about their health, usually to better explain a concern or an issue. In general, those who volunteered information about their own health were among the most verbal and the most critical of providers of services and of the health care system.

The questionnaires used for both the Haitian patients and the Haitian providers consisted of approximately 25 items. The initial items in all the questionnaires dealt with background, demographic information. Haitian patients were asked to specify age category, occupation, income bracket, number of people in the household, and length of time living in New York City. Haitian providers were asked to specify age category, professional specialty, licensing and training, number of years practicing in New York City, location of practice, and nature of patient population. These initial items were followed by specific open-ended questions designed to elicit more sharing of information and the expression of feelings by the interviewees.

The questionnaires given to the white American providers followed a similar style of initial inquiry as discussed above for the Haitian providers. However, these

questionnaires were longer than the others, containing approximately 48 items; some of the items overlapped and were actually sub-sections. Due to the study's subject matter, it was necessary to ask for more detailed information. I was also unsure whether certain information could be volunteered to me. Some of the items discussed included information on professional training, licensing, length of time practicing in New York City, and patient population. In addition, a series of specific items dealt with issues pertaining to servicing particular groups, and specifics on treating Haitians and on peer pressure were explored.

The additional data obtained from the white American providers were crucial in the attempt to better understand professional attitudes and behaviors. For example, professional training and experience provide insight on whether the provider has had limited contact with diverse populations. The question on peer pressure examined the possible existence of peer pressure to conform to a particular attitude were explored.

Before beginning the interviews, I again thoroughly reviewed the study with the participants to give them the opportunity to ask questions. They were informed of their right to refuse to proceed with the interview if they so wished, and also to refuse to answer certain questions. The Informed Consent Form was reviewed with the Haitian patients in English, and in French or Creole if they requested, or if I deemed it necessary to ensure full understanding of the study and of the consent. Consent forms were signed and dated by the Haitian patients before proceeding to the interviews. All interviewees, both patients and providers, were assured complete anonymity. Written interview materials were assigned code numbers as identification.

The interviews were expected to last no longer than one hour. Although most were completed within that time frame, some interviews with Haitian patients and with providers were longer than an hour. Some interviewees deviated to other topics and issues during the interview, especially those participants with strong opinions about an issue. Interviews done at the provider's workplace and at patients' homes were also liable to interruption. Work related activities and home activities at times distracted the interview process. Nonetheless, one positive result of workplace interviews was the opportunity to observe work-related activities and to see the providers "in action" as it were. In one instance, an example of a concern shared by a provider was actually observed.

Interestingly, several of the Haitian women patients were joined by their spouses or boyfriends during the course of the interviews, and the men then contributed in answering questions. However, none of the male partners would agree to be interviewed for the study. This "protective/controlling" behavior on the part of male partners is an essential part of the male ethos for many Haitians.

Detailed notes were taken at all interviews, even more detailed ones at those interviews not tape recorded. Those interviewees who did not want audio recordings to be made were forewarned that the interviews might take longer than planned due to the time consumed in handwriting notes. The participants were understanding and had no problem with it. In fact, after displaying some initial reservations, most interviewees were quite cooperative during the interviews, some pleasant and others quite animated in sharing their feelings. In several interviews involving white American providers and

Haitian patients, I had difficulty terminating the interview as the interviewees were deeply engaged and were apparently using the interview as an outlet for expressing emotionally charged feelings about the “health care system.”

Among the most memorable interviews were some with Haitian patients who are not part of the upper classes. They described their struggles in attempting to provide a better life for themselves and for their families. They shared some of their accomplishments, such as purchasing a house or a car, and were especially proud of the educational and professional achievements of their children. I was shown graduation pictures and awards. One individual insisted on showing me art work done by his son, a college graduate who is now employed as a professional artist.

The above noted interviews were supplemented with informal, unrecorded interviews with other professionals—e.g., nurses, physician assistants, social workers, dietitians—working in the health care field in New York City. These professionals were both Haitians and members of other racial and ethnic groups, who often witness the doctor-patient dynamic at work. Their perspectives were useful and enriching.

Participant Observation

Some of the data analyzed in this study comes from my own personal and professional experience as a Haitian-American social work supervisor and psychotherapist who has been working at a New York City hospital and at a community mental health clinic for more than 15 years.

Participant observation was conducted in four New York City hospitals, three private and one municipal. Most of the data for this study, however, was gathered

during my participant observation as a member of treatment teams at a municipal hospital as well as a community mental health clinic, both located in New York City. I also participated in numerous team case discussions. These are forums in which team members—physicians, physician assistants, nurses, social workers, and psychologists—express their concerns about patients under the team's care, and discuss any issues which may have arisen.

My colleagues at both institutions were aware of my doctoral studies and my general interest in the subject matter of this study. They were, however, unaware of my specific study and that I was functioning as a participant observer while engaging in my normal work activities. My participation in those arenas provided a unique opportunity to gain first hand knowledge of some of the issues under study.

I did not take notes on my observations every day. Notes, sometimes detailed, were taken only in regard to those situations and events that were deemed of possible value to the research project. The dynamics involved in the provision of medical and mental health care to Haitians and others were observed. I was particularly interested in the nature of services provided to Haitians, carefully observing to see if the providers were culturally sensitive in the way they provide services to Haitians as well as to other ethnic groups. I watched for differences in the way Haitians were treated, examined, and analyzed those differences. I also observed the behaviors of Haitian and non-Haitian patients and looks for elements that might have an impact on treatment and the provider-patient relationship.

Additionally, I looked for evidence of other difficulties Haitians experience in the orthodox medical and mental health system. This includes observing the health care practices of Haitians. For example, what do they do before using the medical and mental health services? What are the effects of the Haitian culture on their health care practices and how do they reconcile traditional ways of dealing with illness with the use of the orthodox medical system.

While the nature of my regular employment affords me prolonged access to and involvement with medical and mental health settings, I am also cognizant of what Lofland and Lofland (1984) call the drawbacks that come with such advantage. The Loflands caution the researcher against being overconfident in a known setting, and of being too close to that setting, something which they contend can interfere with objective analysis of data gathered through the close relationship.

I am also aware that as a Haitian-American, there exists the danger of overidentifying with the Haitian participants in the study. Lofland and Lofland (1984) recommend seeking mechanisms for distancing oneself in such a situation. However, being Haitian-American and a member of the team that provides services to a variety of patients of different races and ethnicity, including Haitians, I am in a particularly good position, one where I am exposed to the concerns of both the health providers and the patients. Furthermore, I trust that my professional training, as a social worker and as a psychotherapist, have prepared me well to obtain the necessary psychological distance in order to fairly and appropriately evaluate and analyze what is observed.

Finally, medical and mental health providers, both Haitian and white Americans, have often admitted to me that they sometimes feel as if they are in competition with alternative healers. Thus in order to better understand the use of alternative medicine among Haitians, I embarked on an experience that was totally foreign to my upbringing. I had consultations with a female Haitian herbalist and a male folk healer, both practicing in the New York City area. Members of the Haitian community advised me not to let the alternative healers know of my study, as they are known to be very secretive about their practices and usually do not share information with others. However, in seeking treatment for a condition that I actually have, I actively participated in the consultation process and to some extent did follow the recommended regimens. The regimens included purchasing certain herbs and other items for the preparation of a concoction to be consumed daily, this compounded by frequent paid “visits” to the healer. My involvement with the alternative medicine healers was brief due to financial limitations; the fees charged by the healers as well as the price of the items to be purchased made continuing prohibitively expensive.

Data Analysis

The main hypothesis of this study is that the dynamics involved in the relationship between Haitian patients and white American health care providers appear at times to be negatively different from the dynamics observed between these providers and other non-Haitian patients. There was “something,” a certain *je ne sais quoi*, that made the relationship different. My goal and the research question was to uncover what that “something” was.

Interviews with Haitian patients provided first-hand accounts of their experience in seeking health care in New York City. The purpose of the interviews with the patients was not to inquire in particular about bad experiences per se with white American providers, but rather to hear about their overall experience, good and bad. In addition, I wanted to understand what was different about the experiences described as good and those described as bad. That is, what was different about the interaction between patient and provider, and why the patient characterized an experience as positive or negative.

The purpose of my interviews with white American providers was similarly to obtain some insight on the providers' perspective on treating Haitians and other ethnic groups and minorities. I also wanted to learn if the providers perceived themselves as behaving differently when treating Haitians, and if so, why it was. Further, I wanted to explore with the providers those factors that might affect their behaviors and attitudes.

Being in the distinctive position as Haitian providers working in the American health care system and colleagues of white American providers, Haitian health care providers were interviewed so I might gain some knowledge of how they perceive the interaction between Haitian patients and white American health care providers. I also wanted to gain some understanding of the nature of the Haitian health care providers' relationship with Haitian patients, as well as to determine if the Haitian providers saw that relationship as much different from the one between Haitian patients and white American providers.

Informal interviews with other health care professional supplemented and enriched my data source. As a learning tool, I was eager to garner from all participants, the Haitian patients and the providers, suggestions about cooperative efforts on the part of patients and of providers that might assist in improving the provider-patient relationship.

The participant observation portion of the research afforded me the opportunity to observe both American and Haitian health care providers, and the Haitian patients, “in action.” It also provided an environment in which I was exposed directly to some of the issues and concerns raised by the interviewees.

Data Recording and Coding Systems

The data for this study were recorded using the combination of a computer, a tape recorder, notes, files, and index cards. I made folders for each of the interviewees, both providers and patients, and categorized them. For example, data from female and male patients were kept in separate categories in order to facilitate comparison of male and female experience in seeking health care in New York City. I further divided the files into subcategories—those with medical insurance coverage and those without—again to make comparisons of the experiences of the patients. A similar pattern of categorizing was done with data derived from providers.

All interviewees, patients and providers, were identified by codes I created. The written and recorded interviews identified participants only by the given code. A separate file kept elsewhere contained the participants’ codes with corresponding actual names, addresses, and telephone numbers. This was developed due to the

overwhelming interest participants, both providers and patients, expressed in a desire to be notified of the outcome of the study.

My reflections on the interviews were documented in notes taken during each interview as well as on the tape recording (if the interview had been recorded). I also recorded on index cards those things that had stood out during the interview, and that I wanted to record lest they be forgotten. I carried index cards to work with me, so I might jot down anything I felt was important. These *jotted notes* (Lofland & Lofland, 1984) were later used to write more extensive notes on my observations. I find the use of index cards very helpful as they are simple to carry, to be grouped, and to be reviewed. In addition, following Strauss and Corbin (1990), I labeled those observed behavior patterns that were representative of a phenomenon or an idea. For example, following interviews with Haitian patients, some of the labels used were “poor treatment,” “not listening,” and “humiliation.”

The use of the above mechanisms enabled me to use what Strauss and Corbin (1990) refer to as *open coding*, the examination and categorization of the data. Through this process I was able to connect ideas and note trends shared by the interviewees. This further assisted me in developing concepts and a plausible answer to the central question: “What is that something that exists in the interaction between Haitian patients and white American health care providers?”

Chapter V

FINDINGS

Illness Behavior of Haitians Living in New York City

Intraethnic Variations

No ethnic group is ever absolutely homogeneous. Intragroup differences are common and add to the richness and complexity of human life. A variety of factors affect the way ethnic groups function within a multi-ethnic society such as the United States. A certain degree of acculturation and assimilation will inevitably occur when an ethnic group exists within a dominant culture. Some members of an ethnic group will adjust their own cultural traditions to those of the dominant culture in which they are living. Others will integrate themselves into the dominant culture and assume the beliefs, values, and norms of that culture. These processes also influence the illness behavior of ethnic groups within a dominant culture or society. As with other ethnic communities in New York City, these processes help determine the illness behavior of Haitians.

The literature informs us that variations in health and illness behavior exist not only between societies and ethnic groups, but also within subgroups of societies, such as socioeconomic classes (Kosa & Zola, 1975; Mechanic, 1985; Helman, 1984; Kato & Mann, 1996). Health and illness behaviors, while susceptible to other influences, are

for the most part learned behavior patterns. They are shared and transmitted among cultures and groups, forming an integral part of group identity and how it functions.

As with other ethnic groups, variations in behavior exist among Haitians living in New York City, as is true of Haitians living in Haiti. The more than 7 million Haitians living in Haiti do not all behave alike; as within any other group, individual differences are prevalent. It is possible, however, to generalize to a degree about the behavior of the majority of the population. At the same time, it can also be expected that differences will be noted in health beliefs and practices.

Haitians immigrants from the more rural and less developed areas of Haiti tend to display more of the traditional Haitian health behaviors than those from the more urban areas, such as Port-au-Prince, the capital, who have been more exposed to the western ideology of health and illness and tend to differ in their health and illness beliefs and practices. This does not mean that no urbanites share traditional health beliefs with those from rural areas, nor does this say that certain traditional beliefs and behaviors are not preserved, and practiced, by urbanites.

Among Haitians residing in New York City, variation is observed in illness beliefs, response to illness, and utilization of western medical services. These differences are noted most clearly between the socioeconomic levels: those of lower socioeconomic status are more likely to adhere to traditional Haitian health beliefs than those of upper socioeconomic status. The effect of socioeconomic status appears to be a function of the fact that Haitian immigrants from the less developed areas of that country, due to certain disadvantages and lack of opportunity (minimal education, lack

of marketable skills, limited social contacts), tend to be in the lower socioeconomic strata of Haitians in New York City. They make up the majority of the approximately five hundred thousand Haitians living in New York City (NYC Dept. of City Planning, 1996).

The observation of behavioral variations within ethnic groups has aroused interest among social scientists. Harwood (1981) has suggested that in studying the illness behavior of ethnic groups within a dominant culture, it is important to realize intraethnic variations in health behaviors exist. He further notes that the primary sources of variation to be acculturation and socioeconomic class differentiation within each ethnic group. While the effect of these factors was quite evident in my research sample, what was also noted is that with some Haitians (and this probably would be noted with other groups) the degree of acculturation as well as socioeconomic status does not always determine illness behavior. There are Haitians who in every other area of their lives are fully acculturated into the “American way of life,” yet despite high socioeconomic status, when ill they merge traditional Haitian health beliefs and practices with Western beliefs and practices. This is another confirmation of the puissance of culture and that it can transcend variables such as socioeconomic class.

Deye Morne Gen Morne (Behind Mountains are Mountains)

In his analysis of ethnicity and illness behavior, Twaddle (1979) emphasized the effect of the ethnic group's world view on behavioral decisions related to sickness. Indeed, the Haitian world view—that is, their perceptions of the world—is a powerful factor that must always be considered when examining specific behaviors of Haitians.

No place is this concept more evident than in the illness beliefs and behaviors of Haitians.

In general, Haitians tend to believe that one should be suspicious of the world and that people cannot be trusted (this has historical and political implications dating from slavery in Haiti to the dictatorial government regimes Haitians have endured). They also believe there are "unexplainable happenings and people" in this world. The popular Haitian creole proverb *Deye morne gen morne* ("behind the mountains are mountains") is a proverb that holds meanings of great depth for Haitians. The underlying idea is that if one believes one is powerful, there are others who are even more powerful, thus "behind these mountains there are even bigger mountains." (Mountains have strong symbolic significance to Haitians, as Haiti is very mountainous.)

The need to explain the cause of illness, scientifically or otherwise, is common to most cultures and societies. Deriving the cause of an illness can provide individuals with a certain sense of control over their bodies, as well as giving meaning to the experience of being ill. It also makes possible the creation of "treatment" for the ailment and brings forth "preventive measures" to maintain the body in its normal, healthy state.

Most cultures have their own lay theories of the origin of illness. Helman (1984) noted that within lay theories of illness there are "sites of illness aetiology." The first is that the cause of an illness can be located within the individual who is ill as a result of a breakdown in that individual's body. Often the breakdown is attributed to

the individual's own behavior, such as not caring for oneself properly through poor diet or inappropriate lifestyle (such as heavy drinking and smoking). Secondly, the cause of illness may be attributed to the natural world. Helman (1984) notes that this includes the physical environment and weather conditions, for example, the belief that colds are caused by cold weather. The social world may also be seen as the source of illness. Helman contends that in non-Western societies, blaming the social world—that is, blaming other people for an illness through their use of witchcraft or sorcery—is quite common. The last of Helman's "sites of illness aetiology" is the supernatural world, which he also notes is more common in non-Western societies. Illness here is believed to be caused by supernatural forces such as gods or spirits, and is usually perceived as a form of punishment for some misdeed. Helman does point out that lay theories of causes of illness may be "multi-causal"; individuals in a culture may link various causes together, so that an illness can originate from more than one cause. Even more interestingly, Helman notes that within any culture, differences may exist between people in their explanations of an illness. Thus, for example, in the same culture, some people may attribute an illness to natural causes and others to the malevolence of supernatural beings. This sort of intracultural differentiation is also noted among Haitians.

For most Haitians, illness is typically seen as being of either supernatural or natural origin. This was strongly confirmed in the interviews with Haitian providers. As one provider noted, "In general, Haitians believe they are not supposed to be sick. If they are, they think it is because someone did something to them, like a spell."

Another Haitian provider stated, "Haitians are always looking for an explanation for an illness, even some individuals you would think should know better, like the educated ones."

Illnesses believed to be of supernatural origin are thought to be caused by angry spirits or by a spell placed on an individual. For such illnesses, a voodoo priest is usually sought for assistance, and rituals are performed to eliminate the illness. Voodoo is often used by Haitians as both a religion and as a medical system (Laguerre, 1984). Supernatural illnesses differ from natural illnesses in that supernatural illnesses are believed to appear unexpectedly, usually without any previous symptoms, whereas natural illnesses are believed to be shorter in duration, with "specifically perceived causes." Mental disorders are often considered supernatural in origin, but ailments such as the common cold, indigestion, and "gas" (*gaz*) are believed to be of natural origin.

Laguerre noted "natural and supernatural illnesses have their own modalities and singular features that allow for their diagnosis" (Laguerre, 1984: 124). Nonetheless, the process by which illnesses are defined as being of either supernatural or natural origin can seem somewhat ambiguous. For some individuals, this may involve taking inventory of one's (and one's family's) life situation (whether the individual and/or his or her family may be targets of malevolence), and the individual and his/her family's involvements in spirits and other belief systems. Illnesses initially thought to be of natural origin may later be determined to be caused by supernatural forces, especially if the illness persists after numerous attempts at treatment and also upon evaluation of one's life situation.

Hidden Beliefs and Practices

Social scientists have learned that getting close to individuals being studied and gaining their trust to have even some basic information disclosed can be quite difficult. Wax (1971) informs us of the importance of taking time to develop “mutual trust” with the people being studied. Most individuals are naturally protective of their privacy, which must be respected by the researcher. Ethnic groups within a dominant society often feel the added necessity of protecting their cultural identities and see “impinging” on certain aspects of their lives as threatening. This may be especially crucial to a group if the area under investigation is one in which the risk of misunderstanding and insensitivity is high, such as in this research inquiry on illness beliefs and practices.

It was not surprising that most of the Haitian patients interviewed were reluctant to discuss their views on illnesses believed to be of supernatural origin. Some made comments such as, “I don’t really deal with such things;” others commented that, “Let’s leave that aside, let’s not talk about it.” The discomfort observed among the interviewees when discussing the supernatural was further displayed by their vague comments interspersed with proverbs and humor. Repeated comments were: “*Le mal existe*” (evil exists), “*Aysien Konnen*” (Haitians know a lot), and “*Aysien fô*” (Haitians are powerful).

One person’s comment exemplifies the overall sentiments about the supernatural as source of illness: “All Haitians believe that there are some *maladi* which are of supernatural origin, but these are not things people talk about. These are private matters.” Such beliefs are usually discussed only with relatives and close friends. They

may sometimes be shared with the Haitian physician, if his/her assistance has been sought conjointly with that of an alternative healer.

One of the reasons for keeping such discussions private is the idea of not “publicizing one’s personal affairs.” The ramifications of others finding out that an individual’s illness is believed to be supernatural in origin can lead to comments by others in the community asking, “What did this person do?” and other speculations about the individual. In addition, Haitians do not want others to know of their sufferings and misfortunes.

Another reason for the reluctance to discuss ailments believed to be of supernatural origin is the matter of “impression.” Such discussions are often associated with primitive thoughts and behaviors, as well as with a lack of education and sophistication. Being a Haitian researcher was no advantage to me in this case, as the Haitian patients may have been concerned about my impression of them, with me being a Haitian in their own community.

Haitian patients from the highest socioeconomic strata were even more reluctant to talk about supernatural beliefs. Some appeared to be offended by my inquiring for their opinions. Comments such as, “I know nothing about these things; I don’t get involved in these things,” “I have good medical insurance and I go to the doctor when I am sick,” were common. Acknowledging a belief that illness may be of supernatural origin might also be seen as being inconsistent with their educational and socioeconomic statuses, and that to be sophisticated and acculturated to the western world is to have “rid” oneself of such belief. Within the New York Haitian

community, the comment was often echoed by Haitians of higher socioeconomic status: “Haitians must leave these beliefs behind, act civilized, and move on.” Likewise, those respondents who are of a lower socioeconomic stratum may want to show they are not as “primitive” in their beliefs as others may assume, and that they too have grown and moved on to the western way of thinking.

The participants were more willing to share their opinions when specific questions were asked about treatment practices for illness in general. However, it became clear that it was difficult for them to discuss treatment of illness without implicitly admitting that illness have different origins, including the supernatural. Many of the participants, across all socioeconomic levels, commented that how they would treat an illness depended on the nature of that illness. A few individuals made the comment: “*Gen maladi ki pa maladi doctè*” (there are illnesses which are not within the domain of the doctor), implying that there are illnesses beyond conventional medical intervention and which cannot be treated by a regular physician. When I asked for further clarification, I was told, “You are Haitian; you know what I mean.”

Although none of the participants admitted directly to having utilized the services of an alternative healer such as a folk healer or voodoo priest, some made comments to the effect that: “When someone becomes ill unexpectedly with unexplainable causes, one must seek to find the reason (*chache konnen*).” This comment usually implies that the illness is suspected to be of supernatural origin and that one must look beyond traditional science and medicine for its explanation and treatment. Although the quoted comments came from participants near the lower end of

the socioeconomic spectrum, some participants from the upper levels have admitted knowing people close to them who believe in the *chache konnen*, that is, finding reasons for an illness. These respondents seemed to see this attitude as a rarity among their entourage. On the other hand, most Haitians from the lower socioeconomic strata believe that most Haitians use alternative medicine, regardless of “how much money and education they have.” As one participant commented, “Us Haitians, we always like to do our own thing.”

Interestingly, interviewees from the middle and upper strata readily stated that Haitians from the lower socioeconomic levels (people from the countryside, as they are referred to) routinely use alternative healing practices, and that “these folks believe in their folk healers and voodoo priests.” Although it was obvious that these interviewees wanted to show their distance from alternative healing practices, the reality is that many of them do use alternative healers, albeit perhaps not as frequently as those in the lower socioeconomic strata. As noted above, many of the newer Haitian immigrants to New York are from the lower socioeconomic strata. They are more attached to their cultural traditions, they have limited marketable skills, and may have fewer opportunities, financially and otherwise, to seek conventional medical care.

Ironically, admitting to the use of alternative healing practices such as folk healers and voodoo priests seems to be a taboo among Haitians, this despite the fact that their use is well known, not only within the Haitian community but outside of the community. Many of the interviewees appeared quite comfortable sharing the experiences of “others” with alternative healing practices. At times the extent of the

details provided to me by the participants aroused my suspicions that the experiences might very well be their own. My interviews with Haitian medical providers confirmed my suspicions, as most of the providers reported that many of their Haitian patients, across socioeconomic levels, had admitted their use of alternative medicine.

Understanding who Haitians are as a people can shed some light on the secrecy as well as the difficulties surrounding healing practices. Brodwin (1996) notes that for Haitians, the decision to seek a remedy for illness from either a folk healer or a voodoo priest often presents a moral and ethical dilemma, as use of these “healers” may conflict with their own spiritual and moral values. The majority of Haitians are Roman Catholics, and many Haitians believe it is contradictory to be Catholic and deal with voodooism, as “they don’t share the same concept of God.” Likewise, some individuals believe that to be “morally right” one should not be involved with voodooism, which traditionally has been associated with “the bad and the evil,” again unlike the “goodness and brotherhood” connected with Catholicism.

The Hot, the Cold, and the *Gaz*

As previously noted by Helman (1984), within “lay theories of illness causation,” an abnormality within an individual’s body can be viewed as a cause of illness. This places some of the responsibility for illness on the individual, as he is believed to contribute to his illness through improper care of the body. If the illness is hereditary or the result of normal body breakdown due to aging, the individual is excluded from responsibility.

Within the Haitian culture, illnesses of natural causes are believed to be derived from a variety of abnormalities within the body. The more natural illnesses are believed to be the result of disorder in the blood. The condition of the blood and beliefs about it are central to the Haitian folk concept of illness (Laguerre, 1984). Blood is believed to have the properties of being "cold, hot, weak, thin, thick, dirty, dark or yellow" (Laguerre, 1984:119). The blood monitors the cold/hot state of the body. Illnesses accordingly are ascribed to certain conditions of the blood. Laguerre (1984) gives the examples of a high fever being thought of as the result of hot blood, and physical or mental weakness believed to be caused by thick blood. Certain foods are usually consumed to bring the state of the blood to "normality." When the blood is perceived to be weak, one is advised to eat items from the red food group or other "fortifying foods."

For some Haitians, illnesses of natural origin are also believed to be the result of the body's exposure to hot and cold elements. Illnesses connected to hot/cold factors of the body are exemplified by the Haitian belief that ailments such as headaches are caused by an increased amount of heat and blood in the head, and thus can be relieved by taking a "cold" remedy to lower the heat and decrease the quantity of blood. These etiological beliefs about illnesses, the hot/cold factors as well as the concept of irregularities of the blood bear a resemblance to the similar traditional Chinese idea that illness is related to a lack of balance between the *Yin* (the female element) and the *Yang* (the male element) (Tseng & McDermott, 1981; Twaddle, 1979).

The belief that illnesses can be connected to hot/cold factors of the body strongly influences the general behavior of Haitians. It also proscribes certain activities, and places restrictions on the consumption of certain foods. Various food groups are classified as either "hot" or "cold." Some foods, depending on whether categorized as hot or cold, are to be avoided when engaging in certain activities. For example, it is considered inadvisable to eat fruits such as pineapple or orange after engaging in physical activities such as walking and rope jumping. These fruits are considered to be "cold foods" that may induce shock to the body, thus placing the body in a state of disequilibrium. During an interview with a Haitian patient, he asked me if I had had a long walk to his home, before offering me some juice. He proceeded to say, "I don't want the juice to get you sick." When I declined the offer, in a humorous manner he said to me, "You are probably an Americanized Haitian; you probably don't believe in these things."

Likewise, people are advised not to open a refrigerator, go out in cool air, or take a cool shower after ironing clothes, for fear that the body's exposure to cold after long exposure to the heat from the iron will be a catalyst to developing a cold or even pneumonia.

Laguerre (1984) notes that for Haitians some illnesses are also believed to be caused by "bone dislocation," and returning the bone to its proper location is necessary for the individual to regain normal health. Treatment for ailments believed to be of this origin and other natural illnesses are often sought from folk healers.

Gaz (gas) is another ailment considered to be of natural origin, and believed to have enormous power. Although the general meaning of *gaz* is similar to the common western definition of gas, for the Haitian *gaz* is the culprit in many illnesses. Gas is believed to be able to move from one part of the body to another, and is considered to be responsible for all types of aches and pains. The concern with *gaz* (gas) is so pervasive within Haitian culture that specific home remedies for gas relief are often found in most Haitian households. For example, it is not unusual for families to stock up on specific herbs and ointments known to be effective in relieving gas pains.

The dynamics observed among individuals when they share their experiences with gas discomforts aptly illustrates the preoccupation some Haitians have with the condition of gas (*gaz*). Gas discomforts are openly shared with relatives and friends, usually communicated with great intensity, in a language commonly understood and with the expectation that sympathy for the sufferer will be displayed, as well as suggestions offered on how best to relieve that particular gas discomfort.

The preoccupation with the “*gaz* phenomenon” was clearly noted even within the small sample of this study. Most of the Haitians interviewed (both patients and providers) offered some comments about gas. Many of the Haitian patients readily shared their experiences “suffering” from gas. They seem to have had the expectation that the researcher had similar gas experiences and understood them. I was told, “You know how it feels when this gas hits you and refuses to leave.”

Despite the importance of *gaz* to Haitians, many of the patients interviewed commented that they rarely share their *gaz* ailments with non-Haitians (doctors

included) for fear of being ridiculed. One patient noted that, “Americans do not know *gaz* the way we do, even the American doctors don’t. When you mention *gaz* pains to them they just ignore you.” One woman said, “I know *gaz* pains are real. Doctors or no one cannot tell me it does not exist. Thank God we have our little remedies to alleviate the pain.”

Unlike the resistance I encountered with the Haitian patients in discussing illnesses believed to be of supernatural origin, discussing *gaz* and ailments related to hot/cold factors, as well as other ailments of natural origin, was a very different experience. Several of the patients interviewed shared their own experiences where they strongly believed that hot/cold factors were involved in the way they felt. One individual admitted that he had “committed an imprudence” by taking a shower after a walk. He insisted that for weeks he did not feel “normal” due to this incident.

Talking about these ailments is not perceived to be as threatening as talking about going to a folk healer or a voodoo priest for treatment of an ailment believed to be of supernatural origin, an action associated with lack of sophistication and rejection of modern medicine. In addition, activities in which individuals engage to treat ailments of natural origin can often be accomplished without “outside intervention,” such as a folk healer. Thus relying on oneself for treatment of an ailment is less stigmatizing and more openly acceptable among Haitians.

Although I had been aware that many Haitians of varied educational and socioeconomic statuses subscribe to the cultural belief origin of illness, hearing the participants express some of their views indeed confirms the power of culture. This

also directs me to believe that perhaps far more Haitians actually subscribe to the traditional cultural beliefs about the origins of illness than the community is lead to believe or is ready to accept.

Vocabularies of Distress

Physical and emotional distress are often verbalized in language that is culture specific. It is a learned vocabulary shared by a culture, conserved and transmitted through generations. Not only is the distress acceptable and understood by the specific culture in which it occurs, but the community's reaction to the distress is also culturally prescribed.

The Haitian vocabulary for expressing distress is of great relevance to issues of illness. The language used to express distress is culturally learned and shared by the group, imbued with its own sets of meaning that may not always coincide with the more western medical language, and may not easily be understood by the non-Haitian. The particular language of distress is utilized across socioeconomic levels, albeit possibly to a greater degree by those in the lower strata. Not only may the Haitian meaning of *gaz* be misunderstood, but an individual complaining of "gas," may indeed be experiencing a much more serious ailment than is being communicated. One of the Haitian patients interviewed shared a story in which he felt his heart attack requiring surgery had been preceded by weeks of "gaz pains" around his upper torso.

Vocabularies of distress form an important component of illness behavior among groups, are often specific to specific cultures, and can affect illness diagnosis and treatment. Mechanic (1978, 1982) and Helman (1982) are among those who have

addressed the ramifications of ethnic groups and distress expression. Psychological and emotional distress are often verbalized in language that is culture specific. All of the Haitian providers interviewed stressed that any non-Haitian provider treating Haitians must at least have some familiarity with Haitians's descriptions of illness, the language used to describe symptoms, and that the provider must ask a lot of questions, preferably open-ended. As one provider reported, "As a Haitian I am constantly learning from my Haitian patients; they have their own names for symptoms and illnesses." Another provider noted, "I always tell my American colleagues to be careful about some of the symptoms they hear from Haitians. I tell them about the Haitian *gaz*, that it is not the same gas they know of."

Haitians in general tend to express psychological distress via somatic symptoms, e.g., headaches, dizziness, abdominal pain, nausea, shortness of breath. *Gaz* may also be verbalized, as well, as "feeling of a load in the head." In fact, for some Haitians, using the word "depression" signifies a condition that goes beyond the more common definition of depression as known in the general population. Depression, for the Haitian, represents a state of total physical depletion characterized by weakness, fatigue, and lack of appetite (Bibb & Casimir, 1996). One particular Haitian patient recounted his experience with depression more as a physical condition than a mental one. He said, "I was not feeling well, I felt I was having a depression. I knew I needed to fortify myself, so I followed a regime of *labouyi bannann*." (*Labouyi bannann* is grated plantains cooked in milk prepared similarly to the way oatmeal is made, and popularly believed to be an energizer.)

Among Haitians, emotional and psychological distress carries great stigma, which can affect not only the individual vis-à-vis his standing in the community, but also that of his family. A common comment is: “Stay away from this family. They are crazy.” Furthermore, the display of such distress is considered a sign of weakness as a human being. Thus it is safer to express symptoms somatically.

Symptoms and the Decision for Treatment

The variables affecting the way in which Haitian Americans perceive, evaluate, and make decisions on natural symptoms depend on the individual's attachment to the traditional Haitian concept of illness discussed above, the frequency of the symptoms, socioeconomic status, and past experience with illness for self and with relatives and friends. Individuals tend to compare their symptoms to those experienced by relatives or friends. Usually, if similarity of the symptoms is noticed, an inference about the nature of the ailment is made, and the individual's symptoms may be discounted as not warranting medical attention. If, however, relatives and friends are believed to have been successful in managing the ailment via certain medications, home remedies, folk healing, etc., similar techniques may be utilized. This is especially true if the remedies are provided by an elder in the family. Haitians are generally strongly influenced by their elders.

The Haitian providers interviewed also believe that many Haitians tend initially to deny the presence of an illness or symptoms. They may even rationalize that the symptoms are not sufficiently severe, that it is nothing to worry about, that it can be managed with home remedies, or simply believe that the symptoms are temporary and

will go away. However, while this rationalization is culturally based (as it is within a cross-section of Haitians), for some it is also connected to the socioeconomic realities many Haitians in New York City face. For many, illness is viewed as a costly inconvenience which they cannot afford to address: taking time off from work to visit a physician, paying for the visit and for medications. One Haitian patient interviewed noted that while she is thankful for the medical coverage provided by her job, sometimes paying the co-payment for an examination means not having enough money for carfare to work, or as she stated in Creole: *“Ti kob mwen fè ya deja byen konte”* (the little money that I earn is well accounted for).

The sharing of remedies as well as medications is a common phenomenon among some Haitians. Herbs or medications not found in New York are sent for from Haiti. Most of the Haitian patients interviewed readily admitted to these practices and seem to believe they are common practices among the majority of Haitians. One patient noted, “I don’t know any Haitian who does not do this. Me, I have a medication that is key to most problems. You can’t get it here in New York. I get it from Haiti but it is made in France.” Although self-diagnosis is not an unusual practice among other groups (Kosa & Zola, 1975), it is a growing concern to Haitian medical providers as they believe this practice has led to people greatly compromising their health. It is often reported that individuals seek medical care only when in a state of crisis, usually when the ailment is in a chronic and advanced stage.

At the same time, there is a fear among some Haitians that if medical care is sought, the doctors will “give you all kinds of illness and will make you sicker than you

are.” Fears of having to change lifestyle and eating habits are also factors adding to the resistance. I was actually surprised at the number of individuals interviewed who expressed skepticism about doctors. There were ambivalent feelings shared about doctors. Doctors were viewed with great respect, but at the same time it was felt that “they are not God . . . they can mess you up also.” Interviewees shared stories of people they knew in Haiti “who ate the same type of food they ate for many years, engaged in activities not considered healthy, like smoking a pipe, living long lives and never developed any illnesses.” The resistance to being told by a physician to make lifestyle changes was quite evident. For some of these individuals, maintaining a particular lifestyle, especially in regard to eating habits, has very deep meaning, a remembrance of their childhoods in Haiti, attachment to their culture, and part of their identity as Haitians.

Interestingly, some individuals do make changes in their lives when “they deemed” necessary. For example, some symptoms are perceived as being in a transient state so that with changes in lifestyle such as better diet, proper rest, good spiritual habits, and regular home remedies, the symptoms will be eliminated. The changes are usually decided by the individual or may be suggested by relatives and friends. A Haitian patient shared that he knows exactly what works for him when he is feeling unwell. He stated, “*Lè kom ba po bon, mwen pran yon douch* (When my body is not well, I take a shower). I let the water flow on my head, and I take a daily regimen of *tiza-n leti* [lettuce infusion] an in no time *mwen anfòm* (I am in good shape).” Similar

stories were shared with great enthusiasm in the belief that these practices do affect the presence of symptoms or ailments.

Haitians' Utilization of the American Medical System

The Socioeconomic Factor

The difficulties and barriers Haitians face with regard to health care are the same that have confronted many individuals in the general population for more than twenty years. Lewis, Fein and Mechanic (1976) describes these barriers as economically based, not having the financial resources to pay for medical care, lack of knowledge of available services, sociocultural attitudes regarding the use of medical care, geographical distance from medical facilities, and inappropriate medical treatment of presented illness.

The consensus of Haitian and non-Haitian medical providers is that Haitian utilization of the orthodox medical and mental health system in New York City has increased. This is predominantly due to a heightened acceptance of orthodox medical care, an increased awareness of available services, greater availability of Haitian medical providers as well as increased accessibility (both financial and geographical) of the services. Some Haitian medical providers lower their fees to accommodate fellow Haitians and others who are unable to afford their regular fees. Many health care facilities have also instituted sliding scale fee systems in which fees paid for service are based on the individual's income and financial situation.

Despite the increased utilization of orthodox medical care, interviews with Haitian and non-Haitian medical providers as well as with Haitian patients indicate that in general, Haitians, regardless of educational or socioeconomic status, usually will at least initially attempt self treatment, if they believe themselves ill. The decision to self treat via methods such as home remedies or folk healers seems to depend a great deal on the perceived severity of the illness. For example, if an individual is severely injured or becomes unconscious, in such instances immediate medical care will be sought.

Socioeconomic status becomes a factor in delaying seeking orthodox medical care once home remedies have failed. Those from the lower socioeconomic strata tend to prolong the use of home remedies and of non-orthodox medical treatment, thus delaying the search for orthodox medical treatment. This can be explained by two major factors. First, many Haitians living in New York City and those in the lower socioeconomic strata are relatively new immigrants. Many of these come from Haiti's peasant class and tend to be more attached to traditional methods of healing, and also tend to adhere to less conventional perceptions of the causes of illness. However, this is not to say that Haitians in the higher socioeconomic strata do not adhere to traditional methods of healing. In addition, being new immigrants, some have not yet been in the United States long enough to have become acculturated into the westernized medical system.

Another factor to be considered is that many Haitians, especially those in the lower socioeconomic strata, tend to lack general education and knowledge of illnesses

and their symptoms. This concern was echoed by the Haitian providers. Another important concern voiced by all of the Haitian providers is the lack of preventive medicine practiced by many Haitians, although most acknowledged awareness of the sociocultural and economic factors involved. Indeed, these latter are crucial, as many Haitians in the lower socioeconomic strata lack the financial resources for medical care, especially since many are part of the working poor, who are either uninsured or poorly insured. Some, while they may have a mediocre coverage for major medical expenses such as hospitalizations, lack coverage for regular office visits, whether medical, dental, or mental health services. A few of the Haitian patients interviewed acknowledged that financial constraints do at times interfere with the decision to seek medical care. One patient shared the following: “Sometimes when I am sick and I know I need to see a doctor, but when you have very little money to buy food and pay rent, there is nothing left to pay a doctor and medications . . . you have to make difficult choices when the money is not enough.”

Choosing a Provider

Once the decision has been made to seek orthodox medical care, depending on accessibility many Haitians will choose to receive services from Haitian medical and mental health providers, while others receive services from non-Haitian providers. In addition to accessibility, another factor playing an important role in the decision to choose a Haitian provider over others is the belief that the Haitian provider already possesses knowledge of the Haitian culture, and thus may better understand the patient.

Facilitation of communication is another factor, especially when English skills are limited. However, the research indicates that among those who are fluent in English, individuals in the lower socioeconomic strata still tend to prefer obtaining services from Haitian providers. This was confirmed by the interviews with Haitian providers. A Haitian patient shared that she is able to communicate fairly well in English and has had no difficulties in the past receiving services from an American provider, but, she stated, “I don’t know. There is something unexplainable and comforting when I see a Haitian doctor . . . you feel free to explain yourself the way you want.” She continued with, “Maybe it is because the Haitian doctor knows my culture . . . he can understand you more when you explain to him what you are feeling, and you can explain things in your native language instead of trying to find English words to explain certain things that may not even exist in English.”

There is also a prevalent impression that the Haitian provider will be more helpful in assisting the patient to better navigate the complex web of the medical system, and will “look out” for the patient. This was echoed by most of the Haitian patients interviewed, even those who are not receiving service from Haitian providers. The Haitian providers appear to have come to accept this responsibility placed upon them. As one Haitian provider commented: “Haitians need so much help and often have no one to help them. Somebody has to do it. I don’t mind at all.”

A Haitian patient recounted her gratitude towards a Haitian doctor at a hospital clinic, who intervened on her behalf and had her laboratory tests done on the same day she saw him, so she would not have to take off additional time from her factory job,

where she is paid only for hours she works. Interestingly enough, as the health care system becomes more competitive, hospitals, clinics, and even private doctors' offices have begun to implement providing the patient with an array of onsite services, in one visit. One reason for this practice is to attract patients, especially those with medical coverage who have options available. Another Haitian patient was quite animated when verbalizing the reason for his preference for seeing a Haitian doctor:

I don't have any medical insurance. If I am not feeling well and want to see a doctor, only a Haitian doctor will accept whatever little money I have in my pocket for the visit. . . . I once was sick. After trying a few remedies at home which were not very helpful, I went to see a Haitian doctor. All I could pay him was \$10.00 which he accepted for the visit, and he even gave me free medication samples. Where else can I go and get such services?

White American providers interviewed said that they have no difficulties with their Haitian patients paying their service fees and state that they normally do not get requests for reduced fees from Haitians. However, they are aware that their Haitian counterparts have encountered difference experiences serving Haitians. A few of the white American providers seem to find this difference in behavior quite amusing, but on a more serious note have asserted that they would and have assisted patients in need with paying for services through mechanisms such as payment plans.

The Haitian providers have expressed the need to maintain a balance in their attempts to assist patients financially. Although they want to be helpful to the genuinely struggling patient, they are cautious not to be taken advantage of. One Haitian provider commented that: “

I know that some of the things some of these- patients do, like coming in late for appointments and not having any money to pay for the visit, they would not dare to do to the American doctor."

This issue was addressed in interviews with Haitian patients. There appears to be a perception among the patients that if they do not pay the white American doctors the fees requested, the quality of care provided may be compromised. This fear of receiving poor services is not a question when they deal with Haitian providers, as the trust the patients bestow upon the Haitian providers is quite strong.

Although the majority of the Haitian patients interviewed receive their medical and mental health services at private doctors' offices or health centers, some of them shared that they also receive care at hospital clinics and, in some cases, emergency rooms. These individuals had very strong opinions about this practice. They said that when experiencing ailments for which they believe a private physician might request further testing, they take it upon themselves to go to a hospital, which they know is equipped to do testing and, most importantly, testing that can be done on the same day as the doctor visit, and under one roof.

Economics may play a role in this practice. The patients interviewed who spoke of it do not have any form of medical coverage. They utilize municipal hospitals where, they informed me, given their low income the usual hospital fees can be greatly reduced, often to a fraction of the original fee. They also mentioned the notion of "one-stop health care," which permits them not to miss too many days from work, where they are paid only for hours actually worked.

Another practice observed among a few of the Haitian patients who receive care from Haitian providers is what I term “the rotation of providers.” Individuals rotate which provider they decide to see based on their own assessments of their ailments and its perceived urgency. One individual commented that “My doctor in Queens is a good doctor, but the one I see in Brooklyn is better with certain conditions.” Another individual commented that “My regular doctor has a busy schedule. Sometimes if I have to wait too long to see him, I go to another Haitian doctor who [*sic.*] I see sometimes.” This practice, again, is seen as “the normal” thing to do. Indeed, the Haitian providers are not very happy about the practice, and have tried to discourage it by educating their patients about the importance of continuity of care with one provider. The medical expense and time consuming effort of such behavior has been addressed by Shumaker, Schron and Ockene (1990).

Some Haitians in the middle and upper classes tend to be reluctant to seek medical care from Haitian providers. The data support the understanding that these particular individuals, who usually carry good medical coverage and are among the more financially stable Haitians living in New York, do not want another Haitian to know about their ailments, their personal affairs, lest their reputations be affected. Although none of the Haitian patients interviewed directly discussed situations to support their feelings, one often hears within the Haitian community that: “These Haitian doctors will put your business out.” This is more of a fear than a reality. Such fears appear to stem from concerns about the reaction of the Haitian community when becoming aware of an individual’s ailment or illness; in other words, there is fear that

the illness might affect the individual and his or her family's standing in the Haitian community. For example, an individual's mental illness can be stigmatizing not only for the individual but also for that individual's family. Families have been labeled "the family of crazies." Likewise, if an individual of high standing in the Haitian community suffer from a chronic illness, he or she may be seen differently in a way that may negatively affect that individual's standing. This is true even when compassion is displayed for the individual, as the individual is perceived as lacking the power or attributes previously had.

None of the few middle- and upper-class Haitian patients interviewed admitted the above concerns were reasons for not seeking care from Haitian providers. However, subtle comments were made, such as "I stay away from Haitian doctors. I don't want people to know my business." When I asked for clarification, they were reluctant to cite any specific reasons. Two individuals vaguely mentioned stories that there were long waits at the offices of Haitian doctors, and they felt that would be a problem for them if they were to consider obtaining services from a Haitian provider. I also suspect the issue of "comfortability" may be a factor in their reluctance to seek medical and mental health care from Haitian providers. Given their socioeconomic status, these same Haitian patients may socialize in the same small circles of Haitians as the providers, making distancing between patient and provider difficult. In the past, I have noticed such situations in the New York Haitian community.

Haitian providers interviewed vehemently dismissed long waits at their offices as the true reason for some Haitians refusing to patronize them. One provider asserted,

“These same patients who complain about long waits, would spend hours in a white doctor’s office without complaining.” The general sentiment among Haitian providers is that the many middle- and upper-class Haitians who prefer to receive services from white American providers may be assuming that the skills and knowledge of white American providers are superior to those of Haitian providers. As one Haitian provider stated, “These Haitians hold on to the old belief that white is always better.”

In addition, it is possible that a Haitian being able to afford an American provider who charges higher fees than a Haitian provider may well serve as a status symbol. This suspicion was supported by some of the comments made during interviews. For example, Haitian patients from the middle and upper classes were somewhat quick to volunteer the names of their white American providers, their specialties, hospital affiliations, office locations, and to make comments such as, “The doctor is not cheap but he is good.”

It is important to note that among these same middle- and upper-class Haitians who normally do not receive care from Haitian providers, consultation with a Haitian provider may be customary. Some Haitian patients mentioned consulting Haitian providers after non-Haitian providers gave them diagnoses and treatment plans that were of concern to them. This practice is seen as normal and “the thing to do.” One patient explained, “I went to a Haitian doctor just to make sure the surgery which was recommended to me was the right way to go.” The reason given for this consultation was that, “American doctors are too quick to cut you.” This behavior is indicative of the ambivalent feelings many Haitians have toward Haitian providers. Perhaps there is

the underlying feeling that the Haitian providers will “look out for them” and that their skills and knowledge are up to par with those of their white American counterparts.

Most Haitian providers interviewed seem to take the above practice in stride. One provider stated, “They come running to us when they do not like what they hear. I don’t let it bother me—I guess this means they still trust our opinions.”

The Haitian Expectation

Whether or not the Haitian patient receives care from a Haitian provider, at one point in time or another, the patient will most likely come in contact with a non-Haitian provider. This can happen when referrals are made to specialists for evaluations or when special tests must be performed. Comments made during the interviews indicate that while the Haitian patient may initially be reluctant to trust the provider and readily disclose information about him- or herself, the expectation remains that the health care provider will cure the ailment for which the individual sought treatment.

Medical providers are expected to be genuinely concerned about the individual's medical condition, not just for his or her money, and to display an appropriate bedside manner. One Haitian provider explained that “Haitians like you to listen to them, be respectful and courteous.” The Haitian providers also believe that Haitian patients appreciate it when the provider shows care, concern, and compassion for the individual's ailment and pains, and attempts sincerely to convey a desire to make the individual feel better. Showing interest in other aspects of the individual's life, such as family and work, are also of value. The Haitian providers emphasized that doing this is beneficial to the process of obtaining cooperation and compliance from the patient, and

ultimately facilitates the work of the provider. Nonetheless, the providers cautioned that some patients believe “doctors should make miracles happen, and see doctors as God.”

Based on interviews with Haitian patients as well as both Haitian and American providers, it appears that Haitians find desirable those medical and mental health providers (Haitian and non-Haitian) who respect their own perceptions of their ailments and do not ridicule the patient’s attempts at self-treatment. What is also appreciated and valued is the provider who is culturally sensitive and displays interest in learning about the patient's culture. There is also fear of non-Haitian medical providers experimenting on the patient and providing inappropriate treatment. Thus, careful explanation to the patient of treatment plans and of any necessary changes in treatment protocol is crucial.

Unlike the common perception, Haitians are interested in being educated about health care matters. Some have responded quite well to that education and have made changes in their lifestyles for the sake of their health. What is clear from the data is that individuals very much want to take part in the process of developing their treatment plans. They do not want just to be told to take certain medications and have certain tests done; the reasons for all of that must be explained to the patient in detail. The patients wish to be spoken *to*, rather than be spoken *at*. The benefit of such joint efforts undoubtedly will have positive effects not only on the doctor-patient relationship, but also on compliance by patients.

The long-term benefits of such “mutual participation” (Friedman & DiMatteo, 1990) have even been measured in terms of its positive effect on patients getting well.

Glanz, Lewis, and Rimer (1997) report increased patient satisfaction when providers regard their relationship with patients in a “partner-like” manner which comprises less criticism on the part of the provider, a warmer approach, and more positive words communicated to the patient, as well as more non-medical, social conversation. All of these, which are known to be of value in dealing with the general patient population, are what was verbalized for Haitians and what Haitians declare to be desirable in both Haitian and non-Haitian providers.

Provider-Patient Relationship

The Intrinsically Problematic Relationship

It is not surprising that according to the data obtained in this study, the provider-patient relationship plays an important role in the quality of care received by the patient. Although some degree of friction is commonly observed in the doctor-patient relations in the general population, the doctor-patient interaction is particularly difficult for those not originally from American culture. Difficulties can be rooted in such issues as differing perceptions of the presented illness or problem, as well as in the patient’s own cultural “language of distress,” which may be difficult for the provider to comprehend. These difficulties often lead to frustration on the parts of both patient and doctor. The patient, being the less powerful member of the dyad, usually suffers the consequences of this friction, as providers may resist making any changes in their attitudes and behaviors to accommodate the patients. Some providers seem to have

the attitude that “the patient is the one who needs my services; I do not need to do anything.”

Freidson (1989), who has written extensively on the issue of doctor-patient relationship, notes that the relationship between doctor and patient is “intrinsically problematic,” and the two parties are always in potential conflict with one another, regardless of cultural and ethnic differences or similarities between the doctor and the patient. Freidson views the source of this conflict as due predominantly to the fact that as a scientifically trained professional, the doctor wishes to apply his or her learned knowledge and skills on the patient, who is seen as just another case, while the patient as the layperson who is personally involved, may feel the need to evaluate and control whatever may affect him or her. Thus, Freidson contends, although doctor and patient may be in agreement with regard to the desire to solve the problem for which the patient is seeking assistance, disagreements can occur in the definition of the problem, that is, in how the problem is perceived. Disagreements are also possible in developing a treatment plan, which may include further testing and medications.

White American medical and mental health providers interviewed for this study shared some of the difficulties they encounter in explaining a diagnosis and treatment process to culturally diverse groups. In cases where the patient and the doctor are from “different worlds,” trying to get a patient to accept and follow up with recommended treatment plans can be a time-consuming challenge. Time was a major factor voiced by most of the American and Haitian providers in the study. The providers seem to feel that in this era of managed care and the demands placed on providers to increase their

productivity, spending a lot of time on any one patient can be a costly practice in which few providers want to be involved. Haitian providers were less concerned about time constraints in their practice than were their American counterparts. Most of the Haitian providers and some of the American providers shared that in general they have learned to be more patient with individuals from different cultures or different socioeconomic and educational levels, because of the benefits they feel they gain in the long run. As one Haitian provider noted: "An extra few minutes spent with a patient can go a long way in the treatment and getting cooperation from the patient." An American provider commented:

I take as long as necessary with each individual patient and deal with productivity and the system after seeing the patient. You just can't think about these things if you want to provide good, quality care to the patient and if you want the patient's cooperation.

The same American provider went on to say:

Once I can show patients that I am interested in their well-being and I am open to learning about their cultures, I am usually successful in obtaining their cooperation in the treatment process.

The Haitian providers believe that as immigrants who have had experiences similar to those of some of the patients they serve, they probably are better equipped to deal with patients from different cultures who may require extra time when they are seen.

Both Haitian and non-Haitian providers voice concern about differences in the perception of illness when dealing with Haitians. This was generally more troublesome to non-Haitian providers. The Haitian providers, being familiar with Haitian culture as members of that community, were better able to balance their scientific knowledge with their patients' reference base. They seem to be able to accomplish this task while

providing the necessary medical intervention, as well as education, to the patient, so the patient might better understand the recommended treatment plan.

While the Haitian providers recognized the importance of health education to the Haitian patient, they overwhelmingly agreed that showing respect for the patient's culture and the patient's own perception of his or her illness are major factors that must be addressed as soon as possible in the pursuit of cooperation and compliance from the patient. In contrast, most of the non-Haitian providers believed that differences in perception of illness between provider and patient can best be remedied by providing health education to people from other cultures, with the ultimate goal that of getting cooperation from the patients when they seek assistance. Change on the part of the provider was considered of only secondary importance.

It is naive to believe that change can occur simply through educating patients, with little effort made by the providers. Freidson (1989) addressed this issue by making the valid point that well-educated, acculturated patients who challenge the physician's knowledge can be more difficult to manage than less educated patients (Freidson, 1989: 24-25). This was indeed echoed by some white American providers. As one provider admitted, "One of my most difficult patients is of my gender. We are both white and Jewish, and have very similar backgrounds." The point made by Friedson is further emphasized by recognizing the enormous influence culture has even on the well-educated members of assorted ethnic groups.

We are seen as black, poor and ignorant:
The American Provider and the Haitian Patient

Some Haitians seem to feel that being Haitian places them at a disadvantage when seeking services from white American providers. They feel that given the low social status of Haitians as a black group from a poor country with a high illiteracy rate, providers automatically see them as ignorant and are apt to dismiss any comments they may make regarding the medical care which they receive. They feel discriminated against and stigmatized. Indeed, Goffman (1963) contends that discrimination is one of many attitudes and actions society can display towards individuals who are stigmatized. This stigmatization has been a great concern for the Haitian American community not only in New York, but also elsewhere in the United States, and has been noted to be a major factor in Haitians' low group esteem.

Stigmatization is particularly damaging to the self esteem of Haitian-American youths, many of whom do not have the coping skills of their elders with which to deal with the pains of stigmatization. Some of these Haitian-American youths, à la Goffman, would struggle to be "non-Haitian," for example by dressing and behaving a certain way, in the attempt to see themselves "in non-stigmatic terms" (Goffman, 1963: 107). The damaging effect of low Haitian prestige on the Haitian American community has also been addressed by Charles (1986), Sutton and Chaney (1987), Lawless (1992), and Basch et al. (1995).

This study's research indicates that it is not uncommon for Haitians living in New York City to experience some form of discrimination at one time or another, in the attempt to seek medical and mental health care. Some Haitians feel that being

black, Haitian, and *malere* (a state of misfortune, usually associated with being poor, used among Haitians), are all determinant factors influencing the nature of their interactions with white American providers. One woman commented, "These white doctors as soon as they hear you're Haitian, they already have an attitude., If we were white, it would not be the same. That is why some Haitian mulattoes try to pass as white, they do not want to be associated with us black Haitians." Nonetheless, some Haitians have reported positive interaction with white American medical and mental health providers. A common thread is the provider who has had increased contact with Haitians, whether as colleagues, neighbors, or even as the employer of domestic workers.

The racism that some Haitians living in New York City have experienced in their encounters with white American medical providers seems to cut across socioeconomic status for Haitians, at least during the initial phase of the contact. This study's research indicates that even Haitians from the higher socioeconomic strata have experienced some degree of racism during encounters with white providers, although the provider's attitude and behavior usually changes in a more positive direction once the individual patient is assumed to be educated and of a higher socioeconomic status than the average Haitian American. A Haitian patient who is an attorney reported, "As soon as the medical staff at the hospital became aware I was an attorney, everyone began to be nice to me. They joked with me and spent time explaining things to me and even apologized for earlier inappropriate behaviors by saying they were busy."

This relationship between patient socioeconomic status and provider attitudes concurs with the findings of many researchers in the social sciences, including Hollingshead and Redlich (1958), Duff and Hollingshead (1968), and Freidson (1989). Their studies reveal that the nature of the doctor-patient relationship is closely linked to the socioeconomic status of the patient. Generally doctors tend to be more understanding, tolerant, and kind to patients from the higher socioeconomic strata. This indeed places Haitians at a double disadvantage: they are a black group, and the majority of Haitians living in New York City are from the lower socioeconomic strata.

The majority of the Haitian patients interviewed for this research agreed that white American medical and mental health providers tend to focus too much on the negative, stereotypic assumptions about Haitians. Some reported that in the past the little interest shown to them during interactions with health care providers were comments about politics and poverty in Haiti. As one woman stated:

Before it was about Baby Doc, then the boat people, the poverty in Haiti and the troops the President sent to Haiti. I know these are important things, but there are a lot of other good things about Haiti and Haitians that people should know about.

The same woman proceeded to share that in a situation where she felt the provider was talking so negatively to her about Haiti, she elected to reveal information about herself to the doctor, saying, "I didn't know what the doctor was implying. I had to tell him that I came to New York by plane to further my education and informed him that I was an employed professional and a tax-paying US citizen." In fact, several of the Haitian patients interviewed have admitted that on some occasions they felt compelled to reveal

information about themselves, their families, and their accomplishments to providers.

As one individual noted:

. . . to set the record straight, because us Haitians we may be poor but we are proud people. Me and my family have known bad times here in New York, but we have never gone on welfare, never, never. I rather spend seven days a week cleaning old ladies or cleaning people's bathrooms than go on welfare.

Some of the patients commented that medical providers seem to place all Haitians in one category: poor, illiterate, practicing voodoo and believing in supernatural causes of illness. There was a shared feeling among the Haitians that as a result of these beliefs, health care providers may lack motivation to provide appropriate health service to Haitians. This is a valid concern for this researcher, who while working in both medical and mental health settings in New York City has observed medical and mental health providers make comments about Haitians such as: "I don't think therapy will be any good for this person. . . . What do they [Haitians] know about therapy; there's no therapy in Haiti" and "These people [Haitians] always think they are sick due to a spell placed on them; it is a waste of time trying to help them." The fact that the patients had been motivated enough to seek assistance from the orthodox medical and mental health systems did not appear to be a consideration for the providers.

Other Haitian professionals interviewed, such as nurses, nutritionists, and social workers, have all reported that at their places of employment (hospitals and clinic), they constantly come to the rescue of Haitians who are being treated unfairly. As one nurse commented:

As a Haitian I feel so bad for the way I see Haitians are sometimes treated. . . . Some of these white doctors have no respect at all for Haitians. They treat Haitians in a degrading way. . . . I have seen some scream at patients. . . . I really think that they believe Haitians are not educated enough to know they are being treated poorly. They don't answer patients' questions and sometimes ignore the patients.

Some Haitian patients have reported observing what may be an underlying resentment on the part of some American providers towards the Haitian patient for questioning a proposed treatment plan and asking certain questions. The providers may be defining this as questioning their own authority. One Haitian patient complained:

These doctors use a lot of medical jargon. They either don't answer your questions or give you a quick answer you don't understand. They don't spend time with you and give you a rush job. I don't know why they have an attitude when you ask them questions. They are not God. It's my body and I need to ask questions.

A non-physician Haitian professional interviewed noted that working in the medical field for many years, she feels the general attitude among some white American providers is that "Haitians should not ask for more than they had in Haiti." She insisted that the institution by which she is employed services a wide variety of racial and ethnically diverse groups, and that she does not observe the same attitude toward other groups. "It's the Haitians they do it to . . . I think it's all related to the bad image about Haitians . . . there is no respect for Haitians." Another patient admitted that after a negative experience with a white American provider, where he had felt the provider showed no interest in listening to his symptoms, it took him approximately a year before seeking assistance from another doctor. The man stated, "I felt what's the use, all these doctors are the same. We Haitians must realize that we are visitors in a white country. We really should not be here. Circumstances brought us here."

Indeed, over and over, what was echoed during interviews with Haitian patients was the lack of compassion and interest shown them regarding their illnesses and discomforts. They were concerned that their complaints were minimized or ridiculed, that diagnoses were made too quickly without adequate evaluation (a few misdiagnoses were reported), that questions were not asked, and that treatment plans not explained properly.

Those Haitian patients who have had positive experiences with white American providers consider themselves “lucky” and that the provider was a “blessing from God.” One individual stated, “I have heard a lot of bad stories Haitians have had with white doctors, but I have been very lucky with all of the white doctors I have had. The good Lord was with me all the way.” In the “good experiences” with white doctors that some patients reported, in general the patients felt that the providers were genuinely concerned about them, even in situations where the patient’s expectation of a cure or treatment for an ailment was not met. One person commented, “The doctor really did his best to help me, even if things did not turn out the way I would have wanted.”

Another patient raved, “The doctor listened to me, asked me questions. He answered my questions and explained to me my diagnosis and the tests to be done.”

Another patient explained:

You just felt the doctor cares. He explained everything to me and asked me if I had any questions for him. He told me about some Haitian food he ate once and said a few words to me in French. He even asked me if I was drinking some tea or doing something else at home for my pains. I really felt good about this doctor and I told him everything.

Most of the patients interviewed acknowledged that they are well aware of the busy schedules the providers have, and that they often have only limited time to spend with any one patient. However, the Haitian patients believe that there is an obvious difference between a doctor being busy, and a patient being poorly and unfairly treated. What they want is equal and fair treatment, or, as one patient explained, “I feel all patients should be treated equally. I don’t want to see a doctor treating another patient well and nice, and be nasty to me and give me poor treatment because I am Haitian.”

In some cases where Haitian patients had positive experiences with white providers and received relief for their discomforts, there was a tendency for the patients to align the providers with God, or as one patient stated, “The Lord was right there side by side with the doctor doing his miracles.” Some providers are even seen by some as the representation of a religious saint such as Saint Gerard, known as a “Doctor Saint” because reportedly he was once a physician.

Another patient who enthusiastically shared his positive experiences with a white male provider said that from the initial encounter with the provider, he knew the provider was “different” from others encountered in the past.

The doctor saw me as a human being. I explained my situation to him, and the doctor told me, “You are a hardworking man. I am going to make you feel better.” That white man spent hours operating on my heart and told me to take it easy. But look at me now. I am well again.”

The man proceeded to say that he had sent for a special gift from Haiti to give to his doctor, and stated, “I will forever be grateful to this doctor. I speak about him all the time and send people to him for help.”

The level of gratitude toward white American doctors Haitians feel when they believe they have received good medical care is quite noteworthy and sometimes even leads the patient to cross the boundary lines between doctor and patient, as the patient begins to see the doctor more as a friend than a physician. In addition to giving the provider gifts, some patients have been known to bring Haitian dishes for the doctor and staff, or to invite the doctors to their homes for some function. For example, if a woman has had a difficult pregnancy, the child may be named after the provider, who is invited to the child's baptism. (This is also done for Haitian providers as well.) The loyalty felt towards the doctor when the patient's experience has been a positive one was commented upon by both white American and Haitian providers. As one white American provider said, "These individuals when they are pleased with your services will talk about it to everyone, will send you patients. They do a better job than a marketing service." Some of the Haitian providers described similar experiences. One Haitian provider said, "These patients trust you and will stay with you for life. They will also send their families and friends to you."

The majority of the Haitian patients interviewed had received services from white American male providers. The few who had experience receiving services from white female providers and who had had experience with both male and female providers, tend to feel that female providers are more attentive and sensitive to their needs, and also mentioned that the female providers were more thorough. Although limited, the experience the Haitian patients had with female providers tends to agree with the overall experience of the general population of patients with providers.

The concern voiced by many of the Haitian patients—that very few American medical and mental health providers show any interest in understanding the Haitians and Haitian culture—is especially important in the practice of mental health, where therapeutic alliance and understanding “where the patient is at” are major factors in the treatment process. A Haitian patient who had received mental health services in the past stated:

In Haiti, I didn't know about therapy, and when they told me I needed it, I said no because I didn't know what it was. No one explained it to me. But one day a black therapist explained to me what therapy was. She understood that Haitians do not like to talk to people about their problems. She was caring enough to convince me to try therapy. I did, and I found it helped me a lot to talk about my problems, my concerns.

It is well documented in the literature that patients are generally unlikely to comply with treatment if they believe the provider of services lacks sensitivity and understanding for who they are as individuals. Serafica, Schwebel, Russell, Isaac, and Myers (1990) noted that to provide mental health services effectively to ethnic minorities, it is crucial that providers understand the values and culture of their patients. The provider's insensitivity and prejudice are further noted by Serafica et al. (1990) as major components in failed treatment processes. Indeed, some Haitians feel that by concentrating on stereotypic beliefs about Haitians, mental health providers fail to recognize their struggles as a group and their accomplishments, as well as their adaptive and cultural strengths.

In addition, Serafica et al. (1990) are critical of the tendency in the United States to measure everything based on the “white American experience.” They contend that the prevalent feeling in our Anglo-American society that reinforces immigrant

adaptation to Anglo beliefs and values would deny immigrant groups, such as Haitians, the right to comfortably preserve their own ethnic identities and cultural values.

Research done by Kato and Mann (1996), Serafica et al. (1990), Patel and Rushefsky (1995), and Lewis, Fein and Mechanic (1976) have consistently supported the idea that the medical delivery system in the United States, implemented and led by upper class whites, may not be designed to adequately serve the medical and mental health needs of ethnic groups and other disadvantaged groups. Thus, the developed system may be set up in an environment that is conducive to failure on the part of the special group in need. Often, this provides the opportunity to criticize the degree of motivation of particular groups—a typical case of “blaming the victim”—rather than placing accountability on the part of those who developed the system. This issue is part of the politics involved in health care which was well addressed in the literature over the past decades (Mechanic, 1974; McKinlay, 1984; Alford, 1975; Lewis et al., 1976; Patel & Rushefsky, 1995).

We are regular people with biases. We were only trained to practice medicine. The Voices of the White American Providers

In general, the white American medical and mental health providers were surprisingly candid during interviews. They acknowledged the existence of differences they see in the way certain groups are treated by their profession and questioned whether more class differences are noted. As one provider noted, “I am not going to lie and tell you differences do not exist. They do. Some people are just determined to behave a certain way.” The providers indicated that medical schools and graduate and

professional schools do not teach their students enough about cultural sensitivity and servicing diverse groups. One provider commented, “We are regular people with biases . . . we were only trained to practice medicine.” Another provider noted, “Some people have their own issues and may need help to check themselves before dealing with the public.” Although change has been slow, the providers believe that their professions have come to realize the growing differences in our society and that the once ideal practice consisting only of white upper-class Americans does not exist, or as one physician explained, “You will go under trying to strive for it.”

A frequent complaint of the providers involves something they feel contributes to the “poor attitudes” of some providers, and that is the advent of Health Maintenance Organizations (HMOs) and managed care, both systems they believe are less concerned than they are about quality of patient care. While not directly verbalized, there was a disconcerted feeling that perhaps some of that attitude was being transferred to the patient by the providers. The providers voiced resentment at the low reimbursement they receive for their services from these organizations, and at the lack of control over their practices. They believe that the bureaucracy and the paperwork burden involved in dealing with the HMOs and the managed care organizations take away from crucial time needed for direct patient care. One medical provider complained that she and her colleagues often spend hours on the telephone “trying to convince someone with no medical background that if a patient does not have a procedure done, the patient will die.” The same provider continued on to say,

Sometimes I go ahead and do a procedure on a patient knowing the HMO may not pay for it, but I didn’t go to medical school to let people

die if we have the technology to save them. I also have to constantly protect myself against lawsuits. These are difficult decisions to make while dealing with life and death issues.

Unfortunately, the difficulties and frustrations the providers routinely face may have a chain reaction that affects the patient adversely. The providers acknowledged that although these difficulties should not be used as rationalizations for poor treatment of and insensitivity toward patients, for some providers the situation does result in “cutting corners” in terms of time spent with patients, and often on patients who are considered less desirable, racially, economically, and otherwise.

A few providers admitted that dealing with the New York City melting pot society has been a learning process. One noted: “My upper-class white suburban upbringing did not prepare me to deal with the diversity we see in New York City.” Preconceived notions about groups was identified as the culprit in problems that may exist between providers and patients of diverse groups. A couple of providers indicated that sometimes colleagues have unfounded misconceptions, phobias, and stereotypes about particular groups of people, and try to “rub them off” onto other providers. One provider shared the realization that:

People sometimes use one bad experience about a particular group of people to scare you . . . but you really have to be careful about things like that. It is not fair to the patient, you have to make your own experiences. For example, I end up liking my work with a group of people that others have tried to scare me about.

Peer pressure to act in given ways towards a particular group was also cited by the providers. The providers admit that some peer pressure exists within the profession to conform to a certain behavior or attitude; nonetheless they say that few providers

would admit that peer pressure affects their own behavior towards any particular group.

One mental health provider reported that during one case presentation, he noted how another provider was able to engage others in a discussion based totally on stereotypes about the ethnicity of the patient being presented.

People just went along with what was being said even though they may not have agreed with certain things discussed. Sometimes when you speak with people after a presentation you see they feel differently. I know I am sometimes seen as an outsider because I express my feelings when I do not agree with certain things being said about people.

Some of the providers said they find it offensive when they see patients being unfairly treated and feel any provider who witnesses such behavior and does nothing about it is equally guilty. They believe providers should be made aware of their behavior, and, depending on the situation, either provide education to the provider or direct the provider to an educational source. The providers interviewed also believe that their colleagues are responsible for protecting the reputation of the profession, and not let “some bad apples ruin it for others.” One woman physician asserted, “I will not tolerate anyone around me mistreating patients. My colleagues and I are professionals and have no problems treating anyone.”

There is a general consensus among the white American providers that ethnically diverse patients are not always more difficult to treat than American patients.

As one provider noted:

Such patients present more challenges than difficulties. Providers must be more conscious and alert in treating these patients . . . to be careful to respect the culture and values of the patient and not offend the patients by imposing the Anglo values on them.

Both medical and mental health providers have also stated that the “idealized patient,” the white, educated, upper-class patient, can create just as much difficulty for the provider, something which is rarely discussed other than in private, among colleagues.

A physician noted:

Sometimes these so-called educated, upwardly mobile patients can be a real pain to treat. You can't convince them on a treatment; they don't follow up on treatments; they read too much about their condition, they believe they have all the side effects noted in the books they read, and [they] question your knowledge.

A mental health provider expressed similar concerns, and stated:

Highly educated patients can be difficult to treat. They sometimes take longer to express their feelings, they can be less honest with their problems, and tend to rationalize and intellectualize things.

The providers acknowledge that the greatest difficulty in treating ethnically and socially diverse groups, including Haitians, is their unfamiliarity with preventive care. This issue seems to be of greater concern than language barriers. Providers admit that initially in their careers they had to deal with this problem, and feel that some providers are unable to sympathize or empathize with a patient who has not seen a doctor in years, or one who waits until his condition is chronic before seeking medical care. However, they agreed, even in such circumstances, providers must try to understand where the patients are, to understand their experience in order not to lose patients, and to educate the patients in a non-threatening way on their health condition and on health care in general. The providers interviewed believe that this is a skill many providers do not possess.

Haitians are also reported to have a tendency to withhold sharing symptoms and information pertinent to their medical condition. This can be frustrating to the providers, even though they realize that a certain degree of “fear” may be underlying this behavior: fears of possibly being told one is very ill, of being referred for additional testing, of being hospitalized and out of work. The providers reported that developing a trusting relationship with the patient is beneficial in promoting an honest and open relationship.

The providers reported having to realize the great depth of the influence of culture and the importance of spirituality and mystical beliefs when dealing with Haitians. The providers also reported having come to understand the value of learning about Haitian culture and to not dismiss the patient’s use of alternative medicine. One stated, “I have no problem with most alternative medicines used by Haitians. I see it as complementing the doctor’s services.” Keeping open the line of communication with patients so they know what the patients may be doing at home for their medical condition is important, as the providers believe that if the patient’s use of alternative medicine is criticized, the patients may continue to do what they feel necessary only without informing the providers. Thus, for these providers, working with patients as a team and giving them a certain degree of control is seen as assisting in increasing cooperation from patients.

The providers also believe that it is their responsibility to learn as much as possible about the groups they treat, even if it means conferring with colleagues who come from those groups. Furthermore, despite time limitations, they believe providers

must devote sufficient time and effort to explain treatment plans and procedures thoroughly to the patients, to make certain the patients understand what they are being told, and to encourage patient questions. Patients must be made to feel that the provider is concerned and cares for the wellbeing of the patient. One medical provider said that she writes down instructions for her patients when necessary, and encourages the patients to call her should they have any questions or concerns.

Although the providers do admit that in treating Haitians, socioeconomic level, degree of acculturation, and English language skill all serve to facilitate medical intervention, they did express amazement at the extent to which even upwardly mobile, educated Haitians clung to their cultural beliefs, even as they seem to struggle to separate themselves. One mental health provider noted that he had seen educated Haitians either deny any affiliation with the Haitian cultural belief system, or pretend to be separate from them. "You are told that they don't get involved with the mystical and don't believe in the supernatural. However, you are later told by the same patient that a family member was the victim of a spell placed on him." The issues of shame and being perceived as unsophisticated are factors in this behavior. The providers noted that they attempt to make Haitian patients feel comfortable about their culture by showing interest in learning about it.

The providers reported generally good relationships with Haitians they have treated. The relatively few difficulties encountered they attribute to individual behavior differences, not a group problem. They report finding Haitian culture rich and interesting, and generally enjoy working with Haitians. They assert that in their

experience, they have found Haitians to be unusually appreciative of services rendered, and report having received gifts such as Haitian art work from Haitian patients. All the providers expressed being disturbed that some people thought of all Haitians in terms of stereotypes and what they see and hear in the media. The providers feel Haitians should be given the same opportunities as those afforded to other groups, so the “Haitians can show who they really are.”

*They Speak Our Tongue: The Haitian Patient
and the Haitian Provider*

The high level of trust felt for Haitian providers and the comfort felt when being treated by a Haitian provider was quite evident in the interviews with Haitian patients. Even some of those not being treated by Haitian providers admitted that they would feel more comfortable with their providers if the providers were Haitian. At the same time, some middle- to upper-class Haitians are reluctant to receive services from compatriots due to concerns about confidentiality, social status issues, and the Haitian patient’s perception of the level of knowledge possessed by the white doctor.

Despite numerous concerns voiced about long waits and overcrowding in the offices of Haitian providers, an overwhelming majority of the Haitian patients interviewed stated they prefer going to Haitian providers for services. This is especially so in the lower socioeconomic strata, even though all interviewees were able to communicate in English so language skills was not a major issue. The ability to express pain and discomfort in the *lang natal* (native tongue) appears to be of great importance. One Haitian male tried to explain: “There are discomforts you want to explain where

there are no English words for it or you just can't really explain them in English, like having a *gaz* holding you on your back." The patients believe they are more likely to be understood by a Haitian provider who shares their culture. They also believe that the Haitian provider is genuinely concerned about their health. They praise the thorough exams they are afforded at the offices of Haitian providers. The Haitian patients also believe that Haitian providers will not subject them to unnecessary tests or treatment. The Haitian patients also report feeling more comfortable sharing alternative medicine practices, and issues of supernatural belief with Haitian providers. Some patients have stated that sometimes they elect to wait beyond the first few visits with a provider before sharing such information. For as one patient mentioned, "Some of the Haitian doctors don't believe in such things."

Interestingly enough, the Haitian patients do not tend to feel that Haitian providers are making money on them, in contrast to their evaluation of white American providers. This may perhaps be a consequence of the generally lower fee scales of Haitian providers, as well as the providers' willingness to renegotiate with patients who cannot afford to pay the full fee.

The Haitian Providers: They Come with "*Baggages*"

Most Haitians have difficulty trusting others. Within the Haitian community this has long been recognized. The issue of trust for Haitians is deeply rooted in the historical and political context. Haitians are suspicious of new experiences and require much time to develop a certain degree of trust in new encounters. This is very much the case when they are confronted with the American medical system.

The suspiciousness of some Haitians has led them to be inaccurately labelled as suffering a form of psychopathology. Haitian psychiatrists are concerned about this practice, and suggest that other clinical indicators be explored before making the diagnosis of psychopathology.

Bibb and Casimir (1996) consider this lack of trust by Haitians, the suspiciousness and accompanying behavior, as paranoid ideations rooted not only in the historical and political experiences of Haitians, but also in their religious experience. They note that:

In the past slaves were required to report on those who aspired toward freedom . . . and more recently agents of dictatorial regimes (e.g., Tonton Macoutes) were hired to monitor and harass anyone deemed threatening to the Haitian Government . . . the collective effects of colonialism, torture and other types of oppression, coupled with magical thinking beliefs in voodoo, often explains secretiveness and the lack of personal disclosure to others (Bibb & Casimir, 1996:106-107).

All the Haitian physicians interviewed as well as other Haitian professionals in the health care system have noted that most Haitians, at least initially, do not trust the American medical system. Some seem to believe that as members of a black immigrant group they are not as welcome to the United States as are white immigrant groups, and that American physicians may use them as subjects of research without fear of repercussion. As one Haitian patient said, "We are black immigrants, we are poor, and

we do not count.” Such feelings are pervasive among some Haitians, especially those from the lower socioeconomic levels. They feel that they have less clout and less control over things that affect them than others.

Of the small, but representative, sample of Haitian physicians I interviewed, a few indicated that this lack of trust in the American medical system is a major factor in the poor treatment some Haitians have reported getting from white American physicians. The Haitian physicians described the issue of trust among Haitians as the “extra baggage” many Haitians carry with them when they seek medical care. This is a different and difficult type of baggage, unlike that other ethnic groups may carry.

The Haitian physicians believe that because of not trusting the medical system, Haitian patients often delay seeking medical care and when they do seek it, often withhold pertinent information from physicians. One physician stated, “Haitians never tell you the whole story.” The physicians commented on the fact that some Haitian patients give inaccurate information about their illness, symptoms, how long the symptoms have been present, and what had been done or taken for the condition. The physicians also remarked that Haitian patients tend to arrive at the doctor’s office with a self-diagnosis, ready to tell the physician what they believe should be done for them.

These behaviors, which were specified as objectionable by a few Haitian physicians, are believed to set a negative tone to the doctor-patient relationship, even before treatment is begun. Thus this contaminates the treatment and perhaps even precipitates a sense of impotence in the physician, which quells the physician’s motivation to provide quality to the patient.

This type of reasoning is analogous to the classic “blaming the victim,” wherein victims are blamed for some failure or inadequacy causing the crime against them, rather than placing some responsibility on other factors. Indeed, these few Haitian physicians shared a certain degree of frustration with the behavior of Haitians, although they, along with the rest of the sample of Haitian providers, acknowledged an awareness of the cultural and historical roots of mistrust in Haitians. The other Haitian physicians interviewed appeared to be much more compassionate and understanding of the behaviors of Haitians toward health and health care.

These so-called “objectionable” behaviors of Haitians are not unlike behaviors noted with other ethnic groups. Similar patterns of behavior have also been observed in the general population among the disadvantaged and the lower socioeconomic strata. The relationship between culture, poverty, and health is well documented in the literature (Hollingshead & Redlich, 1958; Kosa & Zola, 1975; Tseng & McDermott, 1981; Mechanic, 1982; Helman, 1984; Pedersen et al, 1996).

The majority of the Haitian physicians interviewed attended medical school in Haiti, but all also received further training in the United States in the form of internships, residency programs, and attending medical courses, in order to be licensed to practice in this country. Thus all are trained in the Western medical system, a system which for a long time has been intolerant of non-orthodox medical care and resistant to incorporating cultural factors in health care.

Indeed, some of the Haitian physicians admitted feeling a certain degree of conflict when treating Haitians. This is a conflict between their westernized,

scientifically based knowledge and the culturally based alternative medicine practiced by many Haitians, and a conflict to which most, perhaps all, are constantly exposed in their personal and social lives.

Although the current environment suggests a degree of willingness, at the least, to explore the efficacy of alternative medicine therapies and to evaluate the cultural aspect of health and health care, these remain an arena which most medical providers in the United States are reluctant to explore. The acknowledgement of cultural impact on health practices may be seen as a rejection of the more sophisticated and scientifically based medical knowledge. One also questions what, if any, repercussions are involved within the medical establishment on a medical provider who is aligned with or supportive of the coexistence of both orthodox medical practice and alternative medical care.

The consequences of such alignment may perhaps be of great concern, particularly for Haitian providers, members of a black ethnic group with a history of negative associations. All of the Haitian physicians interviewed have been practicing in the United States and in New York City for several years and seem well established in their practices, and none has voiced concern over being supportive of alternative medicine, comments such as “as a physician in the United States one has to follow the American system” suggest that concern is present, and not far from the surface.

Some of the physicians have admitted that members of their own families and their friends practice alternative medicine, and have made comments such as, “You know us Haitians, we like our little home remedies, herbs and oils, we deeply believe

in them.” Some even admitted that “for some unknown reasons, some home remedies do work sometimes.” However, they do caution patients of possible negative interactions between certain known home remedies and chemically based medications. What I found interesting is that a few physicians said they were aware of colleagues, that is, other Haitian physicians, who themselves or their families had used alternative forms of medicine, including the use of herbs, oils, and folk healers.

Are we then to believe that some of the behavior of some Haitian physicians is camouflaged, and that in order to be fully accepted within the westernized medical system, a certain degree of rejection of one’s identity must occur? This is analogous to W. D. Wright (1997), when he speaks of black intellectuals in America being pressured to be on the same “cognitive wave links” as whites in order to be accepted. In both cases we are talking of blacks changing their way of thinking in order to be accepted by the dominant white population.

Awareness of the dynamics involved in the situation in which many Haitian physicians may be placed (for all they hesitate to admit it) has indeed evoked a certain degree of compassion for them in me. However, when I hear them comment that “Haitians must change to relieve themselves of the baggages they carry,” I wonder if this criticism is not self serving, with even greater depth and meaning. To get rid of the “baggages” is to strip Haitians of part of who they are, of their identity and culture. The non-physician Haitian professionals (e.g., nurses, social workers) interviewed did not seem to share the above view.

Criticism of the cultural behavior of Haitians is not uncommon among Haitians of higher socioeconomic status and among those from established aristocratic families. While such criticism appears to have diminished somewhat over the past decade, possibly due to a higher level of group self esteem among Haitians, it remains an issue of concern to which serious attention must be paid. History has shown us the devastating effects of such self-hatred. For example, diaspora Jews have a long history of self-hatred. In late nineteenth century Germany, Jews were labelled as either “good” and acceptable, or “bad” and inferior deserving of rejection by society. The more thoroughly assimilated and the more rejecting of traditional Jewish culture, the more “good” the person was (Gilman, 1986). Interestingly, “bad” Jews were also known as “black Jews,” reflecting the negative connotation society had toward blackness.

Ironically, the Haitian physicians interviewed overwhelmingly shared a great sense of fulfillment in providing services to Haitians. Some shared respect for the Haitian culture and for those who retained traditional ties to that culture. They believe that Haitian culture should receive the same respect as the cultures of other ethnic groups. Showing respect for the culture, attempting to understand it, and showing interest in it, increase the patient’s cooperation as a partner to the physician.

The Haitian physicians pointed out a noteworthy Haitian patient behavior. Once Haitian patients develop trust in a physician, they tend virtually to deify him or her, seeing that physician as somehow omnipotent and deserving of loyalty. They become a great source of referrals, recommending the physician to friends and relatives. This response is made to non-Haitian physicians as well, even though some Haitians must,

when choosing a medical provider, take into account higher fees (usually charged by non-Haitians) and language accessibility.

Even those few Haitian physicians who were critical of Haitians shared the need for Haitian physicians to be available to provide needed medical care to Haitians. As one commented, “If we don’t, who will? We at least know the culture and know where they are coming from.”

The Haitian Providers: The General Lack of Respect for Haitians

The dilemma between professional and cultural alignments noted among the Haitian providers was vividly presented during interviews as some of the providers, while critical of their Haitian patients, also voiced compassion. Despite the fact the Haitian providers believe the *baggages* Haitians carry with them may interfere with the delivery of services, the providers also acknowledge there exists an image of Haiti and Haitians as “black, poor, and ignorant.” A Haitian provider observed that “There is a general lack of respect for Haitians. I see it all the time.” This negative image of Haiti and Haitians may possibly be a manifestation of a number of assumptions. As the first black republic in the world, why is Haiti in such poor condition and why have the Haitians not used the accomplishments of their forefathers in a productive way? This assumption is confirmed by the reports of some of the Haitian providers that they are often asked by American colleagues, “What happened to Haiti?” One provider said, “I know what they mean, it’s a complicated thing. I don’t think any Haitian or anyone really knows what happened to Haiti.”

Thus the question before us is: Can it be that people's issues regarding Haiti and Haitians as a group are being acted out in the health care treatment they provide? It indeed appears that society's negative views about Haiti as a country are in some way incorporated into the practice framework of some white American providers and are transferred to the individual Haitian patient in a negative transference way at a time the patient is most vulnerable, when the patient is in need. Furthermore, if the poor image society has of Haiti is to be tied to Haitians as a group, why doesn't this transference take place in the medical setting when providers deal with people from other countries? Why does it seem easier to separate the country from the individual patient when treating others?

A number of factors appear to be operating when analyzing the situation with Haitians. We have a nation of black individuals who are constantly being portrayed as poor, illiterate, and voodoo practitioners. Haitians are very strongly influenced by their culture and tend to hold on to tradition. They are known to be a generally passive group when negotiating systems and are more accepting. This passivity is culturally rooted and is based on the way most Haitians are raised: to respect and fear authority is attached to the notion that if one challenges authority, one is punished. Thus, all of these factors facilitate the formation of a negative transference on Haitians.

The above analysis can best be understood if we consider the difference in attitude our society has towards Asians, who are also known as being passive. However, what Asians have in their favor is the more positive image of them as "passive, compliant, and intelligent."

The devaluation of the Haitian and of his culture not only contributes to further distrust by Haitians of the American health care system, but also produces isolation from other institutions. Indeed, Haitians need to feel reassured of the value of their culture, to feel comfortable with who they are as Haitians, and to be empowered to feel deserving of quality health care.

The Haitian providers interviewed strongly believe that educating Haitians on quality health care and on their rights as patients is crucial if progress is to be made in the care provided them. One provider mentioned that “most Haitian patients are often unaware of the poor medical service they receive.” The notion that “whatever medical service is provided to the patient is far better than what he/she would have received in Haiti” was reflected by the Haitian physicians as well as by non-Haitians..

The Haitian physicians admitted that sometimes diagnoses are made too quickly, tests are either underdone or overdone. Unnecessary precautions too often are taken with Haitians, something not observed with others. As one provider noted, “Even if the numerous tests done for infectious diseases on a Haitian patient are negative, sometimes they still isolate the patient.” Haitian mental health providers have reported that, in general, Haitians are more likely to be diagnosed with chronic mental illnesses, such as psychosis, than the milder neurotic conditions with which whites are more readily to be diagnosed.

A few of the Haitian providers explained that intervening in situations where they believe Haitian patients are being treated unfairly can be quite a challenge. They worry that at times their American colleagues may think they are being too sensitive, or

as one provider commented, “I have to be very careful how I react to situations.”

Sometimes patients who, on the surface, appear to have been treated “nicely” may not be fully satisfied with the services received. The providers reported they have observed Haitian patients asking questions of white American providers but receiving no answers. One of the Haitian providers stated that “Sometimes when the Haitian patient asks a question, the patient is told ‘You will be okay’ and their questions are never answered.” This, the provider contends, intimidates the patient who then hesitates to ask further questions of the provider.

Another concern verbalized by the Haitian providers is that at times diagnoses and procedures are poorly (if at all) explained to the patients, who are not fully informed about the risks and benefits of proposed procedures and the side effects of prescribed medications. Further, the patients are not properly informed about the equipment to be used on them at hospitals or at clinics. One provider comments that patients are often noticed trying to make sense of equipment attached to them, and complaining that “they put this thing on me and couldn’t even tell me why.” Another provider told of an incident where a catheter was placed on a man after surgery, both to facilitate urination and to limit his mobility. Because the man was not informed of the device’s function, he became fearful that damage was being done to his genitalia and that he would no longer be able to urinate normally.

The Haitian providers were very concerned about the language issue, which quite often is seen as a major barrier to providing adequate care to people whose primary language is not English. The providers asserted they believe American

providers sometimes use language as an excuse to limit communication with patients. Language difficulties are used as a barrier even when the Haitian patients are able to communicate in English. Indeed, this rationalization can be used to shorten the length of time a provider spends examining the patient. The effect this can have on the patient's self esteem can be damaging: language skills he or she has acquired are either not acknowledged or are deprecated as being inadequate for communication.

Finally, despite the concerns raised by the Haitian providers on the care provided to Haitians in New York City by white Americans, the majority of the Haitian providers agree that over the past few years they've noticed some positive changes in the care provided Haitians. They believe that some white Americans are trying to be more culturally sensitive when treating diverse ethnic groups, such as Haitians, and have come to realize the growth of diversity in American society. The Haitian providers believe that much of the discriminatory practices observed is generally based on ignorance and the fact that most white American providers come from a different world than their patients. As one Haitian provider noted, "Some try their best, which may not be good enough."

Chapter VI

SUMMARY AND CONCLUSIONS

Over the past few decades, the United States has witnessed a great increase in the migration of Haitians into its territories, with New York and Florida the primary recipient states of this influx of Haitians. Although the number of Haitians leaving Haiti was noticeable by the late 1950s, at the beginning of the Duvalier regime, Haitians were neither heard nor spoken of, and little attention was given to the Haitian population in the United States. They could have been characterized as the “unknown and silent immigrant group.” In fact, until the early 1980s when the “boat people” of Haiti fleeing to Florida began to capture the attention of the media and the subsequent associations of Haitians with AIDS, only minimal coverage was provided on Haitians and their lives here.

What coverage did exist was generally about Haiti the country—its poverty, the dictatorial Duvalier regime, and the mysteries of voodoo. Most people were not afraid of being in the presence of Haitians. Haitians were proud of their cultural heritage and not at all reluctant about sharing it with Americans and others. At that period of time, given that the Haitians coming to the United States were the better educated and of upper socioeconomic levels, Americans had the opportunity to interact with a sample that was not truly representative of the general population, a “different” type of Haitian as I have often heard, one possibly closer to their social class and educational level.

Certainly, there were Haitian nannies taking care of American children; however, many of these nannies were educated and working in such positions during the transitional period in the new country, in order to support themselves and their families. They had not yet managed to transfer their skills from Haiti to occupations calling for those skills in the United States. Many returned to school in this country in order to obtain certification or the equivalent, and now are engaged in professional occupations.

The hostile attitude toward Haitians in the 1980s created change in the way Haitians were perceived by Americans and others, with concomitant changes in attitudes and behavior. It appears that individuals felt that as long as others held Haitians in disgrace (e.g., because of the boat people, AIDS), they too were free to do the same; indeed, it was an invitation to stigmatize Haitians.

Reviewing the literature suggests that anti-Haitian sentiments were not new phenomena. However, the social environment of the 1980s was conducive for these sentiments to be acted out or to reemerge. It also solidified those feelings which may already have been present in some, and allowed others to develop.

The poor image of Haitians permeated different aspects of the Haitians' lives in New York City and the United States. From the child being teased for being Haitian to the adult losing a job or apartment because as a Haitian that person "may have AIDS," discrimination and bigotry, and their expression, were rampant. Unfortunately, the health care system has not been immune from the virus of discrimination. There were widespread reports that Haitians were being unnecessarily isolated in hospital wards

and that extreme precautions were taken when treating Haitians, even if all tests revealed no contagious disease. Many Haitians began to complain about the increase in negative experiences with health care providers. Many described their experiences as being unpleasant and degrading, but were unable to specify details of the interaction because of the subtlety of the behaviors to which they were subjected.

As a health care professional working in a New York City hospital and concurrently at a community mental health clinic, I too began to notice dissimilarities in the way Haitians were being treated and the way others were treated in the interactions between health care providers and health care seekers. “Something” existed in those interactions involving Haitians that was not visible in interaction with other ethnic groups. The current study grew out of my attempt to clarify the nature of the dissimilarities I noticed and to discover the “something” involved in interactions with Haitians that gave a different flavor to the doctor-patient relationship. A natural second component of this study was to use the case of Haitians and their treatment to support the inclusion of cultural sensitivity in the training of health and mental health practitioners.

Haitians receive and have received health care services from providers of many racial and ethnic backgrounds and in different locations in the United States. The focus of this study is on the services they received from white American providers in New York City.

The nature of this research study required the use of qualitative methods that are conducive to the theoretical approach in sociology known as symbolic interaction. The

use of qualitative research methods allowed for greater access to relevant data for the study. Intensive semi-structured interviews and participant observation were the two main modalities utilized. A small sample of white American medical and mental health care providers were interviewed about their experiences in providing services to Haitians. Interviews were also held with a small sample of Haitian providers to obtain their perspective on the experiences of white American providers and Haitian patients. The white American and Haitian providers in the sample were all individuals holding either an M.D. or Ph.D. degree and practicing in one of the boroughs of New York City. A small sample of Haitian patients, a cross-section of socioeconomic strata and ages, all living in New York City, were also interviewed. The thrust of the interviews with the patients was to learn about their experience seeking medical and mental health care from white American providers. The arena focused on was outpatient care services.

Given the nature of the problem being investigated, some areas were deemed of special importance to explore in the attempt to find a possible answer to the research question. In addition to developing an overview of Haiti and Haitians, three main areas were addressed: the illness behaviors of Haitians living in New York City, Haitians's utilization of the American medical system, and the provider-patient relationship as exemplified in that of the white American provider and the Haitian patient.

The study's findings suggest that although socioeconomic status, length of stay in the United States, and level of acculturation or assimilation are all important

predictors of illness behavior, the Haitians' world view and the power of their culture have greater impact and transcend all other factors as determinants of illness behavior.

This is not to suggest that the Haitian community is monolithic. Variations in behavior were noted. For example, Haitians of higher socioeconomic status and those who have been in the United States (or New York City) longer are quicker to seek orthodox medical and mental health treatment, even when concurrently using alternative medicine. Those in the lower socioeconomic strata are more likely to use only alternative medical care, or to use it longer, and delay seeking orthodox services. These individuals are more attached to their cultural traditions and world view, and are more likely to affirm supernatural than natural origins of illness.

Haitians from the upper classes were more reluctant to discuss alternative medicine beyond the relatively acceptable use of herbs and oils, and preferred to say that they "do not deal with these things and have no knowledge of their use." This is essentially a statement for public consumption, and not necessarily indicative of what is practiced secretly. This attitude is a result of the longstanding association of the use of alternative medicine such as voodoo priests and other folk healers with primitivism and lack of sophistication. Haitians from the lower socioeconomic classes, although also reluctant to share too many details of their use of alternative medicine, did not divorce themselves from its use and seemed more accepting of the use of alternative medicine.

However, whether a Haitian upper-class individual with resources and premium health insurance or a lower-class uninsured Haitian factory worker, at one point in time or another many of the interviewees had experienced prejudice and discriminatory

behavior from white American health care providers. The study does suggest that over time and after initial negative experiences, those Haitians who are more educated and from the upper classes do notice a positive change in their experiences, once the provider has established the individual patient's occupation as professional. With the majority of Haitians living in New York City belonging to lower socioeconomic strata, this experience may not indeed be the norm.

The foremost difficulties and concerns echoed by most of the Haitians interviewed for this study involved the nature of their relationship with white American providers. Most felt they were looked upon with disdain by the providers, and categorized as "black, poor, and ignorant." Upon further examination, it became clear this particular doctor-patient relationship has been in a state of crisis and a victim of the poor image of Haitians in our society for quite some time. The consequences of patient dissatisfaction are constantly being addressed in our society in terms of the general population; it must be examined taking note of all groups, Haitians included. Dissatisfied patients are the most likely to refrain from seeking health care until their illnesses have become chronic and require emergency care, which involves high costs shared by all.

Interestingly, most of the white American health care providers interviewed did acknowledge the possibility of bias in some of their colleagues, and expressed the need for the medical establishment to include cultural sensitivity training in professional education. A few of the providers interviewed were apologetic for the biased behaviors of their colleagues, and seemed genuinely concerned about patients being subjected to

discriminatory and bigoted behaviors. These providers said they would intervene on behalf of the patients were they to witness such behavior. They also gave the impression that for some of their colleagues, prejudicial behavior may initially have been unconscious, to such an extent that the individual making invidious distinctions may not even be aware of his or her behavior pattern towards the members of any particular group.

The majority of the providers interviewed expressed concern, frustration, and dissatisfaction with the demands of the managed care companies and the stressed medical system, while meeting the needs of the various groups that make up our ethnically diverse society. These difficulties are indeed realities, but it also appears they are used as rationalization to explain away prejudiced and bigoted behavior toward any group. Such rationalizations also serve to release the providers of any responsibility for their behavior and attitudes. This reasoning also appears to be a defense against addressing the real issues, which for some individuals can involve confronting their own biases. It is noteworthy that the providers appeared more comfortable discussing preferential treatment witness being accorded to the rich than discussing discriminatory maltreatment applied to the poor. Apparently special treatment being accorded the rich is easier to discuss because it is comparatively commonplace, acceptable, and expected. Thus it is safer to discuss than observations of prejudiced treatment of any particular group.

From the data, it was difficult to ascertain whether the health of the Haitian patients had been compromised because of the differential treatment received. One can

certainly presume that such behaviors did nothing to improve their health. As one Haitian nurse noted, “These doctors [white American providers] may do for the Haitian patient only the basic of what is expected of them, just to follow the rules and not expose themselves to any problems . . . but nothing more.”

The Haitian providers interviewed appeared ambivalent about the position of Haitians in the health care system. They readily recognized the possible difficulties white American providers might have with a group such as the Haitians, whom they themselves define as a group with strong cultural belief and whose members come with “baggages.” They also believe that most Haitians are very attached to their cultural traditions and in general have not assimilated well into American culture. The Haitian providers also appeared to believe that much of the observed discrimination against Haitians may be based on ignorance, and the fact that the white American provider and the Haitian patient are from “different worlds.”

However, the Haitian providers were equally convinced that the poor image of Haitians painted in our society invites the lack of respect they receive. They believe being Haitian immediately placed the patient at a disadvantage, reporting that they often have had to come to the “rescue” of Haitians when they witnessed the Haitian patients being the victims of poor medical treatment. One particular Haitian provider suggested that the situation with Haitians is worse than it appears, and that many Haitian patients are unaware of the poor quality of service provided them.

The results of this study suggest that the image a society holds of a group permeates all aspects of that society and is likely to have an adverse affect on that

group. The way individuals in institutions within a society view and act toward a particular group may be indicative of the way that society in general views the group. What was being acted out in the medical arena vis-à-vis Haitians was possibly a micro version of what has been occurring in the larger society.

This study brings into saliency awareness of how individuals such as health care providers can possibly be influenced, consciously or unconsciously. What may have appeared on the surface to be isolated prejudicial behaviors toward Haitians may have deeper roots, politically and historically. The study's results suggest that the "unpleasant and degrading" experiences noted by some Haitian patients in their interactions with white American providers most likely is related to the providers' own biases about Haitians. This also has ramifications for other non-dominant groups whose members are or may become the victims of bigotry.

What is also suggested by this study's findings is that the prejudicial attitudes of some health care providers may not always be "controlled and contained," despite the fact the providers are trained to be objective in their work. For some providers, their attitudes about a group may interfere with the way the group is perceived. This in turn may interfere with treatment even in a health care setting, where the code of ethics is "quality and professional health care to all." This study focused on health care, but prejudicial attitude based on perceived image of a group can affect behavior in other arenas or institutions, such as employment, education, and neighborhood.

The study also accentuates the depth of the effect of prejudicial attitudes and behaviors by white American providers on the Haitian patients, and that these behaviors

may have damaging effects on the self-esteem of individual Haitian patients and on their view of the American health care system. The study indicated that these prejudiced attitudes and behaviors also had an effect on the Haitian health care providers who often witness their compatriots being subjected to unfair treatment.

In addition, this study points out the importance of cultural variables on individual health and illness. It indicates the need to incorporate cultural sensitivity to the training of health care providers.

I believe this study takes its place alongside those of Zborowski (1969) and Twaddle (1979) on differences in ethnic groups and their response to illness. Illness behavior is determined not only by the individual patient's ethnicity, culture, and socioeconomic status, but also how the providers of health care behave toward the individual patient, which also affect the health care practices of the individual. Thus the experiences patients have with the health care system have great impact on those patients' illness behavior in seeking care, in cooperating with health care providers, and in subsequent compliance with treatment.

APPENDICES

Appendix A

CULTURAL DIVERSITY IN MENTAL HEALTH WORKSHOP

- I. Why the need for diversity and cultural sensitivity?
- II. The definition of illness and mental illness as it pertains to culturally diverse groups
- III. Themes in psychotherapy with culturally and ethnically diverse groups
- IV. Mental health issues with specific groups
 - a. African-Americans
 - b. Latinos
 - c. West Indians
 - d. Asians
 - e. East Indians
 - f. Native Americans
 - g. Filipinos
 - h. Italians
 - i. Irish
- V. Considerations for mental health providers
- VI. Treatment modalities and techniques
- VII. Conclusion

Marie J. Mith-Joseph, MSW, ACSW

Appendix B

WORKSHOP

HAITIANS AND HEALTH/MENTAL HEALTH

- I. Brief history of the Caribbean island of Haiti
- II. The country and the people
- III. Life in the United States/Challenges
- IV. Perception of illness and mental illness/illness behavior
 - a. World view
 - b. Natural and supernatural causes
 - c. Hot/cold factors, the issue of *gaz*
 - d. Cultural and socioeconomic factors
 - e. Religion
 - f. Alternative health care: home remedies, folk healers, voodoo priests
 - g. Influence of family and friends
 - h. Denial and shame
 - i. Utilization of orthodox medical/mental health care
- V. Treatment issues/treatment modalities and techniques
 - a. The provider factor
 - b. Transference/countertransference
 - c. Resistance, patience, and trust
 - d. Fear of being misunderstood
 - e. Fear of being labeled/stigmatized
 - f. Empathy, sensitivity, and tolerance
 - g. Understanding the "total patient"
 - h. Language differences and vocabulary of distress
 - i. Education from patient/respect of and interest in patient's culture
 - j. Issue of control/importance of patient's participation in treatment plan
 - k. Importance of family involvement
 - l. Pathology vs. culture
 - m. Depression, poor self esteem, group self esteem
 - n. Therapeutic alliance, cooperation, compliance
- VI. Conclusion

Marie J. Mith-Joseph, MSW, ACSW

BIBLIOGRAPHY

- Abel, T., Metraux, R., & Roll, S. (1987). *Psychotherapy and culture*. Albuquerque: University of New Mexico Press.
- Alford, R. (1975). *Health care politics: Ideological and interest group barriers to reform*. Chicago, IL: University of Chicago Press.
- Armstrong, D. (1996). *Health outcomes: The socio-historical context*. In H. M. Macbeth (Ed.), *Health outcomes: Biological, social and economic perspectives* (pp. 4-29). New York: Oxford University Press.
- Basch, L., Schiller, N., & Blanc, C. S. (1995). *Nations unbound: Transnational projects, postcolonial predicaments and deterritorialized nation-states*. Luxembourg: Gordon and Breach.
- Belluch, P. (1996, May 9). Mingling two worlds of medicine. *The New York Times*, p. B1.
- Bibb, A., & Casimir, G. J. (1996). Haitian families. In M. McGoldrick & J. Pearch (Eds.), *Ethnicity and family therapy* (pp. 97-110). New York: Guilford Press.
- Blane, D., Brunner, E., & Wilkinson, R. (Eds.). (1996). *Health and social organization toward a health policy for the twenty-first century*. New York: Routledge.
- Bloom, S. W. (1965). *The doctor and his patient*. New York: The Free Press.
- Braithwaite, R., & Taylor, S. E. (1992). *Health issues in the black community*. San Francisco, CA: Jossey-Bass.
- Brodwin, P. (1996). *Medicine and morality in Haiti: The contest for healing power*. New York: Cambridge University Press.
- Charles, C. (1986). Mental health services for Haitians. In H. P. Lefley & P. B. Pedersen (Eds.), *Cross cultural training for mental health professionals* (pp. 183-198). Springfield, IL: Charles P. Thomas.

- Chin, J. L., De La Cancela, V., & Jenkins, Y. M. (1993). *Diversity in psychotherapy: The politics of race, ethnicity and gender*. Westport, CT: Praeger.
- Council on Ethical and Judicial Affairs. (1990). Black-white disparities in health care. *Journal of the American Medical Association*, 263(17), 2344-2346.
- Courlander, H. (1960). *The drum and the hoe: Life and lore of the Haitian people*. Berkeley: University of California Press.
- Dana, R. H. (1981). *Human services for cultural minorities*. Baltimore, MD: University Park Press.
- Davies, P. (1996). Sociological approaches to health outcomes. In H. M. Macbeth (Ed.), *Health outcomes: Biological, social and economic perspectives* (pp. 94-134). New York: Oxford University Press.
- Dayan, J. (1995). *Haiti, history and the gods*. Berkeley: University of California Press.
- De Stefano, A. M. (1997, October 1). Immigrant remedies from home. *Newsday*, p. A5.
- Dixon, C. (2000). *African America and Haiti. Emigration and black nationalism in the nineteenth century*. Westport, CT: Greenwood Press.
- Duff, R. S., & Hollingshead, A. B. (1968). *Sickness and society*. New York: Harper & Row.
- Dupuy, A. (1997). *Haiti in the new world order. The limits of the democratic revolution*. Boulder, CO: Westview Press.
- Durkheim, E. (1965). *The elementary forms of the religious life*. New York: The Free Press.
- Feit, M., & Battle, S. F. (1995). *Health and social policy*. Binghamton, NY: The Haworth Press.
- Ferguson, J. (1987). *Papa doc, Baby Doc: Haiti and the Duvaliers*. New York: Basil Blackwell, Inc.
- Fick, C. E. (1990). *The Making of Haiti. The Saint Dominique revolution from below*. Knoxville, TN: University of Tennessee Press.
- Fish, H. M. (1996). *Culture and therapy*. Northvale, NJ: Jason Aronson, Inc.

- Foner, N. (1987). *New immigrants in New York*. New York: Columbia University Press.
- Fouron, G. E., & Glick-Schiller, N. (1997). Haitian identities at the juncture between diaspora and homeland. In P. R. Pessar (Ed.). *Caribbean circuits: New directions in the study of Caribbean migration* (pp. 127-155). New York: Center for Migration Studies of New York, Inc.
- Friedman, H. S., & Dimatteo, M. R. (1990). Patient-physician interactions. In S. A. Shumaker, E. B. Schron, & J. K. Ockene (Eds.). *The handbook of health behavior change*. New York: Springer Publishing Company.
- Freidson, E. (1970). *Profession of medicine: A study of the sociology of applied knowledge*. New York: Harper & Row.
- Freidson, E. (1972). Disability as social deviance. In E. Freidson & J. Lorber (Eds.), *Medical men and their work: A sociological reader* (pp.330-352). Chicago, IL: Aldine-Atherton.
- Freidson, E. (1974). *Professional dominance: The social structure of medical care*. Chicago, IL: Aldine.
- Freidson, E. (1989). *Medical work in America: Essays on health care*. New Haven, CT: Yale University Press.
- Gaines, Atwood. (1992). *Ethnopsychiatry: The cultural construction of professional and folk psychiatries*. Albany: State University of New York Press.
- Gaw, A. (1982). *Cross cultural psychiatry*. Littleton, MA: John Wright PSG, Inc.
- Gerth, H. H., & Mills, C. W. (1958). *From Max Weber: Essays in sociology*. New York: Oxford University Press.
- Gilman, S. L. (1986). *Jewish self-hatred: Anti-semitism and the hidden language of the Jews*. Baltimore, MD: Johns Hopkins University Press.
- Glanz, K., Marcus-Lewis, F., & Rimer, B. (1997). *Health behavior and health education theory, research and practice*. (2nd edition). San Francisco, CA: Jossey-Bass Publishers.
- Glazer, M. (1972). *The research adventure: Promise and problems of fieldwork*. New York: Random House.

- Goffman, E. (1963). *Stigma: notes on the management of spoiled identity*. Englewood Cliffs, NJ: Prentice-Hall, Inc.
- Goldacre, M. (1996). Health outcomes from a medical perspective. In H. M. Macbeth (Ed.), *Health outcomes: Biological, social and economic perspectives* (pp. 31-87). New York: Oxford University Press.
- GoPaul-McNicol, S-A. (1997). *A multicultural/multimodal/multisystems approach to working with culturally different families*. Westport, CT: Praeger.
- Hafferty, F. W., & McKinlay, J. B. (1993). *The changing medical profession. An international perspective*. New York: Oxford University Press.
- Harwood, A. (1981). *Ethnicity and medical care*. Cambridge, MA: Harvard University Press.
- Helman, Cecil. (1984). *Culture, health and illness: An introduction for health professionals*. Littleton, MA: John Wright PSG.
- Hollingshead, A. B., & Redlich, F. (1958). *Social class and mental illness*. New York: John Wiley & Sons.
- Howard, G. (1985). *Basic research methods in the social sciences*. Glenview, IL: Scott, Foresman and Company.
- Hurston, Z. N. (1990). *Tell my horse: Voodoo and life in Haiti and Jamaica*. New York: Harper & Row.
- James, C. L. R. (1989). *The black Jacobins: Toussaint L'Ouverture and the San Domingo revolution* (2nd ed., rev.). New York: Vintage Books.
- Jones, R. K., & Jones, P. A. (1975). *Sociology in medicine*. New York: John Wiley & Sons.
- Kahn, K., Pearson, M., Harrison, E., Desmond, K., Rogers, W., Robenstein, L., Brook, R., & Keeler, E. (1994). Health care for black and poor hospitalized Medicare patients. *Journal of the American Medical Association*, 271(15), 1169.
- Kasinitz, P. (1992). *Caribbean New York: Black immigrants and the politics of race*. Ithaca, NY: Cornell University Press.
- Kato, P. M., & Mann, T. (1996). *Handbook of diversity issues in health psychology*. New York: Plenum Press.

- Kindig, D. A. (1997). *Purchasing population health: Paying for results*. Ann Arbor, MI: University of Michigan Press.
- Kleinman, A. (1980). *Patients and healers in the context of culture*. Berkeley: University of California Press.
- Kosa, J., & Robertson, L. (1969). The social aspects of health and illness. In J. Kosa, A. Antonovsky, & I. K. Zola (Eds.), *Poverty and health: A sociological analysis* (pp. 40-79). Cambridge, MA: Harvard University Press.
- Kosa, J., & Zola, I. K. (1975). *Poverty and health: A sociological analysis*. Cambridge, MA: Harvard University Press.
- Kronenfeld, J. J. (1997). *The changing federal role in United States health care policy*. Westport, CT: Praeger Publishers.
- Laguerre, M. S. (1984). *American odyssey: Haitians in New York City*. Ithaca, NY: Cornell University Press.
- Laguerre, M. S. (1993). *The military and society in Haiti*. Knoxville, TN: University of Tennessee Press.
- Lassiter, S. (1995). *Multicultural clients: A professional handbook for health care providers and social workers*. Westport, CT: Greenwood Press.
- Lawless, R. (1992). *Haiti's bad press*. Rochester, VT: Schenkman Books, Inc.
- Lebra, W. (1976). *Culture-bound syndromes: Ethnopsychiatry and alternate therapies*. Honolulu: University of Hawaii Press.
- Lefley, H. P., & Pedersen, P. B. (1986). *Cross cultural training for mental health professionals*. Springfield, IL: Charles C. Thomas.
- Lewis, C. E., Fein, R., & Mechanic, D. (1976). *A right to health: The problem of access to primary medical care*. New York: John Wiley & Sons.
- Leyburn, J. G. (1941). *The Haitian people*. New Haven, CT: Yale University Press.
- Leyburn, J. G. (1966). *The Haitian people* (Rev. ed.). New Haven, CT: Yale University Press.
- Lofland, J., & Lofland, L. (1984). *Analyzing social settings: A guide to qualitative observation and analysis*. Belmont, CA: Wadsworth Publishing Company.

- Macbeth, H. M. (Ed.). (1996). *Health outcomes: Biological, social and economic perspectives*. New York: Oxford University Press.
- Marmot, R. (1996). The social pattern of health and disease. In D. Blane, E. Brunner, & R. Wilkinson (Eds.), *Health and social organization towards a health policy for the twenty-first century* (pp.42-67). New York: Routledge.
- Marsella, A., & Pedersen, P. B. (1981). *Cross-cultural counseling and psychotherapy*. Elmsford, NY: Pergamon Press.
- Marsella, A. J., & White, G. M. (1982). *Cultural conceptions of mental health and therapy*. Dordrecht, Holland: D. Reidel Publishing Company.
- McKinlay, J. B. (1972). Some approaches and problems in the study of the use of health services: An overview. *Journal of Health and Social Behavior*, 13(July), 115-152.
- McKinlay, J. B. (1984). *Issues in the political economy of health care*. New York: Tavistock Publications.
- McKinlay, J. B. (1990). A case for refocussing upstream: The political economy of illness. In P. Conrad & R. Kern (Eds.), *The sociology of health and illness: Critical Perspectives* (pp. 502-513). New York: St. Martin's Press.
- Mechanic, D. (1972a). Social psychological factors affecting the presentation of bodily complaints. *New England Journal of Medicine*, 286, 1132-1139.
- Mechanic, D. (1972b). Some implications of illness behavior for medical sampling. In E. Freidson & J. Lorber (Eds.), *Medical men and their work: A sociological reader* (pp. 446-452). Chicago, IL: Aldine/Atherton.
- Mechanic, D. (1974). *Politics, medicine and social science*. New York: John Wiley & Sons.
- Mechanic, D. (1976). *The growth of bureaucratic medicine: An inquiry into the dynamics of patient behavior and the organization of medical care*. New York: John Wiley & Sons.
- Mechanic, D. (1978). *Medical sociology*. New York: The Free Press.
- Mechanic, D. (1982). *Symptoms, illness behavior and help-seeking*. New York: Prodist.
- Metraux, A. (1960). *Haiti: Black peasants and voodoo*. New York: Universe Books.

- Mintz, S. W. (1984). *Caribbean transformations*. Baltimore, MD: The Johns Hopkins University Press.
- Mintz, S. W., & Price, S. (1985). *Caribbean contours*. Baltimore, MD: The Johns Hopkins University Press.
- Mishler, E. G., Amarasingham, L., Hauser, S., Liem, R., Osherson, S., & Waxler, N. (1981). *Social contexts of health, illness and patient care*. New York: Cambridge University Press.
- Morse, R. M. (Ed.). (1988a). *Haiti's future: Views of twelve Haitian leaders*. Washington, DC: The Wilson Center Press.
- Morse, R. M. (1988b). Prospects for democracy Haiti, 1492-1988. In R. M. Morse (Ed.), *Haiti's future: Views of twelve Haitian leaders* (pp. 3-12). Washington, DC: The Wilson Center Press.
- Muller, T. (1993). *Immigrants and the American city*. New York: New York University Press.
- Nader, L., & Maretzki, T. W. (1973). *Cultural illness and health*. Washington, DC: American Anthropological Association.
- Nicholls, D. (1979). *From Dessalines to Duvalier: Race, colour and national independence in Haiti*. Cambridge, GB: Cambridge University Press.
- Nicholls, D. (1985). *Haiti in Caribbean context: Ethnicity, economy and revolt*. New York: St. Martin's Press.
- New York City Department of City Planning. December 1996. *The newest New Yorker*.
- Parsons, T. (1951). *The social system*. Glencoe, IL: The Free Press.
- Patel, K., & Rushefsky, M. E. (1995). *Health care politics and policy in America*. Armonk, NY: M. E. Sharpe, Inc.
- Payer, L. (1988). *Medicine and culture: Varieties of treatment in the United States, England, West Germany and France*. New York: Henry Holt & Co.
- Pedersen, P. B., Draguns, J. G., Lonner, W. J., & Trimble, J. E. (1996). *Counseling across cultures*. Thousand Oaks, CA: Sage Publications, Inc.

- Pinderhughes, E. (1989). *Understanding race, ethnicity and power. The key to efficacy in clinical practice*. New York: Free Press.
- Piven, F. F., & Cloward, R. A. (1997). *The breaking of the American social compact*. New York: The New Press.
- Ponterotto, J., & Casas, M. J. (1991). *Handbook of racial/ethnic minority counseling research*. Springfield, IL: Charles C. Thomas.
- Ponterotto, J., Casas, M. J., Suzuki, L. A., & Alexander, C. M. (1995). *Handbook of multicultural counseling*. Thousand Oaks, CA: Sage Publications, Inc.
- Price-Mars, J. (1983). *Ainsi parla l'oncle [So spoke the uncle]*. (Trans. M. W. Shannon). Washington, DC: Three Continents Press.
- Ramirez, M. (1997, October 1). Clash with tradition. *Newsday*, p. A5.
- Robertson, L., & Heagarty, M. C. (1975). *Medical sociology*. Chicago, IL: Nelson-Hall.
- Robinson, D. (1971). *The process of becoming ill*. London: Routledge & Kegan Paul.
- Rodman, S. (1973). *Haiti: The black republic*. CT: The Devin-Adair Company.
- Rubin, V., & Schnaedel, R. P. (1975). *The Haitian potential*. New York: Teachers College Press.
- Ryan, W. (1971). *Blaming the victim*. New York: Pantheon Books/Random House.
- Salins, P. D. (1997). *Assimilation, American style*. New York: Basic Books.
- Schaefer, R. T. (1995). *Race and ethnicity in the United States*. New York: HarperCollins.
- Shumaker, S.A., Schron, E. B., Ockene, J. K., Parker, C. T., Probstfield, J. L., & Wolfe, J. M. (Eds.). (1990). *The Handbook of Health Behavior Change*. New York: Springer Publishing Company.
- Shweder, R. A. (1997, Mar 9). It's called poor health for a reason. *The New York Times*, p. 5.
- Serafica, F., Schwebel, A. I., Russell, R. K., Isaac, P. D., & Myers, L. B. (1990). *Mental health of ethnic minorities*. New York: Praeger.

- Strauss, A., & Corbin, J. (1990). *Basics of qualitative research. Grounded theory, procedures and techniques*. Newbury Park, CA: Sage Publications, Inc.
- Sutton, C. R., & Chaney, E. M. (1987). *Caribbean life in New York City: Sociocultural dimensions*. Staten Island, NY: Center for Migration Studies of New York.
- Tarlov, A. R. (1996). Social determinants of health: The sociobiological translation. In D. Blane, E. Brunner, & R. Wilkinson (Eds.), *Health and social organization towards a health policy for the twenty-first century* (pp.71-93). New York: Routledge.
- Townsend, J. M. (1978). *Cultural conceptions and mental illness: A comparison of Germany and America*. Chicago, IL: University of Chicago Press.
- Trouillot, M-R. (1990). Haiti: State against Nation. The origins and legacy of Duvalierism. *Monthly Review Press*.
- Tseng, W-S., & McDerrott, J. F. Jr. (1981). *Culture, mind and therapy: An introduction to cultural psychiatry*. New York: Brunner/Mazel.
- Tseng, W-S., & Streltzer, J. (1997). *Culture and psychopathology: A guide to clinical assessment*. New York: Bruner/Mazel.
- Turner, B. (Ed.). (2000). *The stateman's yearbook. The politics, cultures and economies of the world* (137th ed.). New York: St. Martin's Press.
- Twaddle, A. C. (1979). *Sickness behavior and the sick role*. Boston: MA: G. K. Hall & Co.
- United States Department of the Census. (1995). *Statistical abstract of the United States*, 115th edition. Washington, DC: The National Data Bank.
- Wax, R. (1971). *Doing fieldwork: Warnings and advice*. Chicago: The University of Chicago Press.
- Weber, M. (1958/1913). Economy and society. In H. Gerth and C. W. Mills (Trans & Eds.), *From Max Weber: Essays in sociology*. New York: Oxford University Press.
- Wright, W. (1982). *The social logic of health*. New Brunswick, NJ: Rutgers University Press.

- Wright, W. D. (1997). *Black intellectuals, black cognition, and black aesthetic*. Westport, CT: Praeger.
- Zborowski, M. (1952). Cultural components in response to pain. *Journal of Social Issues*, 8, 16-30.
- Zborowski, M. (1969). *People in pain*. San Francisco, CA: Jossey-Bass, Inc.
- Zola, I. K. (1983a). Culture and symptoms: An analysis of patients' presenting complaints. In I. K. Zola (Ed.), *Socio-medical inquiries, recollections, reflections, and reconsiderations* (pp. 86-108). Philadelphia, PA: Temple University Press.
- Zola, I. K. (1983b). Medicine as an institution of social control. In I. K. Zola (Ed.), *Socio-medical inquiries, recollections, reflections, and reconsiderations* (pp. 247-268). Philadelphia, PA: Temple University Press.
- Zola, I. K. (1983c). On going to see the doctor: The contributions of the patient to the decision to seek medical aid: A selective view. In I. K. Zola (Ed.), *Socio-medical inquiries, recollections, reflections, and reconsiderations* (pp. 54-67). Philadelphia, PA: Temple University Press.
- Zola, I. K. (1983d). Pathways to the doctor: From person to patient. In I. K. Zola (Ed.), *Socio-medical inquiries, recollections, reflections, and reconsiderations* (pp. 109-120). Philadelphia, PA: Temple University Press.