Expression and Treatment of Depression among Haitian Immigrant Women in the United States: Clinical Observations

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Existing research demonstrates that culture has a profound impact on the expression and manifestation of mental illness, especially on depressive disorders among ethnically diverse populations. Currently, little research has focused on the Haitian population, despite the growing number of Haitians living in the United States. This paper discusses clinical observations of the expression of depression among Haitian immigrant women living in the United States. Specifically, this paper examines three distinctive types of depression (pain in the body, relief through God, and fighting a winless battle), explains their symptoms, and provides case examples to illustrate the expression of each type of depression. Additionally, the paper describes treatment processes for each type of depression and makes recommendations to mental health providers with respect to each type of depression. The information provided in this paper highlights the importance of a more systematic and scientific investigation of depression among Haitian women, men, and youths in the United States.

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EXPRESSION AND TREATMENT OF DEPRESSION AMONG HAITIAN WOMEN IN THE UNITED STATES: CLINICAL OBSERVATIONS

Culture significantly influences the way individuals from various cultural backgrounds experience and express depressive symptoms (Carter, 1995; Lutz, 1985; Kleinman & Kleinman, 1985; Manson, Shore, & Bloom, 1985; Sue & Zane, 1987; Ward, Sellers, & Pate, 2005). Specifically, researchers have outlined the ways in which individuals from different cultures present with depression (Brown, Schulberg, & Madonia, 1996; Kleinman & Kleinman, 1985; Lutz, 1985; Manson, et al., 1985; Sue, Fujino, Hu, Takeuchi, & Zane, 1991; Sue & Zane, 1987; Ward, et al., 2005). These studies have found that an individual's cultural background influences both the manifestation of the illness as well effective and appropriate interventions. This paper addresses the impact of culture on the diagnosis and treatment of depression by first reviewing current literature related to several ethnic groups, and then providing a description of some types of depression found among one specific ethnic group, which has not yet been examined—Haitians. Although this paper does not discuss the nuances of each specific ethnic group, the following review of some cultural groups highlights the profound impact that culture has on the diagnosis and treatment of mental illness.

Cultural Experience of Depression

Research on specific ethnic groups shows how culture plays a role in the experience of depression among various ethnic groups. For example, in a comparative study of Australian and Vietnamese nursing students' perceptions of depression, Fry and Nguyen (1996) found that culture and self-concept influenced the experience of depression. This study revealed that the Vietnamese students believed that a "superior person" would not allow troubling thoughts or emotions to overtake his/her life. The researchers describe this belief in comparison with Australian students, who identify with Western belief systems, and do not subscribe to the notion of control over one's feelings versus seeking help for suffering (Fry & Nguyen, 1996). The results of Fry's and Nguyen's (1996) study illustrate one way culture can affect an individual's understanding and experience of depression.

In another study examining culture's influence on depression, Brown and colleagues (1996) conducted a comparative study of the psychiatric history and presenting symptoms of African Americans and European Americans suffering from major depression. Results of the study indicate

similarities between African Americans and Whites in primary mood symptoms and condition severity. Differences existed, however, in their experiences of somatic symptoms, psychiatric and medical comorbidities, physical functioning, and levels of observed distress. Whereas the White individuals were more likely to report mood disturbances, African Americans focused on physical symptoms and psychosocial stressors. Supporting this research, Barbee and Schreiber (as cited in Schreiber, Stern, & Wilson, 2000) compared differences between the way Black and White women in Canada experience depression. Results from their work demonstrate that Black West-Indian women have a desire to remain "strong," and believe that suffering from depression is not a mental illness, but rather a symptom of life as a woman. White women, on the other hand, did not attribute depressive symptoms to their gender, but instead acknowledged their origination in a mental illness. Ultimately, these studies suggest that Black and White women experience depression differently—supporting the contention that culture impacts one's experience of depression (U.S. Department of Health and Human Services, 2001).

Similar to the studies above, the research by Yen, Robins, and Lin (2000) examined possible cultural differences in the experience of depression. Specifically, they used a Chinese– language version of the Center for Epidemiological Studies-Depression Scale to examine the ways in which Chinese immigrants and Chinese American adults experience depression. Findings from their study indicate that both groups report similar levels of somatic symptomatology (pertaining to depressive symptoms), but such reporting by the immigrant group was more likely to lead to seeking primary care, not mental health services (Yen, et al., 2000). Therefore, the results of this study indicate that while Chinese and Chinese American adults experience depression in a similar manner (e.g., somatic symptoms), the way they conceptualize and cope with it differs according to the culture in which they live.

Manson and colleagues (1985) took a slightly different approach from the previously described authors for examining the impact of culture on depression. Instead of comparing two different cultural groups, they examined the accuracy of the DSM-III and other diagnostic instruments in assessing and diagnosing depression. Their findings indicate that Eurocentric diagnostic tools do not provide accurate recommendations for the diagnosis and treatment of depression in American Indians. For example, according to the DSM-III, a diagnosis of depression requires a dysphoric mood lasting two or more weeks. American Indians, however, generally experience a dysphoric mood for only one week. Therefore, even though

American Indians may be depressed, they may not be diagnosed as such because the duration of their dysphoric mood is not congruent with the established guidelines for the majority culture (Manson, et al., 1985). These results, similar to those reported above, highlight the influence culture has on the expression and experience of depression.

Collectively, existing literature underscore the importance of culture in diagnosing and treating depression among many cultures. To date, this research had not yet included data on Haitians in the United States. Knowledge regarding the Haitian community's experience of depression becomes increasingly necessary as Haitians are one of the largest Black immigrant groups in this country. In fact, the 2001 U.S. Census reports that as of 1996, Haitians became the third largest ethnic immigrant group in the United States, but this accounts for documented naturalized Haitians and therefore, may be an underestimation of the number of Haitians living in the United States To address this gap on Haitian women and depression in the literature, clinical data used in this paper provides (a) a description of three types of depression observed among Haitian immigrant women and (b) recommendations to health care providers on the integration of culture in the treatment of these women in the United States. This knowledge will enable mental health providers to understand the presenting symptoms of these clients and to provide culturally appropriate interventions, which will ultimately lead to better treatment adherence and outcomes.

Description of the Provider

This paper provides information based on the first author's clinical experiences working with Haitian clients in private practice and community mental health centers. The provider is a Haitian American licensed clinical psychologist who immigrated to the United States in her early teenage years. She is fluent in Haitian Creole (official language of the Haitian people) and trained in both psychodynamic and cognitive behavioral therapy. Her office and the community centers focused primarily on addressing the mental health needs of the Haitian community and thus the majority of clients were Haitian immigrants. The information presented in this paper is from seven years of individual, group, and family therapy with Haitian immigrant women and children.

Working clinically with 55 Haitian clients over the last seven years provided the first author with knowledge about the various forms of depression found among this population and the treatment process in working with these types of clients. Below is a description of the symptoms

of the three most commonly encountered types of depression observed among Haitian immigrant women and a description of the recommended corresponding treatment processes. The information focuses on Haitian immigrant women because women were the predominant users of mental health services at the office. Today, not much has changed with regard to the demographics of the private practice office or the community mental health centers. The last agency report indicated that 90% of the client population for the mental health service clinic was women. This is not surprising since it is less common for Haitian males to seek professional help from mental health clinicians (Desrosiers & St Fleurose, 2002). As a result, more clinical data are available for Haitian women than for Haitian men.

EXPRESSION OF DEPRESSION AMONG HAITIAN IMMIGRANT WOMEN

The data used in this paper show that Haitians neither experience nor present with depression in the ways often described in Westernized literature. For instance, Haitian women present with three distinct types of depression:

(a) *Douluer de Corps* (pain in the body), which is often described by symptoms, such as feelings of weakness (*faiblesse*) and faintness;
(b) *Soulagement par Dieu*, (relief through God), which is often associated with specific times, circumstances, and situations in the person's life and is often mediated by the clients belief in God; and
(c) *Lutte sons Victoire* (fighting a winless battle), which often is painted as a very bleak generalized picture of the individual's life.

Depression associated with posttraumtic stress disorder is often seen as of these types. For example, there are traumatized patients whose depression appear to be more somatic, yet there are others who talk about their symptoms as being damaged and having a negative view of their lives.

Description of Pain in the Body

Pain in the body is without a doubt, the most common form of depression that one encounters while working with Haitian immigrants. This group of patients often comes to mental health services after many visits to medical doctors and emergency rooms without attaining a successful diagnosis. These patients typically present with physical symptoms, such as *faiblesse* (feelings of weakness) and *gaz* (faintness, stomach problems), digestion difficulties, pain in the stomach, headaches, etc. After consulting with various medical doctors without success, these individuals

may conclude the symptoms are the result of Voodoo and turn to a *houngan* or *maba* (Voodoo priest or priestess) to alleviate symptoms. The individuals often express a sense of helplessness and hopelessness in discovering the cause of what troubles them. They cannot find solace and continue suffering from their symptoms until they eventually utilize mental health services. It is important to note that although the pain symptoms reported are similar to that of somatization disorder, these clients would not meet the full diagnostic criteria for this disorder. In order to diagnosis a client with somitization disorder, the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM-IV) requires:

(a) four pain symptoms related to at least four different sites or functions;
(b) two gastrointestinal symptoms, such as nausea and diarrhea; and
(c) one sexual symptom, e.g., sexual indifference.

Many Haitian clients may present with some, but not all, of these symptoms. Therefore, pain in the body is a unique and different condition from somatization disorder, yet, the client remains in need of treatment.

Case illustration of Pain in the Body

Emilie (all names and identifying information have been changed to maintain the confidentiality of the clients) is a 44-year-old Haitian woman who was treated by the first author for pain in the body. She came to the United States in her early teenage years, graduated from high school, and obtained a certificate in business administration. She was married (for 20 years) with two teenage children in high school. Emilie's primary care physician referred her to the office, after she was evaluated for a number of health complaints, such as pain (leg, back, stomach, head, etc.), sleep difficulties, transient numbness, and gastrointestinal discomfort (i.e., gas, diarrhea, and digestion difficulties). Numerous diagnostic assessments, such as a CAT scan, upper gastrointestinal endoscopy, sleep apnea evaluation, and blood studies, etc., did not yield a diagnosis. As a result, doctors recommended that she receive a psychological evaluation. Six months after receiving the referral, Emilie scheduled an appointment. During the psychological evaluation, Emilie reported difficulties falling asleep, inconsistent pain in various parts of her body, digestive difficulties that led to a decrease in appetite, and weight loss of approximately 10 pounds in the last six months. She also reported increased conflicts with her husband and other family members, anxiety about the health of her parents (who reside in Haiti), and a lack of satisfaction with her current employment and life in general. This case illustrates how Haitians expe-

riencing depression of the pain in the body type are likely to present predominantly with physical symptoms, as opposed to the more expected mood or emotional responses.

Treatment Recommendations of Pain in the Body

Because clients with pain in the body often associate their symptoms with medical ailments, they rarely accept responsibility for their emotions or symptoms. Rather, these individuals often attribute their symptoms to issues such as poverty, immigration, stressors from their family, someone invoking Voodoo on them, etc. Mocun-Aydin's (2000) research suggests that many clients suffering from depression, especially those with less education, tend to attribute their condition to external controlling factors.

It is the position of this paper that any attempt to explain symptoms of pain in the body using frameworks such as cognitive–behavioral theories, may leave clients feeling defensive and responsible for their current conditions. Such approaches and explanations can eventually decrease treatment compliance. In his work with Turkish women suffering from depression, Mocun-Aydin (2000) outlined the ineffective—and almost detrimental use—of traditional clinical methods when working with these women:

> Helping clients achieve insight, self-awareness, and personal growth may be the counselor's goals; however, unless these goals are owned by the client, no positive outcome will be achieved. It is quite common that the client may want solutions to practical problems without any reference to internal change. In a situation such as this, it is important to recognize that the therapeutic relationship should contain shared and appropriate goals if it is to be effective. In practice, this means that the therapist will find out from the client what are his or her desired goals. The therapist, then, may explain the way counseling works and both parties may negotiate a common purpose (p. 292).

Engagement should be the primary objective of the treatment process for clinicians working with Haitian clients suffering from pain in the body. The therapist needs to engage the client by acknowledging and affirming their experiences and beliefs. As such, mental health clinicians working with Haitian clients who have this type of depression may find that a combination of psychodynamic and cognitive behavioral techniques is more effective. The psychodynamic framework is used to assist the clients in understanding their symptoms, exploring and making connections about childhood experiences and relationships. For example, Emilie became engaged in the treatment process when she received the space to

discuss her life struggles and immigration experiences. Treatment should also integrate cognitive–behavioral techniques, such as skill building and cognitive restructuring, to provide the client with a sense of control and strategies for reducing their symptoms.

Description of Relief through God

Relief through God depression is often associated with specific times, circumstances, and situations in a person's life. For example, clients may find themselves at difficult crossroads in their work and/or relationships, which produces high levels of stress. They often talk about feeling weak, feeling down, crying frequently, being unable to sleep, and continuously thinking about their problems, and they report a peak in these symptoms when faced with high levels of difficulty or stress in their lives. Furthermore, contrary to popular conceptions of depressive symptoms, these clients typically do not report feeling irritable or restless. Although the individuals recognize their symptoms, the symptoms do not preclude them from carrying out their daily work, educational, and/or household responsibilities. Additionally, though some of the symptoms of this condition, for example, sleep difficulties, are similar to the vegetative symptoms of depression, in most cases, these do not interfere with our clients' ability to meet their basic needs. In fact, clients rarely report having a decrease in appetite or sex drive. It is important to note that although some of the symptoms of this type of depression (i.e., crying spells and sleep difficulties) may resemble that of major depression, clients would not meet the diagnostic criteria for a major depressive episode (e. g., markedly diminished interest or pleasure in almost all activities most of the day, significant weight loss, psychomotor agitation or retardation nearly every day, loss of energy nearly every day, diminished ability to think or concentrate, recurrent thoughts of death). As a result, Haitian clients may be experiencing depression, but would not meet the criteria for any of the depressive disorders described in the DSM-IV.

One reason these individuals are able to maintain involvement in daily activities and responsibilities is because of the way in which they conceptualize their symptoms. They rely on their faith in God to relieve their symptoms. In fact, these women often refer to God during therapeutic sessions. For example, they sometimes make statements such as "*Mwen se pitit Bondye*," which literally means, "I am the child of God". In the Haitian culture, this phrase has two predominant meanings: (a) I am the child of God and therefore must accept the good and the bad; (b) I am the child of God, and therefore, do not fear these symptoms and trust that all

will be well in the end. The latter meaning is often the one that these patients use to cope with depression. Their symptoms are not debilitating because they undoubtedly trust that relief will soon come—if they continue to believe. It is imperative that this strong belief in God not be associated with psychotic disorders since that will inevitably lead to the wrong type of intervention for these individuals. Discussing religiosity, religious rationales for pain and suffering, healing rituals, spirituality, and prayer, is often a source of comfort and can be the foundation for healing many immigrant women (Hinkleman, 2001; Mocan-Aydin, 2000; Schreiber, et al., 2000).

Case illustration of Relief through God

Marie is a 55-year-old Haitian woman whose symptoms we recognized as those congruent with relief through God depression. She completed high school in Haiti, came to the United States while in her mid-twenties, and now works full time as a home health aide. She is married and has three children, the youngest is 16 years old and the oldest 28. A previous client of the first author referred Marie for mental health services. During the intake evaluation, Marie did not report feeling "depressed", although her family and friends told her that she might be depressed. Marie, however, acknowledged that she did not have a clear understanding of what the term "depression" meant. She reported not feeling well, having difficulties falling asleep, frequent crying spells, and minimal interest in activities or life. Although the latter symptoms are similar to the DSM-IV diagnosis of anhedonia, Marie reported finding pleasure in work and in leisure activities, but that these activities did not eliminate her distressful thoughts about her difficulties. She reported no changes in her food intake, weight, or sexual activities, but she described having difficulties understanding the purpose of her life and overcoming her belief that her life had been plagued with struggles and difficulties. However, she denied any thoughts of suicide and reported that her symptoms had not interfered with her productivity at work or home. In fact, she noted never missing a day of work because of illness in more than 15 years. In an effort to cope with her symptoms, Marie increased participation at her church by attending services three times a week, and she reports praying in the morning, at mid-day and bedtime, and reading more Bible verses daily. Despite these efforts, her symptoms continued, which prompted her to seek mental health treatment. This case example demonstrates how Haitians suffering from depression may have some symptoms similar to those described in the DSM-IV (e.g., trouble sleeping and frequent crying spells), but that

their symptoms will not completely match (e.g., still able to find pleasure in life activities).

Treatment recommendations for Relief through God

Because of their perception and presentation of symptoms, women with depression of the relief through God type are less likely to seek mental health services and more likely to rely on God for relief. They will, over time, increase attendance at church services and activities and read Bible scriptures more often. Relief through God tends to be one of the most challenging forms of depression to address in the initial stages of therapy. Once in treatment, these clients often doubt that Westernized interventions will provide relief from their symptoms. However, by using culturally appropriate approaches, this type of client can be one of the easiest to treat. For example, through experience the first author has found that helping the client see the therapist as an avenue through which God works can increase compliance and investment in the treatment process, which quickens rates of symptom reduction. Paying close attention to specific cultural factors and differences between Haiti and the United States can help facilitate the clients' engagement into the treatment process.

Description of Fighting a Winless Battle

Individuals experiencing fighting a winless battle depression often present with a very bleak picture of their lives. They complain excessively about their lives and the suffering and tragedies they have endured. These individuals talk about feeling fatigued by their daily struggles and the need to accept fate. Yet, they rarely see such circumstances as an end to their lives. They have endured much hardship, survived horrendous stressors or trauma, and are able to accept the stressors that seem to characterize their lives. In fact, they often report not knowing a time when negative occurrences were not central to their lives. Despite such bleak views of their lives, and an inability to hope that things will improve, these clients continue to live their lives. They talk about biding their time on earth and waiting for their "time to come". Thus, they go to work and attend to their homes and families without difficulty, but they take little pleasure from any aspect of their lives. This type of depression is quite similar to the diagnostic criteria of C disorder as described in DSM-IV. The client is likely to meet the following criteria for dysthymic disorder:

criteria A (depressed mood);
criteria C (symptoms for at least two years);
criteria D (no major depressive episode);
criteria E (no manic episode);
criteria F (no psychotic or delusional disorder); and
criteria G (no substance use or abuse).

However, Haitian clients who are experiencing this type of depression are unlikely to meet Criteria B (presence of symptoms such as poor appetite, insomnia, low energy, low self-esteem, poor concentration, and feelings of hopelessness) and Criteria H (significant distress or impairment). As a result, it is unlikely that clinicians will diagnose them with dysthymic disorder.

Case illustration of Fighting a Winless Battle

Felicia is a 61-year-old Haitian woman who received a diagnosis of fighting a winless battle type depression. She immigrated to the United States at the age of 35. She is unemployed, has four adult children, and lives with her oldest daughter and her daughter's nuclear family. Felicia's daughter referred her mother to therapy because of increased concerns about her. Felicia learned that she had insulin dependent diabetes at the age of 54 and has not been compliant with her medication regimen. In fact, she often engages in behaviors that are counter productive, such as drinking sugar-sweetened cola, using large amounts of sugar in her coffee, and not checking her sugar level, etc. During the intake interview, Felicia reported an inability to recall a time in her life when things were "good". She reported that her life had been afflicted with bad events, such as the loss of both of her parents at an early age, the death of a child and two husbands, and diagnosis with diabetes, etc. She reported no positive aspects in her life and that she was just waiting for her life to "end". She believes in afterlife, and she looks forward to getting a "new start" after her death. She denied any suicidal thoughts or intent, citing religion and beliefs in an afterlife as two of the major preventive factors for not committing suicide. Although she was committed to coming to her therapy sessions, she reported little enthusiasm or optimism that the process would lead to any changes in her life. This case example shows how Haitian clients suffering from fighting a winless battle depression similar to those suffering from relief through God, are likely to present with many, but not all, of the symptoms necessary to receive a mood disorder diagnosis.

Treatment recommendations for Fighting a Winless Battle

In addition to using some of the techniques (i.e., psychodynamic, and cognitive behavioral) discussed for treating patients with the relief through God type of depression, using an empowerment developmental model, such as that described by Lee (1994), may be useful in assisting clients with fighting a winless battle depression gain a sense of control in their lives. Such a model can counteract powerlessness and increase clients' sense of resourcefulness. Lee's (1994) empowerment developmental model, which is often successful when working with oppressed populations, consists of three stages: motivation, competence, and influence. The motivation stage can be both goal directed (e.g., getting a job, self-care) and incentive focused (e.g., incremental awards for goals achieved). The competence stage of the model focuses on educating clients about resources available in their communities and increasing knowledge about symptoms and viable treatment options. Lastly, the influence stage of the model is concerned with ensuring that the client has many opportunities to practice the skills learned outside of therapy and participate in more leadership roles in external activities. For example, towards the end of her therapeutic experience, Felicia began taking more of an active leadership role in her church. She became a Bible school teacher, joined the church council, and eventually became a Deaconess at her church. This empowerment model encourages individuals to increase their connection with others through action-oriented behaviors by creating practice activities and strategies for each stage of the model. Engaging in such activities allows clients to develop a sense of control and empowerment in their lives, which ultimately leads to a decrease in the negative self-talk and evaluations of themselves and their lives and higher social functioning. Having such a framework allows clients to understand the process of mental health treatment and to recognize the changes that occur outside of the weekly therapeutic sessions.

CONCLUSIONS

Depression is a universal phenomenon largely impacted by one's native culture. For instance, while individuals from some cultures present with cognitive or morale symptoms, others describe changes in their body or somatic symptoms (Kleinman & Kleinman, 1985; Lutz, 1985; Manson, et al., 1985). This paper suggests that depression among Haitian women takes different forms and that Haitian expressions and reporting of depression are different from other Western ones. This is consistent with previous

findings found among a variety of other cultures such as, African American, American Indian, Black West-Indian, and Chinese (Brown, et al., 1996; Manson, et al., 1985; Mocun-Aydin, 2000; Yen, et al., 2000). In America and many European cultures, there is a standard cluster of cognitive and morale symptoms, such as an inability to experience pleasure and a lack of motivation, which characterize depression (Kleinman & Kleinman, 1985; Lutz, 1985). As described in this paper, however, depressed Haitians experience, describe, and present with the condition differently than how Eurocentric cultures conceptualize it.

The three types of depression (pain in the body, relief through God, and fighting a winless battle) observed in the Haitian clients described in the present manuscript, are consistent with some of the types of depression that Turnier (2002) noted in his work with Haitian clients living in Montreal, Canada. However, Turnier (2002) also remarked on three additional forms of depression in Haitians: The "*Ou sanble moun mo pete sou li*" ("you look like someone whose soul has been invaded by death") depression, the "*Yo fè li mal*" ("you have been cursed") depression, and the "*Ou se yon anvi mouri kap chèche yon anvi touye*" ("you feel like dying and you are looking for someone that could kill you") depression. The "you look like someone for whom death has invaded your soul" form of depression is mainly characterized by a catatonic–like state of indifference and lack of affect, but the individual remains highly functional in daily life. The "he/she has been cursed" type of depression is characterized by paranoid/persecutory delusions and hopelessness, and the "you feel like dying and you are looking for someone that could kill you" depression is exemplified by behavioral difficulties, such as provoking physical fights and engaging in illegal acts. Because of such differing experiences with depression—among Haitians and between the Haitian culture and Western cultures—clinicians cannot explicitly rely on classifications, such as the DSM-IV-TR, for diagnosing the condition. Rather, it is imperative that clinicians evaluate and treat depression within the cultural context of the client.

Clinicians and researchers working with culturally and linguistically diverse populations need to document systematically the frequency of symptoms and syndromes, develop culturally appropriate diagnostic criteria, and identify effective treatments for the presenting disorders of these clients. Lack of knowledge about the way Haitian culture affects presentation of depressive conditions and treatment processes could lead to under diagnosed and/or misdiagnosed patients. The information provided in this paper may help clinicians attend to clusters of symptoms that might

otherwise have been considered irrelevant, and also offer ways to reach out, understand, and provide culturally effective therapeutic interventions to Haitian women in the United States.

Given that clinical observations suggest that Haitian immigrant women's experiences of depression may be unique to their culture, it is important for researchers to use measures and methods that are appropriate for these women's experiences. Additionally, the findings of this paper should alert researchers to the possibility that other mental health conditions, such as anxiety, may manifest differently in Haitians. Studying mental health conditions from a perspective other than that of the native culture of clients may produce inaccurate findings. For example, Russell and Madrigal (1998) found that data based on Anglo populations was often inaccurate in assessing the abilities, achievement levels, and personalities of immigrant clients.

Although the current paper reveals information about the influence of culture on depression in Haitian women and highlights areas where researchers and clinicians need to be cautious, there are a few limitations to consider. In general, the data are from clinical observations, and therefore, to have a greater understanding of the expression of depression among Haitians living in the United States, researchers need to conduct empirical studies. In addition, although Turnier (2002) found similar types of depression in his clinical work with Haitian clients living in Canada, suggesting that similar types of depression can be found among all Haitians regardless of geographic region, the information reported in this paper came from only one area of the United states, thereby limiting the ability to generalize the findings. It is necessary to conduct systematic and empirical research in various geographical locations in the United States to determine whether similar types of depression exist. Perhaps the types of depression experienced by the Haitian immigrant women were unique to the locale in which the participants reside. Future projects should include Haitian men and adolescents to determine if these observations are consistent across gender and age. Additionally, this project focused on Haitian immigrants, which prevents researchers from establishing if these clinical observations are applicable to American-born individuals of Haitian descent.

Despite the limitations of the current paper, it is extremely compelling for a variety of reasons. First, the present paper is the first to address depression among Haitian immigrant women in the United States. Prior to this paper, the mental health field had not yet examined the specific and different ways in which Haitian women experience depression. Addition-

ally, the information presented in this paper provides researchers and clinicians with some insights about Haitian immigrant women's experiences with depression. By taking culture into consideration, mental health clinicians and health care providers will be able to treat and relate to their patients more effectively, ultimately leading to more successful interventions, a reduction in dropout rates, and a decrease in the health service disparities in this country.

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