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Understanding Distinctive Beliefs and Perceptions about Depression among Haitian Men

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Abstract

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Abstract

As of 2010, depression was the second most serious disorder among developed nations. Historically, African Americans, Latinos, and people of Caribbean descent have underutilized mental health services and have therefore been underrepresented in such statistics. Investigation into depression among Haitian men, from a Western or a non-Western cultural perspective, has been sparse in the literature. Bandura's social learning theory and Mahalik's biopsychosocial framework provided the theoretical foundation for this investigation. The purpose of this quantitative analysis was to explore the relationship between levels of depression in Haitian men related to restrictive emotionality, self-reliance, subjective masculine stress, spiritual well-being, and length of time in the United States. The data were obtained from demographic questionnaires and surveys to among 90 Haitian men residing in the United States, between the ages of 20 to 40 years old. Data were analyzed using multiple regression. The results indicated Haitian men who have been in the United States for a longer period of time showed a significant correlation to depression in comparison to their counterparts who have been in the United States for a shorter period of time ($r = .22$, $p < .04$). These results promote social change by providing information about depression among Haitian men to health care professionals, clinicians, and researchers who provide services to this grossly underserved population.

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Dedication

In loving memory of my grandmother Francessca Ettienne “Tante Franc” who never had the opportunity to attend school. Instead, she cared for her younger siblings as well as struggled through hard times in Cap du North. Although my grandmother was illiterate, she was a business woman who owned her own restaurant ‘Du Cap’. She was active in civil rights, women's rights, and believed in education. She also strongly taught her three sons, Wilfred, Pasilli, and Joseph, to speak the truth and stand by their word (your word is your bond) and when you meet someone, they will remember you because of your actions and your words, whether that be good or bad. Francessca became a very powerful advocate for her grandchildren too, quick to act as their lawyer during their early childhood and their judge during their adolescent years. She also empowered her great-grandchildren by advocating on their behalf. She believed that coming to the United States was a great test and an opportunity, especially for those coming from a less fortunate world.

This dissertation is also dedicated to my beloved sister, Naudlee Valcin- Reese, who has always been my inspiration. When she was a soldier in the United States Army, stationed in Germany, she urged me to pursue my education. Naudlee did more than encourage me; she would research and find resources and opportunities available for minority students and then tell me to apply for this or that financial assistance. To my loving and devoted parents, Joseph Renold Valcin and Bernadette Valcin, who decided to leave Cap-Haïtien, Haiti, in the early 60s, migrating to the United States to seek for better opportunities for themselves and their family. They came to the United States during the

time when segregation was still a reality for people of color. Thank you for continuously keeping me grounded about our culture as well as providing me with spiritual guidance.

I also dedicate this dissertation to my family Hermann “Heri,” Deanna “Dee,” and Imannie “Maam,” who always believed I could do anything. Most sincerely to my girls, Deanna and Imannie, who always need to believe that dreams are possible and can be achieved through hard work, as well as that women of color have a chance to achieve their dreams. To Miss Mattie Mangrum, who has changed my world on numerous levels of paradigms; and to all Haitian women and men who have migrated across the globe seeking a better way of life and dreamed big dreams in this land of possibilities and opportunities. They too, without exceptions, can reach beyond their limitations and make their dreams a reality. Lastly, I am deeply indebted to all those individuals I have encountered who strongly believed that I was not going to accomplish my life goals; this dissertation is humbly dedicated to you. I thank you for the motivation.

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To world-renowned researcher, Dr. Guerda Nicolas, without following her lead there would not have been a dissertation addressing this gender. With her pioneering research on depression in Haitian women, Dr. Nicolas's work gave me the inspiration and opportunity to follow in her footsteps and address the issue of depression in Haitian men.

Moreover, Dr. Nicolas's response to my e-mail gave me an opportunity to engage in an invaluable telephone conversation with her. Although she was out of the country at the time, she scheduled a time when she could speak with me. She offered me assistance by providing me with relevant data and insights into the countrywide Caribbean perspectives and the Haitian population to further my understanding of my dissertation topic.

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To Ms. Mattie Mangrum, EdM, my right-hand collaborator who changed everything by being available at any time of the day or night, working with me to insure that my focus and my translation of my work remained true to who I am. I was able to hold great insightful conversations with her about Haitian people and she also provided me with tremendous reflective processes in understanding American and Western cultural perspectives. You know the depth of my gratitude.

Foremost, I thank all the scholars who previously have addressed the topics of normative and nonnormative, depression, gender issues, men, and social norms. Without your contributions and your invaluable research literature pertaining to my dissertation topic, to address the effects of men’s depression as nonnormative, I would not have been able to either present the cause or reason the topic would be worthwhile.

We gratefully acknowledge financial support from the following foundations: The Haitian Studies Association's, Caribbean Regional Conference of Psychology, and The

Bahamas Psychological Association. In addition, I am forever grateful to all those at whatever organization and to everyone else I did not mention, but who contributed in some way to the successful completion of this dissertation.

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Chapter 1: Introduction to the Study

Historically and currently, there have been "no epidemiological depression studies of" Haitian people undertaken in the United States on the prevalent rate of depression among Haitians by any classification, age, or gender (Jack & Ali, 2010, p. 319). There were a few studies on depression in Haitian women, but none undertaken to examine depression among Haitian men living in the United States (Nicolas et al., 2007). The findings from Jack and Ali's (2010) clinical perceptional data conveyed that Haitian women revealed depressive symptoms through multiple expressions that were culturally different from Western depressive criteria and, therefore, a Western instrument would fail to provide significant measurements that would be ethnically applicable to address depression from a non-Western perspective. At the time of this study, I could find no empirically researched studies that either addressed depression among Haitian men from a cultural perspective or addressed aspects of masculinity and culturally relevant stressors that may contribute to depression symptoms in Haitian men.

On January 12, 2010, the world woke up to learn that the greatest earthquake to occur in the Western Hemisphere had happened in Haiti. This history-making catastrophe familiarized the whole world with the name Haiti even though most people, especially Americans (according to McAlister; 2001), would have been unsure exactly where Haiti was located and knew little if anything about Haiti or Haitian people. What people generally would have known about Haiti and Haitian people was predicated on the erroneous, exploitative, and racist movies that depicted Haiti as a country of uneducated and extremely superstitious natives obsessed with the practices of Voudou, or *Voodoo* as

it is commonly misspelled (McAlister, 2001). The lack of knowledge and appreciation of Haiti and Haitian people is not by accident, but rather by design. Prior to the historical earthquake, the phenomenal resilience of the Haitian people to survive the ravages unending foreign and domestic military domination, foreign economic exploitation, culture and religious restrictions, and legendary political dictatorships was not widely known beyond Haitians themselves (Drotbohm, 2010).

The fact that Haitian men rarely seek professional mental health services due to cultural restraints, religious beliefs, and the social stigma attached to mental illness (Desrosiers & St. Fleurose, 2002) is partially responsible for the void in cross cultural research on depression in Haitian men. In this study, I examined depression among Haitian men in the United States and whether adherence to traditional masculine norms, integrated with religious beliefs in Voodoo, had any impact on their perspectives on depression. Consequently, to gain the maximum amount of insightful and relevant data about depression among Haitian men, I needed to examine Haiti from a very broad and inclusive perspective of culture, history, religion, indigenous influences, male role norms, and patterns of migrations and the "diaspora" (here referring to Haitians who had left the island; Drotbohm, 2010, p.41).

This research began with examining the unique history of Haiti, the origins of Haitian's spiritual connection to the religion of Voodoo, and the marriage of Voodoo and Catholicism. The investigation explored whether the religion of Vodoo had influenced Haitian men's decisions regarding seeking help for depression. I investigate whether adherence to powerful traditional masculine role norms had restricted men's ability or

willingness to disclose personal feelings including symptoms of depression. Because there was a gap in the literature on depression in Haitian men, this pioneering research was of paramount importance as an addition to the increasing number of studies addressing masculine norms and the different ways symptoms of depression may appear in men (O'Loughlin et al., 2011). Researchers have reported that many of the findings on depression were taken from studies of female participants and the results were extrapolated as applicable to men suffering with depression as well (Addis, 2008). Currently, many researchers have been questioning the validity of these findings as applicable to understanding depression in men and have advocated the need to study depression as it is expressed in men (Addis, 2008). The evaluation methodology was applied by implementing procedures designed to address the research questions and achieve the purposes of this study. According to Creswell (2009), "the variables need to be specified in an experiment so that it is clear to readers what groups are receiving the experimental treatment and what outcomes are being measured" (p. 157).The statistical analyses provided a descriptive sample size of the survey of Haitian men residing in the United States, between the ages of 20 to 40 years old (Creswell, 2009). Depression was measured in this study by using the Center for Epidemiological Studies Depression Scale-Revised (CESD-R; Eaton, Smith, Ybarra, Muntaner, & Tien, 2004, pp. 363-377) to examine Haitian men who suspect they are experiencing or may have previously experienced symptoms of depression. The CES-D has been frequently used and highly endorsed among numerous diverse populations (Hammond, 2012). The CESD-R assessment instrument provided a statistical descriptive analysis of Haitian men's

symptoms of depression associated with masculine role norms and showed how the depressive disorder may appear in Haitian men. Quantitative strategies helped me identify correlations and statistical significances. The quantitative approach procedures involved a system of measurement specifically designed to answer the research questions and accomplish the purposes of the investigation.

Introduction to Haiti

Haiti's History Obscured

Haiti's unique place in the history of Western civilization has been obscured by unethical historians, exploited by foreign and domestic tyranny, and misrepresented in the global community as a country unstable in all matters of governance e.g. public safety, development of modern infrastructures, adequate mental and medical health services, education, commerce, transportation, housing, and a stabilized economy (Drotbohm, 2010). Haiti, located on the island of Hispaniola, was the first land where the enslaved Africans in the Western Hemisphere successfully revolted against their slave owners, declared themselves free men and women and established the sovereign nation of Haiti, originally spelled as Ayiti, meaning the first. Historically, Voodoo, with its powerful priests and priestess, played a significant and decisive role in the struggle for emancipation from their European masters (Drotbohm, 2010). From the moment the former slaves declared Haiti a free country, nations conspired, beginning with the French, to collectively negotiate commerce agreements with restrictive and long-binding contracts designed to stifle the newly formed black nation's economic progress and

simultaneously increase their international debt (World Health Organization [WHO] & Pan American Health Organization [PAHO], 2010).

The Haitian Connection to Voodoo

In this modern day, the name Haiti continues to conjure up some image or connection to Voodoo. It is understandable and culturally correct to correlate the name Haiti simultaneously with the practice of Voodoo (McAlister, 2002). Voodoo is an integral and vital factor in Haitian history, culture and religious life and its influence is felt in the ordinary functions of daily living. The problem is the misrepresentation and misunderstanding that surrounds Voodoo. From a Western perspective, Voodoo is most frequently thought of as an evil concoction of spells, hexes, and the working of black magic to accomplish some dastardly deed (McAlister, 2002). Quite the contrary, Voodoo is a religion that is a mosaic of indigenous West African religious beliefs and practices, brought by the enslaved Africans stolen from the West Coast of Africa and transported throughout the Diaspora, i.e. Caribbean Islands, Cuba, America and combined with the practices and beliefs of the Roman Catholic Church (McAlister, 2001). To better understand the Haitian psyche, it is necessary to understand the potent interrelationship between Haitian people and their spiritual devotion to the religion of Voodoo.

During the colonization of Haiti, 1492-1804, the European masters viewed the Voodoo religious practices as a threat to their economic and political wellbeing and mandated all slaves be converted and baptized into the Roman Catholic Church, thus making Voodoo a punishable offense (Drotbohm, 2010). The penalty for practicing Voodoo was now punishable by death. Albeit converted and baptized into the Roman

Catholic Church, the slaves continued to practice their indigenous Voodoo religion and to revere the Voodoo spirits along with the various saints in the Catholic Church (Drotbohm, 2010). In Voodoo, some of the spirits that are venerated are: a lithograph of the Catholic Saint JakMaje`, Saint James the Elder (representing Ogou, the dominate Voodoo spirit of war), Ezilie Freda (the Black Madonna, most popular and one of the few female Voodoo spirits, resolves marital conflicts), a lithograph of Maria Dolorosa (the Catholic Madonna, Ezilie Freda's counterpart), Damballa (the old and wise, responsible for health issues), Kuzin Zaka (the farmer, financial and business matters, protects employment), Legba (protector when travelling), Ge`de`(spirit of the dead, helps communication with ancestors, procreation and sexuality) (Drotbohm, 2010). The key to gaining insight into the religion of Haitian Voodoo is to understand there exist an intense and intimate relationship of reciprocity between the spirits, the lwas, (the spirits, angels) and adherents who serve or work with them (Drotbohm, 2010). An individual inherits his or her unique relationship to one or more specific lwas through the genetic blood line through one of his or her parents (Drotbohm, 2010). Consequently, an individual does not have the option of choosing to become a Vodouisant (one who serves the spirits) because the spirit alone has the autonomous power to choose the individual for a reciprocal relationship (Drotbohm, 2010). Most commonly, the first evidence that an individual has been chosen by a particular spirit usually occurs during a religious ceremony such as First Communion. The individual is overtaken or is filled with this particular spirit and manifests the spirit in words and actions, and no longer has self-control (Drotbohm, 2010). This phenomenon of being filled with this particular spirit is identified as evidence

of a lwa's choice to be served by that individual, to establish a relationship based on reciprocity and mutual respect (Drotbohm, 2010). This will be the beginning of an intimate and personal relationship between that individual adherent and that particular spirit. In the future, that adherent will reaffirm that spiritual relationship and appease that spirit through rituals of singing; playing the drums, dancing, gifts of special foods, flowers, drinks and various other types of offerings essential to Voodoo worship and communing with the sprits. Most importantly, adherents to Voodoo believe that in order to achieve and maintain personal mental, physical and spiritual well-being, it is critical to cultivate and reaffirm their spiritual relationship and continuous commitment to honor the spirits (Drotbohm, 2010).

The Matrix of Voodoo and Catholicism

The religious world of Voodoo is occupied by many invisible spirits who's originally functioned in many African and European cultures. The most omnipotent power is unquestionably God the Creator, often called by the French name, *Bondieu,* (translated as the Good Lord) or by his name in Haitian Creole, *Gran Metl* (translated as the Great Master) (McAlister, 2001). Adherents to Voodoo believe that Gran Met rarely shows himself to men and women and therefore, adherents depend on Christian saints and a series of other spiritual beings. Haitians who adhere to Voodoo also say Christian prayers to Jesus Christ, the Blessed Virgin Mary and all the Catholic saints (McAlister, 2001). Besides these Christian beings, there are multiple lwa (spirits, angels), who converse with sevite (Voodoo spirits) using prophecies, visions, and being overtaken by the spirit**.** Some of the most popular of the lwas (spirits) are: Legba, Marasa, Loko,

Danbala, Ezilie, Kouzen Azaka, Ogou, Jean Petwo, and Bawon Sandi, to name a few (McAlister, 2001).

The invisible realm of the spirits is perceived as an elaborate world which reflects our natural world. The deceased and the spirits are divided from those alive by an expansive invisible sea that symbolizes the Atlantic Ocean that the African ancestors crossed during (the Middle Passage) as they were being shipped as slave cargo to ports in the New World (McAlister, 2001). The deceased and the spirits inhabit the land *an bad lo* (under the sea), a land called *Ginen (*mystical Africa) (McAlister, 2001). Although sevites (serve Voodoo spirits), they also consider themselves as servants in the Catholic Church and usually perform all the other sacraments of the Roman Catholic Church. There is one important Voodoo ceremony that must be performed within one year of the death of a sevite (serves Voodoo spirits) (McAlister, 2001). The Voodoo priests and priestesses perform a ritual to summon the deceased from under the invisible sea and usher them on to God, the Creator or Bondieu, (the Good Lord). Deceased persons who were influential in some manner in life may become ancestral spirits and provide the Voodoo adherent with guidance, healing and assist in living a better life (McAlister, 2001).

Voodoo and Catholicism share the same understanding of God as Creator, Judge, and Giver of Life in the world. Where there is a parting of ways is in the spiritual traditions of Voodoo and Catholicism (McAlister, 2001). In Voodoo, on one side is the world of the deceased and the spirits and on the other side is the natural world of the living. These two worlds are separated by a vast mystical body of water representative of

the Atlantic Ocean (McAlister, 2001). That body of water holds the spirits of the bodies of the incalculable Africans who were tossed overboard during the Middle Passage. In Christian cosmology, the universe is composed of the earth, the heavens and the infernal realms. In Voodoo, the lwas and the recently deceased are spiritual guides. The Trinity, the Blessed Virgin Mary and the saints are the spiritual guides in Catholicism (McAlister, 2001). How is it possible for Haitians and other people of the diaspora (here referring to Haitians who had left the island) to live simultaneously in the worlds of both Catholicism and Voodoo? Haitian people and other of the diaspora (here referring to Haitians who had left the island) sometimes practice Catholicism and Voodoo together and on some occasions, they are separate ceremonies. The invisible worlds of Voodoo and Catholicism do intersect in a central connection (McAlister, 2002). God assigns spiritual beings to expose truths, to safeguard individuals, to assist individuals to make ethical choices, and to lead them in life and in death. The Catholic saints, the Voodoo spirits and the ancestors, are collective spiritual powers available to supplication through prayers and through spiritual rituals (McAlister, 2001). There are Voodoo ceremonies that sometimes require the performance of a Catholic ritual (McAlister, 2002). One ritual that is a commonality is the ritual of baptism. Not only can people be baptized in Voodoo, but objects can also be consecrated or set aside for specific religious purposes, such as preparation for contact with the spirits and the angels (McAlister, 2001). The baptism ritual accomplishes multiple purposes: baptism sets that individual aside from others and that object to be consecrated, baptism presents that individual or that object to the spirits or angels, and baptism confers on that individual a different identity so the spirits and the

angels can recognize him or her (McAlister, 2001). Through the Voodoo ritual of baptism, that individual is initiated into membership into the invisible realms of Voodoo and Catholicism. That individual has become a member of the family of God the Creator and is now prepared to embark on the spiritual journey whose final destination is to dwell with God (McAlister, 2001).

The Haitian World View of Religion-Voodoo

Spiritual Well-Being

One of the purposes of religion (Voodoo included) in the life of an individual is to create a personal sense that one's quality of life is meaningful, fulfilling, and worthwhile. This sense of being content with the spiritual quality and progress in one's life involves more than just one aspect of life, but rather, life viewed from a holistic personal and communal perspective. A prime example of this sense of spiritual well-being not related to variables such as wealth, social standing, education, etc. occurred about 2 -3 days after the Great Haitian Earthquake. The CNN reporter, Anderson Cooper 360, was reporting live from Haiti in January 2010 when he became aware of the sounds of drumming and spirited singing in Creole (Cooper, 2010). It was pitch black and the reporter could only hear the people singing a lively song and the drumming. Although the people were sleeping on the ground, corpses everywhere, no food, no water, no sanitation, no medical care, devastation everywhere, despite these unimaginable circumstances, Haitian were joyfully playing the drums, dancing and singing a song praising God for being alive!

Religion and Voodoo

Religion cannot be overemphasized as it affects the political arena, physical wellbeing and social conduct of life in Haiti (Corten, as cited by WHO & PAHO, 2010). Religion serves a critical role in all levels of Haitian life. Haiti embraces religious diversity by combining "Roman Catholicism, Voodoo (West African traditions merged with Catholicism)" including a range of "Protestant" faiths, all of them evolved into a tapestry uniquely Haitian (WHO & PAHO, 2010, p. 6). Although Roman Catholicism is the official religion of Haiti, Voodoo is recognized and practiced by a majority of Haitians regardless of social status or religious affiliation e.g., Protestant, Catholic (WHO & PAHO , 2010). People who practice, "Voodoo or 'serve spirits" are reluctant to openly talk about it with strangers, clinicians or others outside of the tradition (WHO & PAHO, 2010, p. 7). Depending on the individual's educational level and spiritual affiliation, Haitians acknowledge "Voodoo" regardless of their position in society (WHO & PAHO, 2010, p. 7). The World Health Organization posits that Voodoo is more than just a religion combined of West African traditions and Catholicism; it functions as a health care system for Haitians. In Voodoo, illness is viewed as an inharmonious relationship with the spirit world (McShane, 2011).

Voodoo and Depression

Among Haitian people, mental illness of any kind is viewed as a defect of the individual and is a reproach on the family. Mental illness is very seriously stigmatized in Haiti. Creole, the language spoken by most Haitians, does not have many of the Western psychological terms used to explain symptoms of depression. Consequently, Haitians

express depression in somatic terms e.g. headaches, back pain, fatigue, poor appetite or feeling disconnected (Nicolas et al., 2007). Depression itself is frequently expressed with symptoms of listlessness and passivity, and is often seen as anti-ethical to masculinity (Jack & Ali, 2010). Examining Haitian perspectives on mental illness, explanatory models, idiomatic expressions of mental distress, and strategies may be effective in establishing a relationship between Haitian patients and mental health providers (Nicolas et al., 2007).

Haitians view depression as a possible Voodoo curse, hex, or a case of excessive worrying (McShane, 2011). Depression is also viewed as a shameful family problem that the family must solve without seeking professional medical or psychological assistance. Haitians' reluctance to pursue psychological treatment is rooted in their cultural belief that depression/mental problems are a personal family and religious matter and they will provide the necessary treatment, which will usually result in treatment by a Voodoo priest (McShane, 2011). In lieu of a viable system of healthcare, Voodoo functions as a provider of healing treatments and promoter of both physical and emotional wellbeing (WHO & PAHO, 2010). Voodoo provides information, rituals, and treatments for problems affecting all areas of life, without exception. Haitians are culturally conditioned to accept Voodoo ideologies about physical and mental illnesses, interventions, and corrective prescriptions to modify an individual's actions (WHO & PAHO, 2010). Haitians refer to the African god or deities as l wa-s (loas). A (loas) is believed to be the spirit of an African ancestor, a dead relative and even a figure from the Bible. The "l wa" can be a buffer and a cause of stress. If a man or woman fails to please their l wa-s, he or

she may suffer misfortune, poor health and mental illness (Desrosiers & St. Fleurose, 2002, p. 509). Haitians' cultural resistance and lack of trust in the efficacy of mental health professionals is not unusual and is partially based on the turbulent history of foreign occupation of their country. Furthermore, without the health care professional having a Haitian conceptual understanding of depression it is almost impossible to provide adequate and quality mental health care for this population (Jack & Ali, 2010). Mental health professionals must become aware of their own personal cultural prejudices and value cultural diversity including, "interpret nuances in meaning" (McShane, 2011, p. 10).

The value of this collaborative research is that it is an in depth review and a chronicle of the most current and broadly based literature available on the mental health status of the Haitian people. This research will present an informative overview of Haitian culture, customs, religious beliefs, languages, including idiomatic phrases, and practices; and offer a descriptive narrative on the functioning of the various approaches Haitian people utilize when and if they seek help from mental health professionals (WHO & PAHO, 2010).

Culture and Masculinity

Defining Culture

Culture, by definition, exerts a powerful influence on society's perceptions and treatment of individuals experiencing psychological distress such as depression. Culture embodies the social context that governs individual behaviors by reinforcing societal norms that determine what is acceptable, or unacceptable, including gender-specific

expressions of psychological distress (Mahalik, 2008). It is within the structure of social contexts that information affirming normative and nonnormative group behaviors is codified. Thus, individuals adjust their own behaviors in accordance with the behaviors of other individuals within their social context, e.g. “social proof” of normal (acceptable) and non-normal (unacceptable) behaviors (Mahalik, 2008, p. 175).

Societal Norms

The cultural impact of societal norms and men’s expressions of depression is altered temporarily during catastrophes such as the terrorist attack on the World Trade Center, September 11, 2001, Hurricane Katrina, and the January 12, 2010 Haitian Earthquake (Mahalik, 2008, p. 174). Emergency rescue workers, who were predominately male, acted as a community with a shared vulnerability that allowed them to openly express their emotions e.g. grief, tears, helplessness, depression, and rage (Mahalik**,** 2008). This open display of men expressions of depression, requests for psychological counseling, and acknowledgement of their need for mental help, as they attempted to cope with these most stressful events, became the new normative, “social proof” within the social context of these emergency workers, (Mahalik**,** 2008,p. 175). Men will refrain from expressing symptoms of depression if such expressions are viewed within their social context as non-normative male behavior. In addition, men may also deny their symptoms of depressions and suffer in stoic silence (Addis, 2008).

Studies have shown that men have a strong desire to be viewed as normal by other men within their social context and will present a stoic demeanor rather than risk the isolation of being considered different or abnormal (Schachter, as cited by Mahalik,

2008). Culturally, men are more closely scrutinized by society in the event there is some deviation from masculine norms and embracing non-masculine or feminine attributes (Evans, Frank, Oliffe, & Gregory, 2011). In essence, a man must be prepared to prove he is a real man at any given time or occasion (Evans, et al., 2011). However, as men mature and experience the vicissitudes of life, the perceptions and behaviors of what defines being a real man undergoes a transformation in response to life's challenges (Evans et al., 2011).

Social Stigma

The structure of Caribbean society, combined with the profound stigma on depression disorders, renders Haitians, particularly men, reluctant to disclose problems of depression or seek psychological help (Mahalik, 2008). Society stigmatizes men more strongly than women because the mental health clinic/hospital is perceived as a woman's environment and not an environment for men (McCusker & Galipo, 2011). The most frequent objection connected to accessing and receiving mental health counseling is the social stigma surrounding being a client or patient at a mental health facility (McCusker & Galipo, 2011). Studies indicate individuals in need of psychological help go to great lengths to avoid seeking and receiving help from mental health professionals for several reasons: trepidation about therapeutic care; (McCusker & Galipo, 2011) anxiety about revealing themselves and unwillingness to relive past traumatic and wounded feelings with a mental health professional (McCusker & Galipo, 2011). Recent studies show that the public holds a negative view of counseling and facilities which provide psychological services (McCusker & Galipo, 2011).

Depression across Cultures

Researchers with various specializations can find in the global community a laboratory wherein researchers have the opportunity to investigate, to correlate and to distinguish depression, how society is organized and cultural interpretations (Kleinman & Good, 1985). Because symptoms of depression are manifested differently from one culture to another, the researchers may experience problems in classifying the symptoms as depression across various cultures (Kleinman & Good, 1985). “There is no test that will identify the illness of depression” (Kleinman & Good, 1985, p. 4). Hypothetically, the existence of such a blood test would fail to identify the basic illness we term as depression, but the test would identify a physiological illness. Culbertson reviewed current research on gender differences, assessment strategies and measurement tools, as well as studies on the epidemiology of depression, conducted nationally and internationally (Culberson, 1997). The research on gender differences reported episodes of depression were consistently conclusive that women, in a ratio of 3:1, experienced depression more frequently than men (Culbertson, 1997). For major depression, the ratio has been reported as “4:1”; rates vary with ethnicity and culture (Culbertson, 1997, p. 25).

Statistical data reveal consistent findings that women express depressive symptoms more frequently than men (Mahalik, 2008). There is a need to conduct research into the impact of variables, including the influence of culture, in producing gender differences (Culbertson, 1997). According to Culbertson (1997), beyond studies conducted in the United States, very little research has been done on gender differences

and depression from a cross-cultural perspective. Culbertson cites some of the extensive studies that the World Health Organization (WHO) has undertaken excluded the field of psychology, until recently, and gender differences and depression, cross-culture and depression were not part of the investigation (Culbertson, 1997).

Little research has been undertaken to study depression among black men in any age demographic. According to Love and Love (2006) reported when measuring depression or any mental health malady, a requirement of the survey instrument is that it has to measure the real indicators in the person and in the clusters. The general approach to investigating depression among black people in general and black men in particular is to utilize "study instruments that have been validated on middle-aged white populations and then applied to minority populations across the lifespan" (Love & Love, 2006 p. 174). The problem with applying the survey instrument using that approach is that it does not take into consideration independent variables that such as racial, gender, social, economic and cultural differences in the minority population that could cause an over-diagnosis or an under-diagnosis of a mental health malady (Love & Love, 2006 p. 174).

Although there is an increased investigation in the mental health of men, the research is rarely directed towards depression in African American male descendants of the African Diaspora. A recent search for articles on the subject of depression in African American men yielded seventeen articles written during the period of "1980-2004" (Hammond, 2012, p. 232). Prior to 2000, the literature reflected studies that explored an analytic view of male/female differences but did not investigate socio-demographics as a variable risk factor for depression among African American men.

African American men are also impacted by the expectations of traditional masculine norms however; they are further negatively impacted by lowering social economic factors and racial biases which occur on a daily basis. Not very much is known about the correlation between depression in African American men, traditional masculine norms and stress factors they face which are dissimilar to the masculinity of non-Latino white males. Hammond's recent research added to the literature on the subject of depression in African American men. The researcher explored discrimination based on ethnicity, a stressful and significant biopsychosocial factor for this population; included in the study was a dissection of elements of the traditional masculine norms: emotional self-control and self-sufficiency. Hammond's research consisted of a "cross-sectional study of African American men's health and social lives" (p. 233).

Over the past decade and a half, the work of "Pleck (1981, 1995)" has provided the principal theoretical framework for continued empirical research in gender role strain paradigm (Wong, Pituch, & Rochlen, 2006, p. 113). The premise of this gender role strain paradigm is that the masculine role is more of a composition of cultural influences, consciously and unconsciously, endorsed by a powerful mass communications industry such as; television, films, advertisements, print media, popular music, family, school, and friends (Wong et al., 2006). The combined impact on these societal forces on the developing masculine gender role identity for boys determines quite early during their formative years what are socially allowed behaviors and what behaviors are to be rejected (expression of feminine characteristics such as crying, O'Neil's work 1981 as cited in Wong et al., 2006). Since femininity is frequently connected to the open communication

of one's feelings, the Western cultural masculine gender role constructs cause men to be emotionally restrictive because they have been socialized to view open expressions of emotions such as tears, sadness, fear, shame, and remorse as feminine and not the manly thing to do (Wong et al., 2006).

The Haitian Resilient Spirit

With a 200 year history of struggle with domestic and international oppression, Haitian people have developed a sense of pride and a deeply rooted sense of resilience (McShane, 2011). Haitian men have experienced many and various struggles in their quests for better lives. Haitian immigrants have faced their share of despair (Nicolas, Desilva, Prater & Bronkoski, 2009). The Haitian people, beginning with their inception as a free and sovereign country, have endured a long history of domestic and international injustices, global oppressive economic ordinances and corrupt and violent political regimes (Pierre et al., 2010). Haitians have little opportunity to get an education with a mere "72%" with an elementary education and just 1% is college educated (Pierre et al., 2010, p. 17). Therefore, literacy is a serious problem; in the countryside, "80%" and in the city "47% of Haitians cannot read or write in French, the official language of Haiti. The Haitian government is not proactive regarding education leaving education primarily to "non state schools, 92%, with 82%" of elementary and secondary students enrolled in private schools (Pierre et al., 2010, p. 17). Only the elite in Haitian society are able to afford the privilege of private school education (Caribbean Country Management Unit, cited by Pierre et al., 2010). Haitians living in rural areas continue to cultivate the land, growing indigenous produce and living in homes with no bathroom, electricity and

removed from essential public services (Pierre et al., 2010). However, rural residents have the advantages of living in a safer and more closely cohesive community conscious environment in contrast to urban residents who live with an increased risk for crime and aggressive (Pierre et al., 2010).

Although Haiti is a much improvised country, Haitian's make the most of the resources available by assembling resources such as livestock or provisions that become marketable in the event of a natural calamity or downturn in the economy(Pierre et al., 2010). Craan (2002) underscores Haitians' strong sense of family unity which is a flexible and extensive circle of kinfolk, community people and various acquaintances. Family support becomes more pronounced during trials and tribulations (Pierre et al., 2010). Despite and still, the majority of Haitians have developed and maintain a positive attitude about the future while confronting the most indisputable fact of the greatest adversities imaginable, the January 12, 2010 earthquake (Pierre et al., 2010). Most Haitians continue to have faith that Haiti will see a better day; more Haitians will have the opportunity to receive an education and improve Haiti's quality of life as an improvised country (Pierre et al., 2010). The organized churches, spirituality, as well as Voodoo, provide the foundation for such optimism, and hope beyond the current conditions (Pierre et al., 2010).

Haiti's Historical Earthquake

January 12, 2010

It happened January 12, 2010 when Haiti was hit by an incredibly powerful earthquake that registered 7.0 on the Richter Scales accompanied by several devastating

aftershocks (WHO & PAHO, 2010). The devastation was beyond comprehension (Gros, 2010). Haiti has endured more than its share of disasters, but the January earthquake was a historical natural calamity causing “over 230,000 deaths and leaving 1.3 million homeless” (McShane, 2011, p. 8). Two months later, despite international efforts, there was still insufficient food, water, health care, shelter, and safe areas. These essential needs took priority over mental health problems. The aftermath left thousands of Haitians traumatized and at risk for mental distress, particularly venerable were those individuals already suffering from depression or other mental distress. Although hundreds of thousands of lives were lost, the resilient spirit of the Haitian people prevailed. Survivors sang, prayed, danced and rejoiced at being alive despite dire conditions.

Aftermath

Months after the earthquake, hundreds of Haitians visited triage and emergency rooms, displaying symptoms related to psychiatric disorders. However, these patients complained of heart palpitations, sweats, headaches, and problems with memory. “These symptoms began after the earthquake, and were often due to anxiety, depression, post traumatic stress disorder (PTSD) or possible syndromal psychiatric disorders” (McShane, 2011, p. 9). The outpouring of relief from international humanitarian governments and charitable organizations, including the World Health Organization, was significant; and many of these efforts to revive Haiti continue today (Farnsworth, 2010). As a result of these continuing long-range efforts to assist the Haitian people recover from this catastrophe, a review, such as this, equips clinicians and mental health professionals with invaluable information on fundamental epidemiology (Pan American Health

Organization [PAHO] & World Health Organization [WHO], 2011).

In the aftermath of the earthquake, there have been noticeable increases in requests for mental health care and psychosocial support. Haitian men encounter several social problems and depression disorders continue to be one of the most prevalent in Haiti one year subsequent to the earthquake according to a recent report by the (PAHO & WHO, 2011). The number of individuals suffering mild or moderate mental disorders, including most manifestations of mood and anxiety disorders (such as mild moderate post-traumatic stress disorder), have substantially grown above an estimated pre-earthquake baseline of 10 percent, as projected by PAHO/WHO in 2011 (PAHO & WHO, 2011). People have been utilizing the few available and accessible agencies providing mental health services (for anxiety, depression, grief process, PTSD, psychosis) (PAHO & WHO, 2011).

Current government mental health services in Haiti are restricted to two mental hospitals located in the "Défilésde Beudet in Croix-des-Bouquets", the only hospital for the chronically mentally ill, and "Mars and Kline Psychiatric Center in Port-Au-Prince", the only hospital for the acute mentally ill (McShane, 2011, p. 8). "Mars and Kline Psychiatric Center in Port-Au-Prince is a 52 year old, dilapidated, seriously understaffed, and poorly resourced facility" (McShane, 2011, p. 8*).* Haiti does not have an organized and coordinated health care system. Both of Haiti's psychiatric hospitals experienced destruction from the earthquake. Outpatient mental health services are restricted. Approximately 15 psychiatrists service Haiti's population of 9 million people (McShane, 2011). Despite the occurrences of life's tribulations affecting depression disorders, it is

extremely predominant maladies that have an effect on roughly “10 to 20” percent of the inhabitants (Watkins & Moberly, 2009, p. 48). Since 1994, Project Medishare, of the University of Miami, Miller School of Medicine’s Global Institute, has been working to provide sustainable health care in Haiti (McShane, 2011). PAHO and WHO (2011), continue to spearhead and monitor ongoing efforts to rebuild Haiti. They report that mental health issues such as post traumatic stress, personal and professional losses, issues of abandonment and separation, death of loved ones, etc. have increased thereby affecting families in Haiti as well as Haitians residing in the United States. Mental health professionals who are interested in working with Haitian people should bear in mind the Haitian people’s strong native resolve and optimism Clinicians be in tune with their own personal concepts and attitudes toward Haitians and their cultural understanding of sickness, and be willing to learn from the Haitian client/patient (Pierre et al., 2010). It would help if clinicians were knowledgeable about the medical multiplicity that functions in Haiti. Patients use a variety of available resources to gain assistance. Mental health professionals should not emphasize an either/or stance that potentially encroaches on the Haitian patient’s right to use a hybrid approach of biomedical and traditional healing (Pierre et al., 2010). Make an assessment of the client and the family’s concept and spiritual beliefs regarding the sickness which will enable the mental health professional to establish a relationship and develop an appropriate and effective treatment plan (Pierre et al., 2010).

Selection Process

The problem being addressed is the absence of research literature on depression among Haitian men with a focus on identifying the significance of culture, spirituality/Voodoo, and masculinity on Haitian men's beliefs and perceptions about depression. There was some research studies conducted on depression among Haitian women but no research conducted on depression among Haitian men resulting in a meaningful gap in the current literature. For this study, selected population was Haitian men between the ages of 20 - 40 years old residing in the U.S. The participants were Haitian men who self-report various types of emotional stressors utilizing a descriptive assessment instrument designed to recognize symptoms of depression disorders among diverse populace (Eaton et al., 2004).

Somatization in the Western and Non-Western World

Somatization the Common Vernacular

Among non-Western cultures somatization is seen as the preeminent symptom of a mental disorder. Kleinman and Good (1985) reported, Marcella (1979) examined somatization in cross-cultural literature and revealed that depressive symptoms expressed through somatization were much more commonplace within non-Western cultures. Somatic ailments are expressed through the distinctive culture of the indigenous people and will vary accordingly (Kleinman & Good, 1985). However, when investigating a non-Western culture, somatization should not be automatically interpreted as representational of a psychological malady. Although somatization is most frequently thought of as non-Western in its symptomatology and interpreted as an indication of

depression or another mental disorder. Somatization is not uncommon among Western populations (Kleinman & Good, 1985). Studies show that “in the United States and the United Kingdom, from 1/3 to ¾”cite somatic complaints as the primary reasons for doctor visits and somatic complaints is the foundation for a majority disability claims (Kleinman & Good, 1985, p. 434).

Somatization and Ethonopsychology

Somatization, viewed from a Western perspective, is perceived as an indicator of “lower socioeconomic and educational levels, rural origins, active and traditional religious affiliation, and behavioral ethnicity (Kleinman & Good, 1985, p. 434). Somatization was a highly commonplace experience in the West until it was influenced by the introduction of a psychological style of speech practiced by the “Victorian middle class” to express their mental anguish (Kleinman & Good, 1985, p. 434). The inception and use of psychological speech to express the domain of the inner self among the Victorian bourgeoisie became the principal modern Western cultural model of “ethonopsychology” (Kleinman & Good, 1985, p. 434). According to Max Weber, it is possible that the transformation from Somatic to psychological language is a reflection of Western society’s strongest representation of itself as special attendant in the cultural growth in rationalization of the internal self. From Weber’s perspective, this modern rationalization was “the process by which explicit, abstract, intellectually calculable rules and procedures are increasingly substituted for sentiment, tradition and rule of thumb in all spheres of human activity” (Wong, as cited by Kleinman & Good, 1985, p. 434). The concept of “affect” is a Western cultural idea and an incidence expressed by middle class

that was formerly explained as a physical feeling (somatization) experience now framed to symbolize a “deep” psychological experience and rationalized into discretely labeled emotions (depression, anxiety, and anger) (Kleinman & Good, 1985, p. 434). Consequently, the manifestation of the physical body experience of “feeling” is communicated and understood clearly, tactfully, globally, and most significantly, somatically (Kleinman & Good, 1985, p. 435).

Epidemiological Studies on Depression

The National Institute of Mental Health (NIMH; 1987) reviewed epidemiological studies on depression that included the United States and other Western nations, and the findings showed the lifelong prevalence of affective disorders, including depression, anxiety disorders, substance abuse and the co-morbidity of these disorders (Culbertson, 1997). This study also explored the relationship between gender and depression and found women expressed depression more frequently than did men in a ratio of “2:1” (Kessler, as cited by Culbertson, 1997, p. 27). Possible explanations for this ratio include that women were more inclined than men to search for help and thus, higher numbers were recorded in the database. There was a contributing causal biological factor between the genders and psychological factors which influenced the distinction between male and female gender roles in society. Men may frequently camouflage symptoms of depression with alcohol **(**Culbertson, 1997).

Based on examination of research data, we extrapolated the hypothesis that compared to Caucasians, African Americans seldom seek psychological, psychiatric or social services instead, they more often rely on medical, emergency, religious and clergy

resources to address psychological health troubles (Ayalon & Young, 2005). Next, we concluded that compared to Caucasians' inclination to maintain beliefs in internal control and psychological symptom attributions, African Americans were strongly inclined to look to powerful others" and forces outside of themselves "e.g., God, chance, and powerful others" and somatic symptom attributions (Ayalon & Young, 2005, p. 394). The conclusion is that specific cognitive-affective variables are responsible for the disproportionate behaviors displayed between Caucasian and African Americans in their efforts to obtain help (Ayalon & Young, 2005). The group differences were predictable such as utilizing medical and emergency services and reliance on external control factors and somatic symptom attributions. The group differences in utilizing psychological and psychiatric services substantiated by reliance on internal control and psychological symptom attribution (Ayalon & Young, 2005). The disparity in seeking help through religious agency was expected to correlate to reliance with beliefs in Divine providence (Ayalon & Young, 2005). A final hypothesis of this study found that African American males attribute a significant importance to spirituality in their lives more frequently than do Caucasian males (Ayalon & Young, 2005).

Men: A Different Depression

The National Institute of Mental Health (NIMH) estimates that as many as six million men experience depression annually. The research on depression in men is consistent in two conclusions: one conclusion is that women, for various reasons, are more likely than men to seek help from a mental health professional and the second conclusion is that a minority of men will seek professional mental health services despite

experiencing symptoms of emotional distress. In an effort to educate, encourage and assist men to seek help for symptoms of depression, the NIMH launched a 2003 public education campaign with the title, “Real Men, Real Depression” (Rochlen, McKelly & Pituch, 2006). This is an ongoing campaign to reach out to those men who may associate seeking help for depression or any other mental distress with loss of masculinity, virility, and marginalization or stigmatization within his social and work environments (Rochlen et al., 2006).

Problem Statement

In the field of psychology, there has been a paucity of research and clinical knowledge available on the mental health of Haitian women and no data on Haitian men. Consequently, there is a disparity regarding information critical to conduct culturally relevant assessments, diagnosis, and treatments (Nicolas et al., 2007). The catastrophic earthquake that struck Haiti in January 2010 compounded mental health problems for thousands of Haitians, and particularly vulnerable were individuals suffering with pre-existing mental problems (WHO & PAHO, 2010). Despite the resilience of the Haitian people, the population has had to cope with mounting risk factors for mental health problems: exposure to severe loss and trauma, poverty, basic unaddressed psychosocial needs, ongoing sexual and other violence, massive material and personal losses, uncertainty about the future, family disruptions, and limited community services (PAHO & WHO, 2011).

In order to explore the severity of depression among Haitian people, especially among males, the problems this research explored provide a beginning foundation toward

understanding some of the cultural manifestations of depression in Haitian men. Because there have been no studies on depression among Haitian men, this research will hopefully encourage additional empirical research that will expand the literature and lead to an understanding of this population.

Purpose of the Study

The findings from this research will contribute to the discovery of culturally relevant approaches helpful to clinicians, therapists, and mental health professionals in assessments, diagnosis, and treatment of Haitian men with symptoms of depressive disorders. The purpose of the quantitative approach was to investigate depression among Haitian men living in the United States and whether adherence to traditional masculine norms, integrated with religious beliefs in Voodoo, had an impact on their perspectives on depression. Researchers have found Haitian men were very unlikely to address issues of depression and mental illness due to misconceptions about mental illness that stem from their culture (Desrosiers & St. Fleurose, 2002). For this nonexperimental study, depression was assessed using the Male Role Norms Inventory-Short Form (MRNI-SF; Levant, Hall, & Rankin, 2013), the Subjective Masculinity Stress Scale (SMSS; Wong et al., 2013), Spiritual Well-Being Scale (SWBS; Paloutzian, & Ellison 1991-2009) in conjunction with the CESD-R (Eaton et al., 2004), as the instruments of measurements. Research investigating the impact of culture and gender on the pressures of life, including social support, has been absent, especially in its capacity to recognize and comprehend, within-group, variables that significantly influence well-being (Martiny, Lunde, Unde´n, Dam, & Bech, 2005).

The claims reported by initial researchers who concluded the expression of self-denial was exclusively displayed by women have come under scrutiny by succeeding researchers. As a result of the challenging research, which showed men also expressed self-silencing, the larger question was to investigate whether self-silencing was also an antecedent to depression in menthe same as in women. Experiential indications seemed to confirm self-silencing was a predictor of depression in both sexes (Locker et al., 2011).

Research Questions and Hypotheses

At the time this study was conducted, there were no published research studies that suggested the alternative hypothesis should be directional.

The following research questions and hypotheses directed this investigation.

Research Question 1: Does restrictive emotionality impact Haitian men's beliefs about depression?

$H_0$1*:* There is no significant difference in restrictive emotionality in Haitian men's perceptions of depression.

H_a1: There is a significant difference in restrictive emotionality in Haitian men's perceptions of depression. Positive correlations to high levels restrictive emotionality would predict increase in levels of depression.

Research Question 2: Does self-reliance impact Haitian men's beliefs about depression?

$H_0$2: There is no significant difference in self-reliance in Haitian men's beliefs of depression.

H_a2*:* There is a significant difference in self-reliance in Haitian men's beliefs of

depression. Positive correlations to high levels self-reliance would predict increase in levels of depression.

Research Question 3: Does subjective masculine stress impact Haitian men's beliefs about depression?

$H_0$3: There is no significant difference in subjective masculine stress in Haitian men's beliefs of depression.

H_a3: There is a significant difference in subjective masculine stress and Haitian men's beliefs of depression. Positive correlations to high levels subjective masculine stress would predict increase in levels of depression.

Research Question 4: Does spiritual well-being associated with Voodoo impact Haitian men's beliefs about depression?

$H_0$4*:* There is no significant difference in spiritual well-being associated with Voodoo in Haitian men's beliefs of depression.

H_a4: There is a significant difference in spiritual well-being associated with Voodoo in Haitian men's beliefs of depression. Positive correlations to high levels of spiritual well-being would predict increase levels of depression.

Research Question 5: What is the effect that time of residency in the United States has on restrictive emotionality among Haitian men?

$H_0$5: Length of time in the United States is not related to greater restrictive emotionality among Haitian men.

H_a5: Length of time in the United States is related to greater restrictive emotionality; the longer they have resided in the United States the more restrictive emotionality they endorse.

Research Question 6: What is the effect that time of residency in the United States has on self-reliance among Haitian men?

H_06: Length of time in the United States is not related to higher self-reliance among Haitian men.

H_a6: Length of time in the United States is related to higher self-reliance; the longer Haitian men have resided in the United States the more self-reliance shapes their ability to resolve problems without asking for help.

Research Question 7: What effect does length of time in the United States have on subjective masculine stress among Haitian men?

H_07: Length of time in the United States does not affect masculine stress among Haitian men.

H_a7: Length of time in the United States does affect masculine stress among Haitian men. The longer they have resided in the United States the more adherence Haitian men are to the traditional masculine stress.

Research Question 8: What effect does length of time in the United States have on spirituality associated with Voodoo?

H_08: Length of time in the United States does not have an effect on spirituality associated with Voodoo.

H_a8: Length of time in the United States does have an effect on spirituality associated with Voodoo. The longer they have resided in the United States the increase levels of spirituality associated with Voodoo effect Haitian men's perceptions.

Research Question 9: Can higher levels of spirituality, as related to the practices of Voodoo, predict higher levels of depression for Haitian men?

$H_0$9: Higher levels of spirituality, as related to the practices of Voodoo, does not predict higher levels of depression for Haitian men.

H_a9: Higher levels of spirituality as related to the practices of Voodoo, does predict higher levels of depression for Haitian men. The more spirituality, as related to the practices of Voodoo Haitian men embrace, there is an increase in the levels of depression.

Research Question10: Can spirituality, as related to the practices of Voodoo, affect levels of self-disclosure?

$H_0$10: Spirituality, as related to the practices of Voodoo, does not affect levels of self- disclosure.

H_a10: Spirituality, as related to the practices of Voodoo, does affect levels of self-disclosure. The more spirituality as related to the practices of Voodoo Haitian men belief in, the more it affects levels of self-disclosure.

Chapter 3 includes additional information regarding the research questions, the hypotheses, the independent variables, the dependent variable, and the multiple regression analysis conducted in this quantitative study.

Conceptual Framework of the Study

This study on depressive symptoms among Haitian men explored whether traditional masculine role norms, along with spirituality associated with Voodoo, influenced symptoms of depression among Haitian men and impacted their restriction or willingness to self-disclose emotions that may be possible symptoms of a depressive disorder. Bandura's (1977) social learning theory and Mahalik's (2008) biopsychosocial framework provided the conceptual framework

Rotter (1954) developed his innovative social learning theory at a time when Freud's theory of psychoanalysis dominated the field of clinical psychology. Rotter's social learning theory deviated from the prevailing perspective, which concentrated on an individual's subconscious as the primary determinant in behavior (Rotter, 1954). In Social Learning and Clinical Psychology (1954), Rotter proposed that there is a high motivation for a person to display a particular behavior when that behavior is related to an expected positive consequence.

Empirical Law of Effect

Rotter's (1954) inspirational factor was the empirical law of effect, which suggests that individuals are driven to search for affirmative stimulus and support and to stay away from bad influences. People want to circumvent the negative results of their behavior while, at the same time, they want positive results. If the individual believes his or her behavior will result in the desired positive outcome, there is a high probability the individual will engage in that particular behavior (Rotter, 1954). Rotter posited that personality represents an interaction between the individual and his or her environment.

He theorized that behavior is learned; therefore, behavior may be predicted when examining these four components: behavior potential, expectancy, reinforcement value, and the psychological situation (Rotter, 1954). Therefore, in order to understand behavior, one must consider the individual (including his or her history of learning and life experiences) and environment (e.g., stimuli the individual knows and is responding to). Most importantly, according to Rotter (1954), change the way an individual thinks and the behavior of the individual will also change.

In later years, Bandura (1977) expanded on Rotter's research, as well as the earlier research of Miller and Dollard and the social learning theories of Vygotsky and Lave. Bandura concentrated on the theory of reciprocal determinism, a concept that behavior is influenced by the person's distinctiveness and by the environment (Bandura, 1977). The theory states that behavior is learned by imitating the societal models for how gender is expressed, acceptable and unacceptable behaviors, and observing the behaviors of others in the environment (Bandura, 1977). In essence, individuals learn from their environment and from watching what other people do or fail to do, being always aware of the consequences of failure to conform and the rewards of conformity.

The general assumption in the extant literature was that men and women are socialized within their culture along proscripted gendered behaviors that inform their respective identity. Men and women engage in gendered behaviors that illustrate their ideas of what constitutes masculinity and femininity, those behaviors that embrace cultural norms and societal values (Addis & Mahalik, 2003). Ideologies about what it means to be masculine and how much a man internalizes and manifests these masculine

characteristics as normative can fluctuate and become situational. Masculine role norms can also produce male role conflict when a man will suffer negative mental and physical outcomes as a result of adherence to the hegemonic masculine model that views men as tough, able to withstand pain and suffering without complaining, in control of his emotions, able to resolve his own problems and issues independently, and be a leader in his family and social environment (Addis & Mahalik, 2003).

Concepts of the role male socialization play have been shown to be directly aligned to the etiology and treatment of depression. The research literature on the socialization of men has an implicit connection to clinically understanding the issues surrounding men seeking help for depression and other mental health problems (Addis & Mahalik, 2003). The psychosocial approach is relevant in addressing male role problems and assist men to free themselves from the restraints of stereotypical masculine expectations (Mahalik, 2008). Several studies (Mahalik, 2007, 2005, 1999; see also Addis, 2008, 2003) further explained that men are significantly impacted by societal messages, via public media portrayals of descriptive, injunctive, and cohesive characteristics of masculine norms. Descriptive masculine norms allow a man to observe the behaviors of other men in a particular situation such as men expressing their feelings of sadness or depression. After observing other men express their experience with depression, a man may no longer think of depression in men as nonnormative (Mahalik, 2008). One function of injunctive masculine norms is to reinforce the cultural perimeters of masculine behaviors; for example, a man should not cry in public, a man is strong and resilient and resolves his own problems (Addis & Mahalik, 2003). Conversely, a man

may feel that because his life does not reflect those projected public images and messages, he may be unduly influenced to see himself as nonnormative (Addis, 2008).

Addis and Mahalik (2003) also posed the question relevant to my investigation with possible implications for social change: Does the public presentation of epidemiological or individual interview information about the normality of a problem affect willingness to seek professional help? Across all strategies for normalizing problems and decreasing stigma, information should elicit reactance and may possibly encourage men to consider the benefits of seeking help from mental and physical health professionals (Addis & Mahalik, 2003). Additionally, mental health professionals should be informed of barriers that inhibit men from seeking help and, as a result of this cultural competency, have the range of appropriate knowledge and skills necessary to design and implement strategies that make treatment effective (Addis & Mahalik, 2003). The theories relate to the quantitative approach because the overarching question was as follows: Do traditional masculine norms, in conjunction with Haitian cultural spirituality associated with Voodoo, exert a significant impact on Haitian men's beliefs about depression?

Both Bandura's (1977) and Mahalik's (2008) research findings indicated that gender socialization modeling begins in early childhood and continues through adulthood; adherence to the masculine role norms can create gender-role conflict that inhibits men's willingness to self-disclose and seek help for depression within their cultural/social environment. Haitian culture functions on the patriarchal model; therefore Haitian men, because of strict masculine role norms, may be unable or reluctant to

recognize their own symptoms of depression “alexithymia” or they may express mental distress as somatic symptoms (Addis, 2008, p. 158). The intent of this study was to comprehend the opinions and perceptions about depression among Haitian men living in the United States. More details and information appear in Chapter 2.

Nature of the Study

The nature of this study included a quantitative design to investigate the relationships between masculine norms, spirituality associated with the practice of Voodoo, and depression among Haitian men living in the United States. The sample size was 90 Haitian men between the ages of 20 and 40 years old. The participants were selected throughout the Haitian community in Brooklyn and Queens, New York, and Miami and Fort Lauderdale, Florida. All of the participants were surveyed using quantitative assessments similar to the Likert scales, and the data collected were obtained from questionnaires completed by participants in various locations approved by the Walden University IRB. The goal of using the quantitative approach was to obtain a descriptive analysis of Haitian men suffering with symptoms of depression. A stepwise multiple regression power analysis was utilized to identify how the dependent variable (depression) associated to the five explanatory independent variables. A multiple regression analysis was used to analyze the relationship between the independent and the dependent variables. The independent variables were restrictive emotionality, self-reliance, subjective masculine stress, spiritual well-being, and length of time in the United States. The response variable, depression, was measured by the CESD-R (Eaton et al., 2004). The multiple regression statistical findings were reported and presented in the

documents. This is discussed in more detail in Chapter 4.

Definitions of Terms

Throughout the literature reviewed, other authors used the Haitian dialect of Creole. This is the language spoken by most Haitians and appears in the literature to provide a deeper and clearer explanation of Haitian culture. Creole language does not contain Western psychological terms such as depression (Hillel, Desrosier & Turnier, 1994 as cited by Pierre et al., 2010 also see WHO & PAHO (2010). The following is a list of definitions of the terms used to explain these traditional Creole words so the reader grasps the meaning of the words within the context of the literature review (Pierre et al., 2010 also see WHO & PAHO (2010).

Bòkò:Cast and remove curses, spells usually is paid for services rendered.

*Bondieu:*The Good Lord.

Bondje: God the creator.

Dépression: French word to mean discouragement.

Dépression mentale:Depression as understood in Western psychiatry.

Doktè fey/medsenfey:Ttraditional healer, leaf doctor, or herbalists.

Doktè zo:Bone setters, treats conditions such as broken bones.

Endispozisyon:Indisposition, spells of weakness, fainting.

Fanm jaden:Garden woman.

Fanm kay:House woman.

Fanm mariye:Spouse.

Fanm saf: Midwives peri-natal and natal care.

Fou:Crazy.

Ge`de`: Spirit of the dead.

Gran Metl:The Great Master.

Gwo bon-anj:Big good angel.

Kò kadav: body cadaver

Lakou:Courtyard where extended family units share a common courtyard.

Legba:Protector when travelling.

Lèt gate:Contaminated breast milk.

Lonbraj:Shade.

Lwa-s (loas):Spirits, angels, African gods or deities.

Maladi-Bondye:Domain of visible.

Maladi fe-moun mal (or maladi diab):Domain of the invisible.

Maladi lwa:Domain of the invisible spiritual.

Mambo:Vodou priestess.

Movesan:Bad blood.

Nam/tibon-anj:Little good angel.

Ougan:Vodou priest.

Pèdisyon:A false pregnancy or nonprogressive pregnancy.

Pikirist:Injectionist, administers potential preparations.

Pitit bon anj:Little good angel.

Plasaf:A system where a man has multiple common-law wives.

Poto mitan:The central pillar of the family (the mother).

Timoun se riches malere: Children are the wealth of the poor.

Racine: Spiritual roots.

Restavek:Stay with (as in unpaid domestic worker).

Sevites:Serve Voodoo spirits.

Sezisman:Seized-up-ness, or surprised-ness, producing paralysis from shock.

Ti bon anj:Guardian angel.

Toufe:Suffocate.

Estates Unite: United States.

Vanyan:An honor name.

Vikim:Victim.

Vivavek:Living with (co-habitation).

Vodou:Stems from the Fon word meaning spirit.

Vodouisant: One who serves the spirits.

Zonbi (zombie):One under the control of a bòkò.

Operational Definition of Terms

The following terms and phrases are defined as they are used in this study.

Depression or major depressive disorder: Symptoms or a malady that can disrupt the ability to carry on daily routine, functions. According to the Diagnostic and Statistical Manual of Mental Disorders (4th ed., text rev.; *DSM-IV-TR*; American Psychiatric Association, 2000), criteria for major depression embodies a longer period of chronic psychological pain which may include a combination of symptoms such as depressed mood, loss of interest of daily activities, hypersomnia, insomnia, agitation, irritability,

weight loss or significantly poor/increased appetite which interfere with the person's daily activities.

The Subjective Masculinity Stress Scale (SMSS): Structured to assess the meaning of masculinity among men. Subjective Masculinity Stress Scale measures the significance of traditional masculinity norms to a man's view of himself as a man (e.g., "As a man, I must be the breadwinner"; Wong et al., 2013, p. 149).

Restrictive Emotionality Scale: Disclosure of emotions which may be indicative of depression disorders and its measures the traditional masculinity norms that surround sharing personal feelings (e.g., "a man should never reveal worried to others"; Hammond, 2012, p. 234).

Self-reliance Scale: Designed to measure traditional masculinity norms surrounding keeping everything to one's self and resolving one's problems without asking for help (e.g., " a man must be able to make his own way in the world"; Hammond, 2012, p. 234).

Assumptions

This study offered Haitian men an opportunity to understand how recent destructive life events, as well as negative recurrent experiences, are associated with depression symptoms. An assumption of this study was that there are misconceptions about Haitian men and cultural practices (Destrories & St. Fleurose, 2002). I also assumed that Haitian culture is similar to other non-Western cultures, but differences exist such as language and traditions (Kleinman & Good, 1985). There are also significant variations in the way societies organize themselves, in their shared conception

of morality, and in the ways they interact with their environment (WHO & PAHO, 2010). There was another assumption that all Haitians only speak Creole. Moreover, the native language is the original language, which is Creole (WHO & PAHO, 2010). I made this assumption essentially because everyone who comes from Haiti speaks Creole and can understand anyone else speaking Creole (WHO & PAHO, 2010). Another assumption was that not everyone in Haiti, depending on their educational background, speaks the official language, which is French (WHO & PAHO, 2010). Another assumption was that a culturally competent clinician cannot also be a responsible, caring clinician who avoids biased first impressions and stereotypes. A competent clinician treats clients with respect and has skills, knowledge of cultural attitudes, and expresses genuine interest in clients as individuals, avoids biases and misdiagnosis to ensure that all participants seeking help receive appropriate and effective treatment (Nicolas et al., 2006).

Scope and Delimitations

The results of this study were only be applicable to Haitian men, between the ages of 20 through 40 years of age, living in the United States who volunteered to participate. Participants in this study lived in either the borough of Brooklyn or Queens, New York, or Fort Lauderdale, Florida. Participants responded to my outreach via the Haitian sites of communication, such as regional radio announcements, flyers, and personal solicitation at IRB approved locations.

The study was delimited in evaluating Haitian men's beliefs about their distinctive depression in the United States. Another delimitation of this study was the lack of literature documented on the subject of depression in Haitian men. There is

research that addresses depression among Haitian women, including cultural issues that affect gender disparities in seeking treatment; but, there is no research that addresses depression or treatment of Haitian men who are depressed.

Limitations of the Study

As with other research studies, this research project had limitations. One of the limitations of the study was the void in literature on the subject of depression in Haitian men. A second limitation was that the study included only Haitian men who currently resided in the United States. A third limitation was there were no available descriptive statistical analysis data to show any results for comparison or to examine results; therefore, results cannot be stated with true accuracy whether masculine norms influence symptoms of depression and reluctance to self-disclose feelings due to the misconceptions about spirituality associated with Voodoo and depression. Furthermore, a fourth limitation was that Voodoo's reputation has been tarnished by association with bad magic or evil and the consequences of Voodoo (Destrories & St. Fleurose, 2002). A fifth limitation was that the respondent's age may or may not be related to the dependent variables. I assumed that the age of the respondent and length of time in the United States and/or if he came to the United States as a child would influence if he would be assimilated and/or if the traditional masculinity role and spirituality associated with Voodoo would have an impact on him. Because of the void in the research literature, there were no descriptive statistical analysis to relate and compare limitations of internal and external validity, construct validity, and confounder variables. Covariate variables may have been age, assimilation, and spirituality associated with Voodoo. As a religion

in the Haitian culture, Voodoo is associated with protection from evil spirits (Nicolas et al., 2006). Often Haitian men may not willingly disclose depression or mental illness due to their beliefs in Voodoo. Some Haitian men may not want to address future depression malady due to negative preconceptions resulting from periods longer than the initial timeframe and may not address relapses that may have occurred after the study period. A final limitation was that there was no research data available. I received permission to use assessment tools that were developed to measure, assess, and diagnose depression symptoms from a non-Western perspective. The responses to Western scales by Haitian men may have differed from responses from subjects with Westernized perceptions, attitudes, beliefs, and values. Because of the void in the research literature, these Westernized scales may not completely answer the questions of validity and reliability.

Significance of the Study

The findings from this study may contribute to the recognition and further understanding of cultural factors that may negatively impact and hinder Haitian men from seeking help for mental symptoms related to depression. Also, this study may help develop culturally sensitive approaches that can help Haitian men recognize symptoms of depression and seek available clinical treatment despite their cultural beliefs and orientation. The long-term social implication of this research will be to provide support that will engage Haitian men when and if they seek treatment. This study recognizes that treatment will be a challenge for many reasons, language barriers being one of the major challenges to both clinician and client. There are many challenges involved in addressing mental health needs within the Haitian population (notwithstanding their unfamiliarity

with clinical therapy) and overcoming these challenges to implement positive therapeutic alliance is vital.

The altruistic goal of this research was to improve the overall quality of life for this underserved immigrant population when they seek treatment, as well as influence positive social changes, which includes a better understanding of Haitian men and their cultural perspectives of depression. As individuals assimilate, the understanding of culture becomes more complex. Therefore, as health care professionals involved in the assessment of Haitian men, it is important to acquire knowledge about cultural differences. As researchers address concerns such awareness of cultural diversity, equality in human subject research, appropriate treatment of Haitian clients, they avoid the implication and risks of improper treatment based on racial bias.

Implication for Social Change

America's Changing Demographics

As far back as 1990, the U.S. Census reported America's changing demographics. Changing demographics is another way of expressing the "diversification of America" and this change in demographics is the direct consequence of dual simultaneous developments (Sue et al., 1992, p. 478). For the first time in history, America is experiencing the greatest number of immigrants regardless of immigration status: legal, illegal and expatriates. Current immigrants differ from historical Caucasian immigrants who wanted to blend into American society and become a typical American. Immigrants to America today are mainly "Asian 34%, Latino 34%," and the remainder consists of other racial and ethnic clusters. Modern immigrants are not so interested in assimilation

or blending unnoticed into the American mosaic instead, they choose to retain their cultural identity (Sue et al., 1992, p. 478). During the 1980's, the Asian American population (mostly Indochinese refugees) grew by "80%" in response to changes in the 1965 immigration laws (Sue et al., 1992, p. 478). The largest and fastest growing demographic will be the Latino population which is expected to become the dominant ethnic group by 2025 (Sue, et al., 1992).

Births and Longevity

The second development is the aging factor. American Caucasians are experiencing a longer lifespan however, Caucasians in child-birthing demographics are conceiving and birthing fewer children, "1.7 per mother" (Sue, et al., 1992, p. 478).Compare "1.7" children to the birthrates of other groups: "African Americans=2.4, Mexican Americans=2.9, Vietnamese=3.4, Laotians=4.6, Cambodians=7.4 and Hmongs =11.9" (Sue et al., 1992, p. 478). A logical extrapolation of these rising dynamic birth numbers in non-Caucasian populations is that the American demographic will be dominated by a non-white, ethnically and culturally diverse population. Educators, therapists and other professionals working with children and youth are very well aware of this demographic in the student population across the country, especially in California. In California, Caucasian students have decreased to less than "50%" and 1 out of every 4 students live in a home where English is not the mother tongue. Out of every 6 students, 1 student is foreign-born (Atkinson, Morten, & Sue, in press cite by Sue et al., 1992, p. 478).

Challenging Mental Health Professionals

As counseling professionals, we must confront and address the "political reality" of life in these United States (Sue et al., 1992, p. 479). Whether the individual is a counselor or the client, both are inextricably connected through a shared history of racial discrimination and systemic oppressive laws and ordinances designed to deprive classes of citizens their human and Constitutional rights (Sue et al., 1992). If the individual seeking help is African American, that individual is prone to arrive at counseling or therapy session with a considerable amount of skepticism and a ready defensive attitude to combat the counselor's intentional or unintentional racial overtones. If the counselor or therapist is Caucasian, he or she has been socialized in racial and ethnic biases as practiced historically by the dominant Caucasian society (Sue et al., 1992). The therapist and the minority client/patient, though engaged in counseling or therapy session, each has already been impacted by the state of racial conditions in the general society.

Regardless of the lofty goals of the therapist or the therapy session, if democratic ideas such as "equal opportunity" "liberty and justice for all" and "pursuit of happiness" do not seem realistic for the minority client, it is a Herculean effort make such ideas applicable to the client through counseling (Sue et al., 1992, p. 479). Traditionally, these lofty American goals have been interpreted and used to preserve the status quo for the majority society. Therefore, if the counselor or therapist employs these "status quo" ideas to limit rather than to promote a sense of optimism and personal growth in the minority client, this is tantamount to an "overt and covert form of prejudice and discrimination" (Sue et al., 1992, p. 479).

Culturally sensitive mental health professionals recognize that helping patients/clients is not a process that takes place in separation from the reality of what is happening in the general society (Sue et al., 1992). We mental health professionals also have an obligation to be knowledgeable and attempt to comprehend the various elements and incidents that occur in society and how they impact us as individuals and professionals (Sue et al., 1992). A case in point is the changing demographic in America. This change will be experienced in education, economics, social, politics, the legal system, law enforcement, religious and cultural organizations (Sue et al., 1992). Unfortunately, the obvious rise in racial and ethnic minorities has also brought an increase in racial intolerance. Another version of racial and ethnic intolerance was the "English-only movement" which would have had a devastating impact on mental health professionals, educators, as well as professionals serving in the public interest. Fortunately, research reported that the English-only movement had "negative consequences for the delivery of psychological, education, psychometric, and health services for linguistic minorities" (Sue et al., 1992, p. 479).

Knowledge is essential to addressing different aspects of culture diversity for healthcare professionals, educators, psychologists and other researchers who provide mental health services to culturally diverse groups of clients. These mental health professionals are advised to recognize the significant influence of culture on mental illness. Healthcare professionals are encouraged to incorporate cultural knowledge to avoid misdiagnoses and inappropriate treatment (APA Multicultural Guidelines; American Psychological Association [APA], 2002 cited by Nicolas et. al., 2006). This

progress of incorporating cultural knowledge will help healthcare educators recognize that standardized assessments have a place in the arsenal of methodologies to implement and appropriately assess individuals from different cultural perspectives.

Four Salient Multicultural Counseling Competencies

According to Delsignore et al. (2010) there are "four salient multicultural counseling competencies (MCC)" concepts identified, along with their operationalities, within the clinical multicultural counseling environment: "attitudes/ beliefs, knowledge, skills and relationships (Delsignore et al., 2010, p. 352). Attitudes/beliefs are explained as a willingness to self-examine one's own prejudicial racial concepts and a cognizance that the mental health professional's prejudicial racial concepts can, and usually do, exert a negative influence on the delivery of appropriate, competent and effective multicultural counseling treatment (Delsignore et al., 2010). Knowledge is explained as an embodiment of the white mental health professional's comprehension of their personal views of the global community, awareness of the impact of history and today's social and economic issues on their help-seeking clients and concrete cultural information about the diverse clients to whom they provide multicultural counseling services (Delsignore et al., 2010). The concept of skills refers to the category and implementation of applicable and culturally appropriate treatment modalities for a particular ethnic clientele (Delsignore et al., 2010). The "fourth concept of MCC" infrequently investigated is the relationship where researchers examine the caliber of the white mental health professional's personal ability to experience a reasonable sense of ease and cultural competency when working with clients of color (Delsignore et al., 2010, p. 353). The critical ethical issue for mental

health professionals is multicultural competencies; lacking cross-cultural education and practice in addressing diversity but proceeding to provide mental health treatment to individuals from different ethnic and racial backgrounds is possibly grounds for unethical and negative charges including potentially a violation of human rights (Sue et al., 1992). The natural conclusion is that we American people, regardless of educational background, socioeconomic status or geographic location, must learn to live, work and play in a country that is multilingual, multi ethnic and multi cultural (Sue et al., 1992).

Cultural Competencies a Paradigm Shift

America is very rapidly moving towards a "multiracial, multicultural, and multilingual" country (Sue, Arrendondo, & McDavis, 1992, p. 478). Researchers "consider multiculturalism psychology's fourth force" (Sue et al., 1992, p. 478). There are psychologists with faulty assumptions on the issue of multiculturalism or cultural competency as a core requirement in the psychological curriculum. The faulty assumptions may be based on a perspective that cultural competency is not as "legitimate" as other requirements in the field of psychology (Sue et al., 1992, p. 477). The majority of mental health professionals lack cross-cultural experiences as a core foundation in their education. This lack of cross-cultural experiences with individuals of different racial and ethnic backgrounds extends to the routine of their personal lives (Sue et al., 1992). There is ample evidence that traditional counseling strategies have proven ineffective when used with racial and minority clients/patients (Sue et al., 1992). The determinant factor that mental health professionals are sorely lacking in cultural competencies is the primary reason traditional therapeutic strategies prove ineffective

when used with racial and ethnic minorities (Sue et al., 1992). Culture has many different facets and one treatment aspect is not sufficient to understand depression, culture, and society. Mental health professionals are affected by the influences of race, culture and ethnicity, not exclusively minorities; and mental health professionals must acknowledge they are not exempt from these influences (Sue et al., 1992). As health care professionals, it is necessary that we become acutely aware that we must be culturally competent to provide biased-free care for a more culturally diverse population of patients/clients (Sue et al., 1992). It is obvious that cultural differences exist between people, such as language, dress, and traditions. There are also significant variations in the way different cultures organize themselves, their shared concepts of morality, and in the unique ways they interact with their environment (Fung, Andermann, & Lo, 2008). To be culturally responsive, it is important that mental health professionals grasp the full meaning of cultural competency. First, to interact appropriately and effectively when formulating an accurate and un-biased diagnosis and effective treatment plan that will be reflective of the individual's cultural norms (Sue et al., 1992).

Microaggressions are Pervasive

The very nature of racial biases is so insidious and subtle that at times, even the most experienced and trained mental health professional may question, what really happened here? Researchers in Social Psychology report empirical evidence that supports the reality of unconscious racial biases among Caucasians with the best of moral and racial perspectives (Sue et al., 2007). Nevertheless, the mere fact of being native born and raised in America assures each of us will inherit a litany of racial prejudices which are

prevalent in society. The determinant of whether a racially biased event has transpired, intentionally or unintentionally, is best made by the recipient of the bias action rather than the privileged, and often unaware, perpetrator (Sue et al., 2007). “Microaggression” is defined as a brief verbal or action that appears innocuous on the surface but transmits a message, purposefully or not, that is racially demeaning, insulting and hurtful to the person of color (Sue et al., 2007, p. 271). Professing to be oblivious to an individual’s skin color is another primary approach to “microinvalidation” (Sue et al., 2007, p. 271). Microinvalidation is essentially a refusal to acknowledge the reality of another individual’s ethnicity and cultural identity; and at the same time, appear to be unbiased (Sue et al., 2007). For the mental health professional any occurrence of racial microaggression is a hindrance to effective and biased-free clinical practice and often is a benchmark for the following outcomes: client unwillingness to self-disclose, missed appointments and early termination of therapy (Sue et al., 2007).

Understanding Haitian Cultural Concepts Before Assessing

The goal of this research is to assist mental health professionals with the cultural and clinical knowledge essential to better understand, diagnose and develop appropriate strategies to treat depression in Haitian men. This research may also help to avoid clinical errors in diagnosis and identification of Haitian men’s symptoms of depression. There are research studies that reveal the need for mental health professionals to possess a knowledge and understanding of at least two principle competencies before assessing, diagnosing and prescribing therapeutic treatment for a client whose ethnicity and culture differs from that of the mental health professional. First, the mental health professional

must be fully cognizant of his or her own cultural biases and how such biases may influence their objectivity. Second, the mental health professional should possess some knowledge and understanding of the prospective client's ethnic and cultural background primarily to avoid the possibility of misdiagnosing symptoms because of cultural differences that may exist between them. If necessary, a cultural coach may be used to translate and explain cultural nuances in meaning. Men in general are reluctant to seek help for depression or any kind of mental condition. This reluctance is compounded for Haitian men because of several factors: Haitian men experience marginalization with all the discrimination that comes with being an immigrant from a very poor first world diaspora nation. Depression or any symptoms of mental illness within the Haitian culture is highly stigmatized, neither the word depression nor the western concept of depression exit in the Haitian language. Haitians view any form of mental illness as a result of a hex or a curse and can only be rectified through indigenous cultural means (Voodoo) and finally, Haitian men, bound by cultural norms of masculinity, are resistant to self-disclose or seek help for symptoms of depression or mental illness to anyone outside of their cultural confines.

Respecting Cultural Differences

From the perspective of respect for cultural differences, it is crucial for mental health professionals, who provide care to Haitian clients, to understand the Haitian psyche and how it is formed and strongly influenced by the religion of Voodoo (Desrosiers & St. Fleurose, 2002). A 2010 study investigated the functionality of multicultural counseling within a multicultural counseling environment by examining

two dominant components of multicultural counseling (Delsignore et al., 2010). According to Delsignore et al. (2010) “MCC and Racial Identity Theory (RIT)” are two dominant components of multicultural counseling expressed by white mental health professionals who provide multicultural counseling services within the MCC clinical environment (Delsignore et al., 2010, p. 354). The stated purpose of the study was to address the lack of information available about white mental health professionals who provide counseling under MCC, by specifically investigating their “assistance-seeking behaviors in their clinical work” (Delsignore et al., 2010, p. 354). Furthermore, according to the authors, the search for literature that focused on statistical data and/or types of help requested by white mental health professionals practicing in a MCC clinical environment yielded zero results (Delsignore et al., 2010).The American Psychological Association [APA], (2010) guidelines establish a community-educational program to build trust for counselors to take responsibility to provide services to clients regardless the cultural background (para A-E).Thus, “Respect for the dignity and worth of human beings is expressed in different ways and different communities and cultures. It is important to acknowledge and respect such cultural differences” (Jack & Ali, 2010, p. 81). APA (2010) focus on cultural difference recommends counselors to assess, observe and accurately examine all the facts accordingly to avoid violation of the ethics code, including awareness of certain biases and stereotypes. Multicultural counseling has been defined as the counseling process where the ethnicity, culture, language, and customs of the client differ from ethnicity, culture, language and customs of the mental health professional providing the counseling services (Delsignore et al., 2010). “Racial Identity

Development (RID)" is the psychological process through which an individual develops a reaction to racial understanding and attitude about oneself and others with his/her same ethnic identity (Delsignore et al., 2010, p. 352). RID indicates how one interacts one's own racial and cultural ethnicity and with others who are members of a different racial and cultural ethnicity. Furthermore, due to the increased study and awareness of RID, the level of racial identification affects "thinking, perceptions, emotions and behaviors towards persons from other groups" (Delsignore et al., 2010, p. 352). Mental health professionals should monitor personal biases or beliefs being careful not to transfer such biases to clients/patients. In order to alleviate the possibility of biases, diagnosing healthcare professionals need to be familiar with ethnic differences, racial differences along with cultural factors.

One of the more salient implications for social change will be the rapidly changing racial demographic from a majority Caucasian population to a non-white majority population. This change will affect all systems of society that provide services e.g. education, research, mental health, pharmaceutical, politics, healthcare, economic, and cultural institutions. There will be a greater expectation that mental health professionals will be better educated, informed and qualified to provide culturally competent assessment and treatment to a diverse population of people seeking help. The stigma attached to men suffering with depression, gender norms which are created during the formative years and identified by society as characteristics of masculinity will be more appropriately researched in conjunction with public education about men and

depression. Consequently, an informed public will result in diminishing the stigma associated with men seeking help for depression.

Chapter Summary

Research has illustrated that culture has a significant impact on mental illness, especially on depressive disorders among ethnically diverse populations (Addis, 2008). Hammond's (2012) research addressed the concerns that correlate discriminatory actions to depression and mental distress of African American men by objectively observing masculine responses to these types of stressful discriminatory events. According to Love and Love (2006), approximately 7% of Black men will suffer from depression in their lifespan; however, considering the small amount of available data on depression in Black men, that figure could quite easily be an underrepresentation of the number of Black men affected by depression. It is estimated that as many as "500,000 Haitians live in the United States, mostly in New York, Boston, Miami and coastal cities of Texas and Louisiana" (WHO & PAHO, 2010, p. 4). Despite the growing number of Haitians living in the United States, researching the Haitian population presents challenges due to the lack of data regarding mental illness (Turmier, as cited in Nicolas et al., 2007). There are some data on depression among Haitian immigrant women living in the United States (Nicolas et al., 2007).These data were not surprising because it is less common for Haitian men to seek professional help from mental health clinicians (Desrosiers & St. Fleurose, 2002, pp. 508-514). As a result, more clinical data are available for Haitian women than for Haitian men (Nicolas et al., 2007).

Haitian men are less likely to address their issues of mental illness due to

misconceptions about mental illness that stem from their culture (Desrosiers & St. Fleurose, 2002). In this study, I constructed an overview of their behaviors, along with acknowledgment of some of the cultural implications and methodologies utilized when providing treatment for depression in Haitian men. This research revealed those internal and external factors representing theoretical constructs that appeared to influence Haitian men's concepts about depression. These factors included cultural views of mental illness, patriarchal roles, lack of community resources, access to care, self-motivation, language barriers, treatment expectations, and psychiatric or personality disorders (WHO & PAHO, 2010). Many researchers have since recorded results that showed that, on the contrary, men expressed self-silencing behaviors even more frequently than did women (Locker et al., 2011). Currently, the lack of relevant data, as well as appropriate services for treatment of depression in Haitian men, has left this subject open to further research and discussion (Nicolas et al., 2007).

The overarching research question that emerged was as follows: What are the implications of male cultural norms that influence Haitian men's characteristics and inability to disclose depression disorders? This study answered this question by analyzing information obtained from a convenient sampling of Haitian men between the ages of 20 and 40 years old. Depression was measured in this study by utilizing CESD-R (Eaton et al., 2004) assessment instrument. There are undoubtedly comparable differences (within-group) between Black, Hispanic, and White male clients from the low socioeconomic status; nevertheless, the result is to assume particular external social behaviors that are stereotypical of male roles in Western society (Skilbeck, Yamamoto, Acosta, & Evans,

1984). This study provides important information towards understanding depression in non-Western males and specifically addressed psychosocial distresses that may be attributed to traditional Haitian male norms and men's understanding about depression **(**Mahalik, Talmudge, Locke, & Scott, 2005). Nevertheless, research investigating the impact of culture and gender on the pressures of life, including social support, was absent, especially in its capacity to recognize and comprehend, within-group, variables that significantly influence well-being (Brown et al., 2000).

Additionally, this study provides mental health professionals with a cultural context of Haitian language, customs, religious and secular practices that will aid the clinician' s understanding of the Haitian client seeking mental health services (Nicolas et al., 2006). Because of the scarcity of literature on the role of non-Western, specifically Haitian, men's adaptations to social norms and how they express symptoms of depression; this research endeavored to provide clinical information, from the Haitian perspective, on Haitian men and the manifestations of depression where there is currently a void on the subject (Nicolas et al., 2007). When addressing the Haitian population, it is critical to understand all of the challenges involved, especially the fact that Haitians, in general, seldom use therapy (WHO & PAHO, 2010). It is vital to gain knowledge of the Haitian culture and their religious beliefs in order to overcome these challenges and implement a positive therapeutic alliance within the Haitian community (WHO & PAHO, 2010). One social change implication for this much-needed research on depression among Haitian men is that the investigation will help identify how Haitian men express symptoms of depression as expressed within the cultural construct and consequently

provide some insight into assessment and treatment that is both culturally appropriate and acceptable.

Chapter 2 explored previous research on male gender conflict and depression, as well as present finings on depression, gender, characteristics of masculinity, and normative and nonnormative behaviors as identified by society (Mahalik, Burns, & Syzdek, 2007). Understanding depression in men is predicated on understanding the deeply rooted male cultural norms that are characterized and influenced by the social context in which depressed men live (Mahalik, 2008). Social contexts exert a dominant influence on depression in men (Levenson & Acosta, 2001; "The True Toll," as cited in Mahalik, 2008, pp. 175-176). It is within the confines of social context that the group social norm dictates or models what will be acceptable as "normal" and what is unacceptable as "deviant" responses and behaviors (Mahalik, 2008, pp. 175-176). Cialdini (1993) espoused the idea that people are influenced by their observations of others because the "social proof" these descriptive norms provide saves time and cognitive effort while giving guidance about behavior that is likely to be effective (Mahalik, 2008, p. 175). If depressed men have not had the experience of seeing other men exhibit signs of depression correlated with *DSM* standards, such as "verbalizing their feelings of melancholy or seeing men weep," they are liable to think this is "social proof" that validates the assumption that these occurrences do not happen to real men (Mahalik, 2008, p. 175). Consequently, viewing these social norms that depression is nonnormative, men will not generally exhibit nonnormative behavior "verbalizing melancholy feelings, weeping," or try to find professional help (Mahalik, 2008, p. 175).

Men's belief that depression for men is nonnormative may possibly influence or shape their individual understanding of their own personal experiences and lead them to question whether their experiences were symptoms of depression or another problem (Mahalik, 2008). To assist and to better serve the Haitian people, mental health professionals must understand two critical issues (Nicolas et. al., 2006): (a) the psyche of the Haitian people and (b) how the Haitian people perceive and express depression symptomatology (Nicolas et al., 2009). The current research study provided important information about their symptoms and intergradations of their culture (Jack & Ali, 2010). As a result, mental health providers will be better informed and enabled to understand the symptoms of these clients and, thus, be more able to provide culturally appropriate interventions, treatment and better outcomes (The APA Multicultural Guidelines; American Psychological Association [APA], 2002). Furthermore, Chapter 2 will also address the gap that remains in the literature regarding Haitian men who have been diagnosed with depressive disorders.

Chapter 3 will present a quantitative approach to the research study designed to analyze information regarding treatment (Creswell, 2009). I used a quantitative approach to investigate the impact of traditional masculinity norms, spirituality associated with Voodoo, and Haitian men's beliefs about depression. A quantitative method was used to address the variables that influence Haitian men's willingness or unwillingness to self-disclose their emotions. The quantitative approach facilitated evaluations that were applied by implementing procedures designed to address the research questions and achieve the purpose of the research (Creswell, 2009). Chapter 3 addresses the possibility

that life events may contribute to symptoms of depression, which can be measured by three subscales of the MRNI-SF (Levant et al., 2013) and CESD-R (Eaton et al., 2004). Additionally, in Chapter 3 I also describe the SMSS, ethical protection of participants, as well as data collection methods and data analysis process used in this study (Creswell, 2009). Finally, this chapter will discuss potential confounding variables and verification of findings.

Chapter 4 will describe the data collection process, which includes the information obtained from the MRNI-SF, the SMSS, SWBS, and CESD-R instruments; these measurements tools were administered to Haitian men and were collected via a nonexperimental design in designated Haitian community social settings (Hammond, 2012). The process of quantitative data analysis is described in Chapter 4. In addition, Chapter 5 will begin with an overview of the study, followed by a discussion of the findings, implications for social change, recommendations for action, recommendations for future studies, reflections, and a summary.

Chapter 2: Literature Review

Background

The problem investigated by this research was the absence of research literature on the subject of depression among Haitian men, and the purpose of this research was to begin to fill this void in the literature in the field of psychology on depression in Haitian men.

Much of the current literature establishing the relevance of the problem was the research studies conducted by Dr. Nicolas. Nicolas et al. (2007) stated that depression is evidenced differently among diverse cultural groups. The cultural and ethnic background impacts the expression of the individual's malady. These authors discussed "the importance of culture in the diagnosing and treating depression among many cultures" (p. 86).Nicolas et al. stressed that, "to date, this research had not yet included data on Haitians in the United States" (p. 86). In 2007, Nicolas et al. pioneered research of depression in Haitian women living in the United States. The authors recommended further research on Haitian men and adolescents to determine if their observations were consistent across gender and age. Conduct systematic and empirical research in various geographical locations in the United States to determine whether similar types of depression exist. This investigation was an endeavor to further the research literature on depression among Haitian people, with an emphasis on Haitian men living in the United States.

Major sections of Chapter 2 provide a plethora of research literature relevant to depression as manifested and understood from Western and non-Western perspectives,

including masculine role norms, expressions of depression across borders, baptism in Haitian Voodoo, Haiti, theories on normative and nonnormative perspectives, the significant impact of culture on Haitian men's beliefs and perceptions about depression, and the importance of addressing depression in Haitian men.

The primary purpose of this research was to explore depression among Haitian men living in the United States and whether adherence to traditional masculine norms integrated with religious beliefs in Voodoo had any impact on their perspective on depression. This research addressed the significance of Haitian culture, with a focus on their religious and secular beliefs and customs, and its influence on men's ideas about depression and mental illnesses (Nicolas et. al., 2009). In this study, the literature review provided an overview of the cultural expressions of depression from the Haitian perspective, explored the impact of emotional differentiation and expressions of depression on masculine norms, and finally, reviewed the complex issues that surround the standardized male and female gender roles as they are expressed in western society (Nicolas et. al., 2006).

Haitian American immigrants are less inclined to address their issues of mental illness due to misconceptions about mental illness that stem from their native Haitian culture (Desrosiers & St. Fleurose, 2002). This chapter included a review of existing data to explore how nonnormative characteristics of masculinity, from a cultural perspective, influenced Haitian men's perceptions of depression. The review of the literature also focused on the broader explanations of traditional masculine norms and identified the psychological distresses created by society's traditional and inflexible definitions of male

gender identity, roles, and responsibilities (Locker et al., 2012).

In the review, I also reflect on how societies influence gender through preferences that establish in whom people may have confidence in disclosure of emotions or whether emotions are internalized (Jack & Ali, 2010). The main principles of cultural perspectives stem from the perceived limitations of both behaviorism and psychoanalysis (Kleinman, & Good, 1985). I was interested in exploring new approaches focused on depression in Haitian men and in providing an understanding for assessment of the Haitian masculine experience. Furthermore, in the study, I endeavored to address the masculine functioning role (Mahalik, 1999). It was critical to the study to comprehend the immense influence of stigma portrayed by normative and nonnormative perspectives (Mahalik, 2008). Normative and nonnormative perspectives are formed by society, along with various moldings that shape different cultures (Klienman & Good, 1985). In order to address depression disorders and the implications resulting from Haitian men not seeking mental services, it was vital to approach depression symptomatology and highlight the importance of cultural aspect, and male gender characteristics as measured by the SMSS, which determined whether culture shaped Haitian men's perceptions regarding their masculine identity and depression (Wong et al., 2013, pp. 148-155).

A paradigm shift in the biomedical field occurred in 1977 when George L. Engel, a psychiatrist at the University of Rochester, espoused the theoretical model that came to known as biopsychosocial (Engel, 1977). Biopsychosocial is a broad-spectrum model or theoretical approach that posits the idea that the biological, the psychological (involving thoughts, feelings, and behaviors), and the social (involving the social environment,

economic status, and cultural influences) collectively combine to substantially impact human conduct in response to health problems (Engel, 1977). Engel espoused his biopsychosocial model at a time when the medical profession viewed sickness and disease purely through a biomedical lens (Engel, 1977). In the 21st century, medical and mental health professionals understand that health is ideally viewed through understanding the combined influences of biological, psychological, and social elements as opposed to a solitary in biological factor (Engel, 1977). Engel's biopsychosocial theoretical model has been further advanced through the research and publications of Mahalik. In this literature review, my goal was to integrate Mahalik's (2008) conceptual biopsychosocial perspective framework and Bandura's (1977) social learning theory to provide a solid theoretical framework for a clinical investigation and comprehension of the impact of culture on Haitian men's unwillingness to self-disclose symptoms of depression and mental illness. Furthermore, I hoped my research data would determine whether there were significant differences in aspects that culture has an influential impact on Haitian men's perceptions of depression, along with their beliefs about mental illness. Finally, I was acutely aware of the lack of research literature on depression in Haitian men and, by conducting this study, I began to address the issues of depression among Haitian men, ages 20 to 40 years, and contribute to the research literature on depression in this neglected Diaspora population.

This review of relevant literature was conducted and yielded materials on Haitian men and depression published between 2004 and 2010. The search for literature was conducted primarily through Walden University's electronic research databases,

specifically Academic Search Premier, PSYCINFO, PsycARTICLES, SocINDEX, PsycBOOKS and Mental Measurements Yearbook. I used several search terms including mental health, major depression, masculinity, spiritual well-being, social support, family, and gender role conflicts to obtain full text articles. In addition, electronic and book resources were reviewed and obtained through the Brentwood Public Library Portal. Keywords used for the search were *Haiti, men and depression, Haitians, Haitian men and mental illness, Haiti and mental illness, Haiti, mental illness and men, Haitian men and mental depression, Haitian men,* and *mental illness and depression*, but all searches yielded no results. Searching *Haitian depression, depression and men* yielded four articles appearing in the database EBSCOhost, but none addressed depression in Haitian men. Two articles focused on Haitians, mental depression, culture, and mental illness related to women and children, and two articles were unrelated to Haitians.

The quantitative approach involved examining the influence of culture on Haitian men's beliefs about depression and their reluctance to self-disclose mental or emotional problems. The quantitative approach helped me investigate the relationship between the Haitian cultural concepts of masculinity and the stigma attached to the disclosure of male depression (Creswell, 2009). I used the quantitative approach to gather strength of multiple variables to discover the prevalence of depression among Haitian men between the ages of 20 and 40 years of age who reside in the United States (Creswell, 2009).

Additionally, the discussion reviewed the significant effects of cultural values which created disequilibrium in treatment interventions (Waite & Calamaro, 2009). The review of the literature also focused on exploring the rationale and the reasons why it is

important to study depression among the “Haitian men” population (Nicolas et. al., 2007, p.96). Other issues related to treatment are the implications of characteristics domain interplay between judgment of male and female on the basis of inequality in expressions of depressive symptomatology (Panzarella, Alloy, & Whitehouse, 2006). I also considered the ethical and legal importance associated with responsibility in administering a psychological assessment, including addressing obstacles Haitian men face in the healthcare system (Nicolas et al., 2007). The research explained their symptoms and provided examples of the findings in the study to expand the various types of processes for depression.

The catastrophic earthquake that struck Haiti on January 12, 2010 astounded the global community and familiarized everyone with the name “Haiti” along with unforgettable heart-rending images of death destruction and human suffering. Before this singular historical event and in the two years since, the researcher has been unable to find any research studies or peer-reviewed articles on depression in Haitian people in general, and Haitian men in particular. There were the pioneering research studies of Dr. Nicolas (2006) on depression in Haitian women in the United States but, absolutely no research studies on depression in Haitian men. I entered keywords into the search databases were: Haiti, Haitian, depression, men, Haitian men and depression, Haitian men, culture, mental illness, mental depression, depressed persons; Haitians. Currently, there are no available results for these keywords. For this reason, the researcher resorted to the literature on pioneering work that addressed culture and depression, gender roles and other studies that addressed culture and mental illness.

Research Question

The following research questions were investigated in this study:

1. Does restrictive emotionality impact Haitian men's beliefs about depression?
2. Does self-reliance impact Haitian men's beliefs about depression?
3. Does subjective masculine stress impact Haitian men's beliefs about depression?
4. Does spiritual well-being associated with Voodoo impact Haitian men's beliefs about depression?
5. What is the effect that time of residency in the United States has on restrictive emotionality among Haitian men?
6. What is the effect that time of residency in the United States has on self-reliance among Haitian men?
7. What effect does length of time in the United States have on subjective masculine stress among Haitian men?
8. What effect does length of time in the United States have on spirituality associated with Voodoo?
9. Can higher levels of spirituality, as related to the practices of Voodoo, predict higher levels of depression for Haitian men?
10. Can spirituality, as related to the practices of Voodoo, affect levels of self-disclosure?

Theoretical Perceptions of Gender and Depression from Western and Non-Western Perspectives

The theoretical perceptions regarding gender and depression from a western society and non-Western society perspective remain questionable (Klienman & Good, 1985). Developed by Rotter in 1954 and expanded by Bandura in 1977, Bandura's social learning theory proposes that individuals learn from being in the same environment from looking at others in their environment, mimicking and copying the behaviors they see (Bandura, 1977). Moreover, the concept of learning from looking at people in one's environment has frequently been referred to as a connector between behaviorist and cognitive learning concepts because it covers concentration, recall, and personal drive (Bandura, 1977).

Furthermore, at an early stage, boys are likely to show signs of distress that last through childhood (Jack & Ali, 2010). During the developmental stage, patriarchal hierarchy prohibits young men from self-disclosure of their vulnerability, as well requiring them to deny their emotions about their bodies (Jack & Ali, 2010). Jack and Ali (2010), addressed the perspectives of cultural implications regarding how the patriarchal structure hinders young men from speaking openly about their feelings of depression because patriarchal structure associates expressions of emotions with vulnerability, a domain assumed to be for women. This inequality still persists when controlling one's belief (Jack & Ali, 2010). According to Mahalik (2008), whose research is a continuation of the work of Joseph Engel, the pioneer theorist of the mode known as "bio-psychosocial perspective" understanding depression in men is predicated on

understanding the deeply rooted, characterized as well as predisposed by the social community in which depressed males reside (Mahalik, 2008, p. 174). The social community exerts a dominant influence on depression in men. It is within the confines of social context that the group social norm dictates or models what will be acceptable as "normal" and what is unacceptable as "deviant" responses and behaviors (Mahalik, 2008, p. 176). (Cialdini & Trost, 1999) Cialdini (1993) espoused the idea that individuals are impacted by what they see others do, as "social proof" that descriptive norms provide conservation of time and cognitive effort while at the same time it gives directions about how to act in way that is socially acceptable (Mahalik, 2008, p. 175). There are contributing influences that may explain why men appear to suffer less than women with symptoms of depression such as: few men are involved in mental health studies, lack of awareness about good mental health, types of study tools utilized and orientation in traditional male gender roles (Love & Love, 2006). Gender role norms are socially reinforced and learned expectations of acceptable male or female behaviors (O'Loughlin et al., 2011). The process of gender socialization predicts that it is culturally appropriate for women to express emotions and seek help at the same, it is culturally inappropriate for men to express emotions and seek help (O'Loughlin et al., 2011). This cultural division between the female and the male role normative is a contributing factor in the phenomenon of male restrictive emotionality, the repression of men's natural expression feelings and responses (O'Loughlin et al., 2011). Traditionally, males and females were socialized differently by society regarding taking initiatives to be proactive about personal medical/mental health issues; with men making great efforts to avoid and/or

deny experiencing emotional pain/ distress (Love & Love, 2006). Depression is more than a fleeting feeling of sadness, a case of the blues. Depression embodies a longer period of chronic psychological pain, agony that can disrupt the ability to carry on daily routine functions (Love & Love, 2006). According to Love and Love (2006), the American Psychiatric Association (1994) estimated probability across one's lifespan of receiving "a diagnosis of a Major Depressive Disorder in the community has varied "from 10% to 25% for women and from 5% to12% for men" (Love & Love, 2006, p. 175). Another Western model of masculinity places taking care of yourself and concern about the wellbeing of other individuals as violating the tough and vigorous stamina men present in body and mindset (Oliffe et al., 2010). Also, the Western masculine psyche is socialized to think of themselves as logical thinkers, resolute and stoic, sustained by beliefs that a tough man disregards physical and mental symptoms, and a man is considered puny if he is affected by stressful life events (Oliffe et al., 2010). Oliffe et al (2010) reported the masculine norms that socialize men to be tough, strong, self-reliant, and independent at all times, is also responsible for self-denial and unwilling to ask for help when help is needed. There is also the perception that asking for help for depression or a mental disorder is anti-ethical to masculinity, an inappropriate masculine response to the depressive disorder (Oliffe et al., 2010). Some men view depression as an indicator of fragility and if his condition was known would make him a target of shame, dishonoring the dominant characteristics idealized as masculine (Oliffe et al., 2010). Albeit, gender-based norms have been categorized as applicable to both male and female, the toughness norm, a character trait which is most identified with concealing physical and mental

discomfort and simultaneously striving to remain self-reliant, was previously thought to be specifically salient to males and thus pertinent to an in depth understanding of the rate male seek services (O' Loughlin et al., 2011). Researchers found that when women and men adhered to the toughness norm, the results were the same for both. Both men and women were more likely to adopt an attitude of wait and see if the problem with work itself out without outside intervention (O' Loughlin et al., 2011). Both men and women were more resistant to seeking help for symptoms of mental or physical discomfort.

Researchers also identified some of the tangible and concrete obstacles that may possible hinder men from seeking help for mental problems such as depression (O' Loughlin et al., 2011). The serious issue of no insurance or insufficient insurance coverage can prevent men from seeking help (O' Loughlin et al., 2011). However, the greatest impediment to men seeking help for depression continues to be a mindset that a man who seeks help for depression is outside of the social male norm and there risks the sting of being stigmatized within his social community (O' Loughlin et al., 2011). Men who are experiencing an episode of depression may present symptoms that appear to people and to mental health professionals as typical male behaviors. Male depression is often expressed as anger, difficulties with impulse control, anxiety and cantankerous, violent behavior, drug use, reckless behaviors (e.g., driving under the influence of alcohol, extreme drinking), escapist activities (e.g., workaholic and/or fanatical about sporting events), frozen feelings, reluctant or refusal to share feelings, deficient personal interactions, and killing oneself (Oliffe et al., 2010). Current research is beginning to show that the conventional expressions of depressive symptoms such as sadness,

worthlessness, and obsessive guilt may not be as applicable to men to as to women (Rochlen et al., 2006). This research is also beginning to recognize that men may express symptoms of depression differently and this difference is now identified as 'male-based depression' (Rochlen et al., 2006). Some of these masculine symptoms of depression or male based depression may be manifested as extreme tiredness, loss of interest in work recreational activities, short-temperedness, rage, insomnia, and relationship difficulties (Rochlen et al., 2006). Research reinforces the data that men medicate themselves with alcohol and drugs which often camouflages depression in men. More research is being conducted to investigate whether men who are depressed attempt to conceal their depression through excessive work or participation in high risk activities. When depression goes without treatment, the consequences can be devastating to the man personally, to his family's financial security, and possible suicide (O'Loughlin et al., 2011). Fortunately, statistics show eight out of ten cases of depression respond effectively to treatment. According to the research of University of Texas psychologist, Dr. Rochlen, the more a man needs mental health services, the more likely he is to firmly resist or deny seeking mental health services (Rochlen et al., 2006). Other researchers are using the expression to define men's increased problems with restrictive emotionality which is a likely contributor to depression and an obstacle to effective treatment (Rochlen, et al., 2006). A study of men in the United States between the ages of 30 -51 years old and diagnosed with major depression, found a significant correlation between depression and masculine expectations of performance. Participants cited depression due to lack of meaningful relationships with others, unable to contain oneself, convoluted hiding of the

truth out of anxiety of being viewed as fragile and assigning blame to self for inability to triumph over depression (Oliffe et al., 2010).

The most recent research studies concluded that genetic investigations conform to the evidence which shows the majority of depressions evolve out of the integration of genes “e.g. polymorphisms in the serotonin transporter genotype” influenced by a stressful incident (Kessing, 2007, p. 87). Through observation of the distinctions in the ages of African American men, data revealed significant indicators among African American men, the experience of daily episodes of racial discrimination and conformity to established masculine expectations. For researchers in anthropology, the primary interest is “the system of normative meanings and power of relations which mediates the interconnections between person and society” (Klienman & Good, 1985, p. 8). Depression is presented by dual but decisively different “states of person; one normal, the other pathological” (Klienman & Good, 1985, p. 8). This difference is commonly not acknowledged in studies on depression in diverse cultures and among ethnic groups in the same society (Klienman & Good, 1985). Consequently, there is misunderstanding and a general lack of agreement among researchers in the field (Klienman & Good, 1985). Normative meanings and power are important to discuss in terms of cultural norms. For some clinicians, the definition of depression as a psychological or an emotional state is “reification of Western categories” therefore, normative meanings and power of relations become problematic when viewed from the perspective of “indigenous non-Western categories” (Klienman & Good, 1985, p. 9). The theoretical dichotomy establishes the differentiation in terms of clinician’s analysis on depression as a disorder and deadly

malady (Klienman & Good, 1985). Numerous implications addressed the malfunctions of the nervous system and the vulnerability of genetic attrition. Discussions further addressed the grief aspect as a type of depression; however, psychologists touched the perspective of grief to fluctuate within the two points of view (Klienman & Good, 1985). Psychologists view this from the psychoanalytical view as definitely "abnormal or maladaptive behavior" of the emotion and disorder (Klienman & Good, 1985, p. 9). Ethnographical and "epidemiological" studies critically point out obvious dissimilarities between the two positions (Klienman & Good, 1985, p. 9).

The clinical and the epidemiological perspectives on depression form a dichotomy regarding depression. Clinicians regard depression as distinctly distinguished as a qualitative from non-depressive state and classified as an "entity" (Kessing, 2007, p. 87). From an epidemiological perspective, the nature of depression is seen as an ongoing, evolving energetic state or condition. When Kessler, Zhao, Blazer and Swartz (1997), reviewed the data from "the National Comorbidity Study, the researchers "divided depression into minor depression with 2-4 symptoms, major depression with 5-6 symptoms and major depression with 7-9 symptoms" (Kessler, Zhao, Blazer &Swartz ,1997, as cited in Kessing, 2007, p. 87). Explicit and consistent connections were revealed relating the three indicators of depression to the amount of previous depression events, length of the event, and chronicle of family mental health, psychological and social performances and "comorbidity with anxiety or addictive disorders" (Kessing, 2007, p. 87).

Expressions of Depression Across Borders

Depression in non-Western populations is much more commonly expressed as a somatic idiom distress rather than expressed as an underlining pathology (Klienman & Goods, 1985). It is vital to comprehend the non-Western expression of depression among non-Western cultures. The CED-S when analyzed showed several key indicators that routinely emerged: “somatic symptoms, depressive affect, positive affect, and interpersonal behavior” (Love & Love, 2006, p. 174). Researcher using the CED-S reported it evidenced an increased reliability “of .85” while others have utilized “principal component factor analysis with normal Varimax rotation to extract four factors using Eigen values greater than 1, with each item loading above .40” (Love & Love, 2006, p. 174).When the CED-S has been used in the assessment of minority ethnicities, there was not a differentiation between symptoms of depression and somatization (Love & Love, 2006). However, differences occur in the “psychometric properties” when variables such as ethnicity and gender are taken into account (Love & Love, 2006, p. 175).

The author, Obeyesekere, discusses the Buddhist perspective on depression as expressed and understood in Sir Lanka culture (Klienman & Goods, 1984). In Sri Lanka, Buddhism postulates the nature of the world and to overcome the cause of sorrow is generally attained through meditation; thus achieving cessation from suffering (Obeyesekere, as cited in Klienman & Goods, 1985, pp. 137-148). This presents an ontological problem regarding the existence of nirvana. Whereas, in the Yoruba and Ashanti cultures of Sinhala, their beliefs are that there are life conditions and these affects

do not contribute to disease because their view of illness is a cultural conception surrounding the disease (Klienman & Good, 1985).

The available research informs us that Haitian people use a somatic approach to express depression (Nicolas et al., 2007). Haitians speak Creole, a language that does not contain psychological terms commonly used in Western culture. Therefore, Haitians describe depression symptoms using somatic terms such as body pains, aches, and feeling badly (Desrosiers & St. Fleurose 2002). Haitians also have a tendency to recall their situation with explicit information to help the clinician visualize the conditions surrounding the situation. Haitians will emphasize the significances for the clinician to memorize several of the details that they expect the clinician to recall later (Pierre et al., 2010). At the end of a session, the Haitian client will look for the clinician to present a solid solution. If the clinician attempts to be impartial and limit his/her comments the Haitian patient/client will see the session as a waste of time. Solid solutions may come in the form of help with fundamental necessities such as provisions or garments (Desrosiers and St. Fleurose, 2002; Gopaul-McNicol, Benjamin-Dartigue, and Francois, 1998; as cited in Pierre et al., 2010). If a relationship is established between the patient and the clinician, the Haitian patient's expectation is that the clinician can and will resolve every problematic situation expeditiously.

Haitians have a wide range of spiritual and cultural beliefs that give meaning to stressful life events such as mental and physical sickness (Pierre et al., 2010).The cultural understanding and belief systems along with spirituality, locality and social status are determinants that influence when and if an individual will seek help for a physical or a

mental condition (Pierre et al., 2010). Haitians frequently use a combination of approaches to resolve issues of sickness and maintain a sense of wellbeing. Consequently, an individual may receive assistance from various resources at his or her disposal (Pierre et al., 2010). Haitians classify sickness according to type, and there are many types: including: "*maladi Bondyè* (God's diseasen), *maladi peyi* ("country", ailments), *maladi mounfè mal* (magic spells sent because of human greed), maladi *bon lwa* ('disease from spirit') and *maladi Satan* (Satan's or "sent" sicknesses)" (Pierre et al., 2010, p. 24).

Many Haitians ascribe to a "humoral theory" of wellbeing and sickness. Heat and cold must maintain a balance within the body to prevent mental and physical sickness (Pierre et al., 2010, p. 24). The lack of balance between heat and cold is thought to cause sickness. The lack of balance may originate "from environmental elements such as rain, wind, sun, and dew or emotional reactions to the physical environment (e.g., witnessing lightning strike)" or the behaviors of other individuals (Pierre et al., 2010, p. 24). Well-being can be re-established with treatment of "herbal teas, regulated diet, compresses, baths, and massages" (Pierre et al., 2010, p. 24). Balance is restored by reversing the direction of the disequilibrium (Miller, as cited in Nicolas et al., 2006). When medical tests can find no evidence of a medical condition or an illness that could contribute to the patient's complaints of illness, the implication of the malady is to seek treatment from a nonwestern source (WHO & PAHO, 2010). A male Haitian patient often rationalize that the solution to his illness is to seek treatment from a "oungan or a Mambo" whom the patient believes is culturally empowered to get to the fundamental source of his malaise

(WHO & PAHO, 2010, p.19). The oungan “Voodoo priest” and the mambo “Voodoo priestess” are knowledgeable of the traditions, have power and are very well respected in the Haitian community (WHO & PAHO, 2010, p.19). The oungan and the mambo have a major role as a medical person who also possesses an extensive knowledge of herbs and the use of diagnostic procedures that are critical to healing. The oungan and the mambo seek answers for ‘non-physical’ or ‘unnatural’ causes of sickness and if there is none found, then they may recommend the client to seek biomedical treatments (Pierre et al., 2010). Mental health professionals working in Haiti may collaborate with trusted religious and spiritual leaders as consultants or co-therapists to encourage clients to accept help and follow recommended treatments (Pierre et al., 2010).

Haitian culture has a variety of explanations for illnesses based on popular cultural, religious and social beliefs. These explanatory theories can determine if and when to seek help. Other factors that influence help-seeking behaviors are location, religion, social class; usually a client will use a hybrid of helping resources. Voodoo serves both as a religion and a health care system via its healing practices, health advocacy, prevention of illness, and promotion of personal wellness (WHO & PAHO, 2010). Voodoo supplies information on how to promote, prevent and treat health problems, with theories on illnesses, treatments, interventions, and prescriptions for behavior that are congruent with popularly held explanatory models (Pierre et al., 2010). The primary interpretation of illness is based on the requirement to establish a harmonious relationship with the spirit world of the ancestors (Pierre et al., 2010). In Haiti, the African god or deities are called “l wa-s (loas)” and represent the spirit of

African ancestors, deceased family members and biblical figures. “Lwa-s” is a buffer and a cause of stress. If a man or woman fails to please the “l wa-s”, he or she may suffer misfortune, declining physical health and mental illness (Desrosiers & St. Fleurose, 2002, pp. 509-511). Mentally ill people may be thought of as a victim of powerful forces over which they have no control, and therefore the community supports them. However, humiliation may be connected with the decline in functioning in critical mental illness and the family may be unlikely to reveal that a family member is mentally ill (Pierre et al., 2010).

Haitians believe that emotional and physical distresses are essentially caused by a mystical influence that affects the inability to perform routine activities, including intellectual deficiencies, are all possible results of a jinx, a spell, or a curse initiated by an envious individual (Pierre et al., 2010). Being the object of such action can be a stimulus to the ego because usually a spell is sent or initiated against an individual who is good looking, prosperous, educated and socially well-established (Pierre et al., 2010). The decision to look for mental or physical help is determined by how closely the individual is connected to Haitian cultural beliefs about mental and physical wellbeing (Pierre et al., 2010). Haitians put emphasis on the individual’s societal and ethnic investment (Pierre et al., 2010). Sterlin’s work draws the distinction between the Western “anthropocentric” perspective on wellbeing, sickness and custodial care where the individual is presented as the main center of the universe, to the Haitian “cosmocentric” perspective which sees the individual as sharing the universe with “spirits, ancestors and the natural world” designed to function harmoniously to benefit the wellbeing within humanity (Pierre et al., 2010, p.

25). Haitians believe personhood is not individualistic but communal, spiritual and multi-dimensional.

Baptism in Haitian Voodoo

The religion of Vodou, (the Creole spelling is substituted with the Westernized spelling as Voodoo), shares a practice or ritual that is common among religious faiths globally. Albeit one may be born into a family of believers of a particular religious faith, the decision to practice a religious must eventually be a personal decision (McAlister, 2001). Although babies are initiated into the faith, mostly for reasons of spiritual protection of their innocence, that is a substitution until the baby has grown of age and has the cognitive ability and desires to accept the religious belief with evidence of some type of ritual of baptism (McAlister, 2001). Regardless of the age of the person being baptized, infant or adult, the ritual of baptism in Voodoo is a combination of both the Catholic sacrament and the indigenous West African rituals in Voodoo (McAlister, 2001).

Differences in Voodoo and Catholic Baptisms

There are some distinguishing characteristics that accompany a Voodoo baptism (McAlister, 2001). When an infant/small child is baptized, the gender is not a factor; he or she is given a unique non pwen (meaning a point name) or sometimes identified as a non vanyan (meaning an honor name) (McAlister, 2001). This is the name the newly baptized must use to identify him/her during prayers or supplications to the spirits. When this young person becomes the age of cognitive consent and decides to be a Vouduisant (one who serves the spirits) a newer name will be given that reflects the adult personality

(McAlister, 2001). By bestowing a newer name, the religion of Voodoo therefore, acknowledges the changes that have occurred in a person's character traits, ethical behaviors, and life conditions (McAlister, 2001). Because Catholicism is the official religion of Haiti, eventually one must be baptized into the Roman Catholic Church in order to receive the all-important official Certificate of Baptism required for registration in a school or an application for a passport (McAlister, 2001). Once the adherent is baptized into the religion of Voodoo, the ritual is usually followed by a celebration of this personal commitment to a relationship with the spirit world and with God the Creator (McAlister, 2001).

Voodoo, like the resilient spirit of the Haitian people, has shown great resiliency as it has traveled across the global landscape without losing its relevance on different shores from Africa to America (Drotbohm, 2010). As Haitians migrated to Canada and America in search of a better life, their belief and practice of Voodoo interwoven into daily functions, sustained them in the migration and adoptions to different ideological, economic and political way of life (Drotbohm, 2010). Consequently, the spirits, ancestors, and the saints in Voodoo have become integrated into more places of worship with a more diverse congregation of adherents (Drotbohm, 2010).

Although Voodoo is not commonly thought of as a religion but rather as a form of black magic, thanks to Western commercialization. This is far from the truth. Not only is Voodoo a religion, but adherents to Voodoo must also be members of the Roman Catholic Church! The official religion of Haiti is Catholicism (Drotbohm, 2010). A

customary Haitian adage is “pour sevilwayo se pou’w bon katolik” which translates as “you must be a good Catholic to serve the spirits.” (Drotbohm, 2010, p. 38).

Haiti

Ayiti Means Mountainous Land

At the time that Christopher Columbus discovered Ayiti, the Carib tribe and Tainos of the Arawak tribe were the indigenous occupants living on the island. The name Ayiti was the indigenous Taino or Amerindian name for the island translated as mountainous land (Nicolas, 2011). Columbus named Ayiti Espanola, translated as “Little Spain” in respect of the Spanish king. In 1804, after declaring independence from France, the forefathers decided to change the spelling of the name Ayiti to Haiti, abandoning the French name Saint Domingue, to show that Haitians had reclaimed possession of the land that was taken from the indigenous Carib tribe and Tainos of the Arawak tribe; the land on which they had been enslaved and used as forced laborers (Nicolas, 2011). The name Ayiti was changed to Haiti to declare a new era had begun and also to free themselves from the remaining vestiges of slavery. Nicolas (2011), mentioned the Constitution, Haiti was the name given to the whole island of Hispaniola on January 1, 1804. During the revolution of 1843, the Haitian soldiers were driven away from the eastern section of Hispaniola and in 1844, Santo Domingo or the Dominican Republic. From this history, the nations of Haiti and the Dominican Republic have shared this island, originally named Ayiti (Nicolas, 2011).

Indigenous People

Although Haiti was originally inhabited by the indigenous Taino /Arawak people, the Taino/Arawak no longer exist as a people due to the extreme cruelty they suffered as slaves under Spanish colonists (World Health Organization [WHO] and Pan American Health Organization [PAHO], 2010). The Spanish colonists replaced the diminishing slave labor of the Taino/Arawak with Africans captured during the Atlantic slave trade (WHO & PAHO, 2010). The Haitian Revolution was the result of a long struggle on the part of slaves in the French colony of Saint Domingue. The Haitian Revolution was also propelled by free Mulattoes who faced trials of being denoted as semi-citizens. This revolt was not unique; there were several rebellions of its kind against the institution of plantation slavery in the Caribbean (WHO & PAHO, 2010).

French, Creole, and Color

The official languages of Haiti are Creole and French, with French being written, spoken and comprehended by a minority of people, 20%, composed of elite and middle class city dwellers. The lexicon (patois) of Creole is predominantly French-based combined with “African and Arawakan languages, Spanish and some English” (WHO & PAHO, 2010, p. 3). Haiti is well known for its very strict and very influential class hierarchy built on one’s education, language, economic status, and culture (Desrosiers & St. Fleurose, 2002). Literacy in the French language functions as a “social filter”, granting entrance into the powerful circles of politics, economics and social society (WHO & PAHO, 2010). Haiti, as in other formerly colonized countries, has inherited a legacy of discriminatory stratifications based on gradations of color; the lighter the skin,

the more prestigious the position one can aspire to and attain in society. The darker skin, the more difficult, if not impossible, it is for one to advance in society. Darker skin people are relegated to a lower social and economic class and very much marginalized (WHO & PAHO, 2010).

Haiti on the Globe

The country of Haiti is only 600 miles from the Florida coastline and is situated in the Caribbean Sea. In the Western Hemisphere, Haiti is listed as “154 out of 177 countries on the Human Development Index” (WHO & PAHO, 2010, pp. 2-5). Almost 50% of Haitians live in severe poverty; unemployment rates are “49%”urban areas “37%”less populated areas**,** “36%”in the countryside (WHO & PAHO, 2010, p. 3). Haitians, by the thousands, seeking opportunities to better themselves and to financially support their families, have migrated to Canada and America (WHO & PAHO, 2010). Of the more than 9 million Haitians living on the island in 2003, largely 60% of the population resides in non-urban areas (WHO & PAHO, 2010).The majority, “50%, of Haiti’s population is under the age of 20. Approximately 51% are single and 44% are married or cohabiting” (WHO & PAHO, 2010, p. 2).

Theoretical Approaches that Concentrate on Normative and Nonnormative Perspectives

Of particular significance is the “line-length” study by Asch **(**Mahalik 2008, p. 175).Participants in Asch's study agreed that the confederates were correct. The participants questioned their own better judgments; even though they looked at the actual materials in front of them. The participants failed to make a determination for themselves

that differed from the confederate's opinion (Asch 1955 and 1956 cited by Mahalik, 2008).The participants trusted the confederates rather than their own physical reality and concurring data. Asch's study demonstrated the immense authority of the group on individual behavior within the confines of the social context. Participants subjugated their better logical judgment to avoid disagreement with the confederates. Mahalik (2008) uses Asch's study to substantiate a salient point: In reviewing the results of Asch's line-length study, we became more informed of the difficulties individuals, men in particular, would encounter in expressing symptoms of depression when such expressions are viewed as non-normative (Asch, as cited in Mahalik, 2008). Finally, research seems to be conclusive that the dominant power of the "social norm" is that it motivates men to choose to "conform to the norm" rather than risk exclusion or negative identification as "aberrant" (Mahalik 2008, pp. 175-176). Applied to men's depression, it is more important to maintain social parity within the social community than to risk rejection as a result of expressing symptoms of depression. Cross cultural research evaluates the culture variations in depressive mood, different meanings and forms of depression, as they are expressed in different societies; cultural differences not only in depression, but also in mood and expressed symptoms of depressive illness (Kleinman & Good, 1985).

The SWBS is a widely used measure of spiritual well-being and has established "psychometric properties test-retest reliability of .93 and alpha coefficients of .78 to .89 in rehabilitation populations" (Korrte, Veiel, Batten, & Wegener, 2009, p. 93). These life pressures had a strong correlation to depression and poor psychological and spiritual health (Korrteet al., 2009). The belief in the effectiveness of their support resources

produced a positive effect on psychological and spiritual health and also served as an inspirational factor in depression (Korrte et al., 2009) The SWBS is a well-conceived and reasonably well-researched 20-item paper-and-pencil rating scale. The authors believe that personal well-being is more than existential, and requires a religious dimension which can be nonsectarian. The SWBS is composed of self-belief declarations uniformly separated between existential and spiritual domains and is calculated on a 6-point Likert scale. Respondents rate their answers on a spectrum from Strongly Agree to Strongly Disagree. The questions are written evenly in positive and negative modes, consequently coercing some responders to be more alert and decreasing possible response-set partiality. The authors appeared to have thoroughly researched their subject and chose the two domains pertinent to the instrument. The religious well-being domain is specifically carefully differentiated from other related constructs, such as 'religious cognition' and 'religious commitment. The SWBS asserts that it uses a multidimensional conceptualization of spiritual well-being, similar to that developed by Moberg (1979) incorporating 'transcendent concerns which involve meaning, ideals, faith, commitment, purpose in life, and relationship to God' (Ellison, 1983). Bufford, Paloutzian, and Ellison (1991) succinctly point out “the scale is currently useful for research and as a global index of lack of well-being” (p. 56). The main purpose of the SWBS, according to its developers, is to assist mental health clinicians whose primary task is to assess and correct dysfunctionality.

This study provided important information towards understanding depression in non-Western males and specifically addressed psychosocial distresses which may be

attributed to traditional Haitian male beliefs and their understanding about depression (Mahalik et al., 2005). Nevertheless, research investigating the impact of culture and gender on the pressures of life, including social support, is absent, especially in its capacity to recognize and comprehend, within-group, variables which significantly influence well-being (Brown et al., 2000). There is tremendous proof that correlates the stresses of life to poor physical and mental conditions (Brown et al., 2000). A significant amount of research shows that males with comparable unfavorable social conditions as females face an increased risk of having a poor health diagnoses such as suffering a disability, long-term sickness, accidents and death at an earlier age (Evans et al., 2011). Traditionally, the health of men is not investigated exclusively on its own basis of masculinity. “Statistics Canada in 2005, men are 39% increased risk of death from diabetes, 84% risk from arterial diseases, and 78% from heart disease” (Evans et al., 2011, p. 7). In addition to men’s higher rates of cardiovascular disease, decisions to end their lives and injuries from automobile accidents, men also suffer more loss of quality of life (Evans et al., 2011).

Additionally, this study provided mental health professionals with a cultural context of Haitian language, customs, religious and secular practices which will aid the clinician’ s understanding of the Haitian client seeking mental health services (Nicolas et al., 2006). Because of the scarcity literature on the role of non-Western, specifically Haitian males, adaptations to social norms and how they express symptoms of depression; this research endeavored to provide clinical information, from the Haitian perspective, on Haitian men and the manifestations of depression where there is currently

a void on the subject (Nicolas et al., 2007). When addressing the Haitian population, it is critical to understand all of the challenges involved, especially the fact that Haitians, in general, seldom use therapy (WHO & PAHO, 2010). It is vital to gain knowledge of the Haitian culture and their religious beliefs in order to overcome these challenges and implement a positive therapeutic alliance within the Haitian community (WHO & PAHO, 2010).

Analyzing cultural views, in terms of biases, mental illness is frowned on in Caribbean culture. Mental illness has always been viewed as a hush hush affair. It is seen as a personal defect and the family can suffer social isolation. It is vital that researchers, along with professional mental health providers, attempt to comprehend, to circumvent, and to alleviate psychological disorders and encourage good mental health for Haitian clients (Nicholas et al., 2008). The removal of the stigma surrounding mental illness within the Caribbean community is a reason for attempting to educate the Haitian community about mental health.

Theoretical Concept Models Regarding Treatment

Researchers acknowledge that culture plays an integral and powerful role in affecting clients' perceptions and expressions of depression. There are consequences, benefits and negative costs of male “conformity and nonconformity to masculine norms” (Mahalik et al., 2005, p. 662). Evans et al., (2011), reported Connell (1987) had identified time frame, cultural traditions and geographical location as significant determinants in defining masculinity not as a single definition but as multiple masculinities. Each cultural group has a totem pole understanding of masculinities which places an unrealistic and

impractical masculine image as the dominant hegemonic standard (Evans et al., 2011). Looking at masculinities from a Western perspective, the hegemonic man is idealized as Caucasian, dates or is married to a female, earns a respectable income, is recognizably aggressive, bold and self- confident in his physical attributes and abilities to dominate others (Evans et al., 2011). Numerous studies have concluded that as men aspire to achieve the hegemonic Western cultural masculine gender role norms, they are likely to suffer difficult and challenging consequences including a higher probability of dysfunctionality in their ability to emotionally connect and maintain a meaningful relationship with family, friends or an intimate partner, (Wong et al., 2013). Research has been conducted on male emotional responses utilizing the Restrictive Emotionality Scale (RES), a subscale of the Gender Role Conflict Scale, to quantify personal differentiation among men who are adherents to the hegemonic Western cultural masculine gender role norms, (Wong et al., 2006). Restrictive emotionality is described as "having difficulty and fears about expressing one's feelings and difficulty finding words to express basic emotions"(O'Neil, as cited by Wong et al., 2006, p. 114). Empirical evidence continues to indicate that the hegemonic Western cultural masculine gender role norms have a direct corollary for men to restrictive emotionality and correlate to "alexithymia" (Wong et al., 2006, p. 114), "shyness and toughness" problems being intimate with significant partner, displeased with marriage, uneasiness, a routine of behaviors indicative of symptoms of depression, a pessimistic opinion about seeking for psychological help, and "an increased similarity in personality style to that of chemical abusers" (Wong et al., 2006, p. 114). Although a propagation of hypotheses abounds to explain male lack of

emotional expression nevertheless, the connection between restrictive emotionality and additional emotionality-related hypotheses is yet to be formulated (Wong et al., 2006). Researchers in this area might encounter difficulties recognizing the distinguishing characteristics of emotionality-related hypotheses such as: suppression, repression, inhibition, and alexithymia. Also, it remains ambiguous how the RES is differentiates (specific area of emotions it measures) from additional assessment instruments that measure the deficiency in emotional expressiveness e.g. the very popular "Toronto Alexithymia Scale-20 (TAS-20)" (Wong et al., 2006, p. 114).

With these characteristics defining hegemonic masculinity, men who choose to define themselves otherwise and choose to behave differently are subordinated and marginalized (Evans et al., 2011). Within the framework of multiple masculinities, social diversity is exemplified through subordination and marginalization of a classification of men using determinants such as: age, race, ethnicity, class, culture, sexual orientation, and physical ability. Additionally, men who were classified as subordinate or marginal because of race, ethnic background or sexuality faced a greater probability of experiencing health issues. For African American men, the primary determinants for their health outcomes were: racial discrimination, poor social/economic status and imprisonment (Evans et al., 2011). According to Hammond (2012) direct attention was focused on the stress of continuous discrimination as daily "microaggression" experiences (p. 233). Researchers conceptualize that these "microaggressions of racial discrimination crosses with masculine norms unfortunately positioning African American men to face increased risk factors for unfavorable psychological outcomes (p. 233). The

findings of the research indicated symptoms of depression which were closely aligned to the negative influences of chronic stressful events and provided an excellent calculation of relevant clinical depression. The nonclinical samples were simpler to assess. The value of Hammond's (2012) research findings succinctly identified discriminatory practices that place African American men "in a nonclinical sample" at greater jeopardy for depression and poor mental health outcomes (p. 239). Love and Love (2006) research has revealed "that blacks are under-diagnosed for affective disorders such as depression, while they are over-diagnosed for schizophrenia" (Love & Love, 2006, p. 176). Love and Love (2006) found that regardless of the age demographic, black men, more than any other ethnicity or cluster of men, suffer an increased risk for death whether death is a result of a violent crime, failure to access medical/mental intervention and treatment, unsafe living environment or even suicide. Statistically, a black man is one and a half times more likely to die of heart disease than a black woman and twice as likely to die of heart disease as a white man. Furthermore, African American men die "5.5 years" earlier than Caucasian men and die more frequently of "stroke, homicide, diabetes and HIV" (Evans et al., 2011, p. 9). The research concluded for homosexual men, the consequences of marginalization included discrimination against homosexuals, victims of physical assaults, exclusion from social circles, risky sexual behaviors, and statistically high suicide rates (Evans et al., 2011).

Although studies show that being male or female is a strong determinant in health outcomes, the World Health Organization (WHO) 2000 called for research studies to investigate the significance of being male correlated to the disproportional health

outcomes of men and women; consequently providing insight as to why women live longer than men (Evans et al., 2011).One observation the researchers found to be a salient view is that men suffer negative consequences, as well as provide reward, as they conform or fail to conform to established male gender norms (Mahalik et al., 2005). A male who displays nontraditional male behaviors toward masculine acceptable standards may adversely affect the lives of significant persons in his life. However, men's conformity to masculine acceptable norms may also benefit the male and his immediate circle because he modeled acceptable masculine identity, he receives promotion of social acceptance within his social circle and provisions of social monetary rewards (Mahalik et al., 2005). According to Hammond (2012), support of "masculine role norms" among African American men depends on these two factors:"race/ethnicity" and the amount of social leverage (p. 233). The study recognizes the subsequent logical task would be to find out whether "restrictive emotionality and self-reliance" are unequivocally connected to depression or if "masculine role norms exacerbate or diminish racial discrimination's effect" related to depression among men of African descent (Hammond, 2006, p. 233).

The traditional conformist male is most likely to be viewed as a man, who has his life's priorities in order, has what it takes to get ahead, and has the respect of his fellow colleagues and his social community (Mahalik et al., 2005). The customary masculine standards of behaviors are: appearing emotionally distant/removed or restrained in expression, driven to achieve success, and exercising domination in his personal relationships (Ahern, & Galea, 2006). Men who do not conform to traditional masculine gender norms are more apt to risk rejection by their social groups (Mahalik, 2008).

Clinicians can determine, utilizing several methods of assessment and measurement, whether male clients' responses to standards gender roles are traditional or nontraditional responses (Mahalik, 2008). "The Conformity to Masculinity Norms Inventory (CMNI)" is one comprehensive assessment tool useful by clinicians with their male clients to improve client's understanding of self and their conformity or nonconformity to traditional masculine gender roles (Mahalik et al., 2005, p. 662). The clinician may utilize assessments, interviews, inventories and discussions to help the male client become more aware of the conforming and nonconforming masculine gender norms which are affecting his life and his interactions with his social world (Mahalik et al., 2005).

Negative Life Experiences Influence on Depression

Epidemiological research concludes that negative life experiences influence the development of depression (Korrteet al., 2009). Fundamentally, the query becomes how and why do negative life experiences influence or produce the response of depression? The hopelessness theory of depression hypothesizes that unconstructive life events/happenings function as "occasion setters" whereby individuals become hopeless; although individuals do not constantly turn out to be hopeless as well as depressed as a result of negative life events (Brown & Harris, 1978; Lloyd, 1980a, 1980b cited by Abramson, Metaskly and Alloy, 1989, p. 360). Hopelessness is a negative effect and painful emotional state that is usually correlated with symptoms of depression (Abela, Parksion, Stolow, & Starrs, 2009). The hopelessness theory cites three categories of inferences that individuals may possibly draw about negative life experiences that determine their prognosis for becoming hopeless and subsequently, begin to exhibit

symptoms of hopelessness depression (Abramson et al., 1989). Why did the negative situations happen to me? What are possible consequences of the negative events? Thirdly, how do the negative life experiences relate to concept of self?

In Beck's research, he reports, as a cornerstone, the inferences that one concludes about self, self worth, abilities, personality, and desirability regarding negative life experiences influences whether hopelessness depression occurs (Beck, Steer, & Robert 1978). The more negative the view of self, the greater the propensity for expressions of negative characteristics and futility in affecting a positive outcome, thus, the development of hopelessness depression (Beck & Alford, 2006). The hopelessness theory is characterized by non-normative self attempts motivational symptoms which is the result of the helplessness element of hopelessness; an attitude of nothing I do would make any difference. Sadness is manifested as the future is believed to be without improvement, dismal (Beck et al., 1961).

Factors that Produce Symptoms of Depression

The inability to make sense of the challenges with vulnerability and stress models causes a domino effect with some ethno-cultural groups encountering even more stressors (e.g., ethno-political conflicts, lack of resources/access to care and differential reporting of stress levels (Panzarella et al., 2006). Across cultures boundaries, Self Silencing and depression focuses on women from different sectors of the globe such as; Germany, United States, Poland, Portugal, Canada, Nepal and the Caribbean to examine the role of gender, sociopolitical barriers, and basic class distinctions. The most observable differences that influences the manifestations of depression exist between the powerful

and the powerless, culture, social pressures, disorder (Nicolas, Hirsch, & Beltrame cite by Jack & Ali, 2010). Prevalent, as in most societies, the Haitian social class is determined by the following criteria: income, education, family status, skin color and culture (Nicolas et al., 2009). Similarly, Haiti has inherited a culture of color consciousness, typical of all colonized and enslaved peoples of color. The color code is organized around shades of color, the less color, the higher the social status (Pierre et al, 2010). Because this color system is a strict discriminatory practice among members of the same ethnic group, fair-skinned individuals make up the socially and economically elite class. Contrast that scenario with the life of people whose skin color is unmistakably a darker hue and you will find them occupying the lowest social and economic levels of Haitian society, regardless of their abilities, skills or academic achievements (Pierre et al., 2010). Additionally, social class is important because each culture have its own description of social class. However, the principles of Haitian culture are interwoven with one vital tradition, root and social observation. By incorporating these elements of root and social class into the initial assessment of the individual, the therapists would be more informed and thus better prepared to provide appropriate treatment (Waite & Calamaro, 2009). The culturally informed therapist will assess the influence of the fundamental stressors and factors that may have fostered the perception of the patient's depression illness. On the other hand, the symptoms that Haitian men appear to exhibit may resemble depression which can be exacerbated due to life circumstances such as political disparities, poverty, and most recently, the earthquake that occurred on January 12, 2010 outside the capital of Haiti (WHO & PAHO, 2010).

The Significant Impact of Culture on Haitian Men's Beliefs and Perceptions about Depression

The gender role of Haitian men is historically characterized as being in the domain of the physically powerful. Men are traditionally viewed as resistant to seeking help regardless of whether it is a medical doctor or a psychiatrist. Researchers who studied this male gender resistance to seeking help; without regard to age, social background, ethnicity or national origin, were consistent in their findings that men are not inclined to obtain assistance when they have issues with symptoms of depression, alcohol, or drug addiction, physical disabilities and stress related life situations (Addis & Makliha, 2003). Researchers sought to answer the questions: "why do many men have difficulty asking for help?" (Addis & Makliha, 2003, p. 5). What is the impact on masculine models, male typecasts, and philosophy concerning men receiving help in resolving mental or psychological issues? The stigma attached to individuals who seek psychological help for depression is more strongly pronounced if that individual is a male living in the United States. Men who voluntarily seek psychological help for mental problems are perceived as not masculine, fragile, and lacking personal fortitude (McCusker & Galipo, 2011). Men who have been socialized from a hegemonic or traditional concept of masculinity can encounter gender conflict when they seek psychological help (McCusker & Galipo, 2011). Men experiencing gender role conflict seem to manifest characteristics of depression and conceal pessimistic thoughts about asking for psychological intervention. Consequently, men stigmatize themselves are also not inclined to disclose themselves nor seek psychological help in contrast to men who do

not stigmatize themselves thus, can self-disclose (McCusker & Galipo, 2011). A plethora of research studies have concluded that men have a more negative attitude than women; therefore, men rarely seek or accept psychological help for depression or other mental distresses (McCusker & Galipo, 2011). This avoidance of seeking psychological help is a conditioned response to the difference in gender role expectations in which males and females are socialized to seek or not seek help. Males and females are socialized according to cultural norms of masculine and feminine roles. Males are taught to be physically and mentally tough, independent and in control of emotions are benchmarks of masculinity (McCusker & Galipo, 2011). Symptoms of depression in men can be "masked" or presented in an expression not matched to the general assessment of depression criteria (Addis, 2008 cited by McCusker & Galipo, 2011, p. 276). Men also present standard symptoms of depression expressed as unhappiness, suicide ideation, fluctuations in desire for food, inability to sleep or sleeping too much, feeling exhausted, difficultly in focusing, inability to enjoy leisure activities, culpability, and inactivity/hyperactivity (McCusker & Galipo, 2011).

Neighbors and Howard (1987) reported African American women sought "medical assist more" frequently than did African American men however; their hypothesis was that the women more often recognized the need for assistance (Addis & Mahalik, 2003, p. 6). Men and women generally are socialized differently and these learned social paradigms dictate attitudes, behaviors, cultural values, and the definitions of what constitutes masculine as well as feminine within the confines of the society. A further review on studies of the role of men in society, the identification of masculinity

and the conflicts that occur within the manifestation of male gender found two critical overlapping focus points. Theories and commonly held ideas about men, as they are viewed by society, measure how individual men are able to adapt and express their masculinity as masculinity is defined as appropriate within the society (Pleck, Sonenstein, & Ku, 1993; Thompson & Pleck, 1986, as cited in Addis & Mahalik, 2003).

The adverse results were identified "for men's well-being of adopting particular masculinity ideologies "e.g., gender- role conflict" (Courtenay, as cited in Addis & Mahalik, 2003, p. 7). The internalization of the idea that a man should be tough, competitive, and keep his emotions inside often has a destructive effect on a male's mental as well as physical condition (Courtenay, as cited in Addis & Mahalik, 2003). According to Addis and Mahalik (2003), cited that (Pleck 1981, 1995) in his report on gender-role strain paradigm postulates that "masculine gender roles are socially constructed from stereotypes and norms, are multiple and contradictory, and create problems for individual men and others e.g., women and families" (p. 8). The dual effects on how men interact in society and the traditional concepts of masculinity within the contexts of seeking help are mediated by the following fundamental social psychological questions: Is the problem perceived to be normal? How important is the ego to the problem? Would social status be affected by disclosure? Would there be any loss of personal control? Studies have shown men are less reluctant to seek help when the perception of normative is evident; and conversely, seeking help is unlikely when the perception of the problem is non-normative (Mahalik et al., 2007).

Numerous studies have discovered that ideologies of normality impact individuals' efforts to access help. However, when the problems are thought of as nonnormative, that greatly jeopardizes the individual's sense of self-worth (Addis & Mahalik, 2003). Consequently, the cultural issues regarding men's unwillingness to search for assistance, whether medical or physical or both, present challenges to the mental health providers, and society as a whole, to moderate traditional and stereotypical masculine paradigms for men (Addis & Mahalik, 2003).

The Importance of Addressing Depression in Haitian Men

When addressing depression among Haitian men, there is a pertinent normative that connects among non-Western cultures; namely these non-Western cultures conceptually have no equivalent word in their vocabulary that defines depression disorder (Kleinman & Good, 1985).The Haitian people do not have a cultural concept of a depression disorder. Haitian people do not understand mental illness as a medically treatable illness; thus, they usually look elsewhere to address their mental issues (Jack & Ali, 2010). The first appeal is to see a medical doctor; their primary physician. When medical tests and examinations fail to diagnose a medical problem then the next resort is to look for cues through a voodoo priest who will discern the possibility that he/she has been the victim of a curse or spell. On the other hand, Nicolas et al., (2007), report analysis of three distinct types of depression as described by Haitian women. Moreover, the research indicated that Haitian women express depression differently; and also reported those symptoms of depression differ from Western society.

Other research has also confirmed this. Nicolas et al., (2007) reported Haitian

women living in Montreal, Canada, expressed three types of depression: physical pain, God's help, and impossible to overcome. Their research also mentions that Haitian women expressed three additional forms of depression: depression symbolized by a catatonic-like state, inanimate and lacking response to environment, however, the individual is able to perform the daily functions of living. A full definition of the depression disorders is essential to help distinguish the differences between each type of symptom manifested. Once a clarification of symptoms is identified, then explanations of the cultural biases were answered (Nicolas et. al., 2007). Clinician evaluations of non Western clients with depressive disorders should include valuable cultural information that informs the clinician of the client's cultural perspectives religious and secular beliefs, customs, social status, education on such illnesses (APA, 2002). This level of cultural knowledge and understanding helps to equip researchers and clinicians to answer the question of why it is important for healthcare professionals to address the depression disorder among non western clients, especially members of the Haitian community (Nicolas et. al., 2006). These objectives will provide the reader with a better understanding of Depression Disorders and the direct effects they have on Haitian men and the community.

Culture, by definition, has its own set of boundaries which inform us with whom we should or should not associate, and thus, who and what defines our social circle, as well as our position within the group. However, the principle focus of gender characteristics will address the “gender role theory” wherein males and females are taught acceptable behaviors including acceptable attitude which are constant with family

and cultural mores (WHO & PAHO, 2010). Generally men in Western and non Western societies do not easily express their emotions which are learned behaviors from their male gender roles of socialization (Addis & Mahalik, 2003). The theory of differentiation between male and female roles in the culture are determined by the social values of the culture proposes that the social structure is the underlying force for gender differences (Jack & Ali, 2010). This theoretical perception of gender differences influence various affects of depression among Haitian men as revealed by the Silencing the Self Scale. The Jack and Ali (2010) verbalized a culturally scripted voice circle of "Over Eye" which is a form of moral theme among women. "The Silencing of the Self Scale" would render her silenced self (p. 5). The Silencing the Self Scale was applied to the expression of depression in Haitian men. The self silencing theory addressed the cultural aspects of women pressured to care for and sustain relationships while remaining in totally silence of their emotions (Jack & Ali, 2010). Depression itself is frequently expressed with symptoms of listlessness and passivity; and is often seen as anti-ethical to masculinity. In women, the Silencing of the Self was necessary to her role in the family and in society therefore, when a female chose to express her emotions, her actions would create a paradigm shift in gender expectations (Jack & Ali, 2010). To view depression as a sign of self silence is to concede the cost of perpetuating patriarchal norms and values in all their subtle and not so subtle manifestations (Jack & Ali, 2010). This study reported that cultural variables have, in fact, negatively impacted women's abilities to express depression.

According to Baron, Branscombe and Byrne (2009), social psychologists mainly

focus on understanding the causes of social behaviors and social thoughts on identifying factors that shape our feelings and behaviors. Major event trends have influenced the field of social psychology. Culture is another way to understand the individual approach and the way he/she thinks. Social psychology can also get a grasp of how the individual relates to the world around them. In this article, the author limits his commentary to the social confines of the hypothesis bio-psychosocial parameters with emphasis of comprehension of the outcomes of men's symptoms of depression as nonnormative (Mahalik, 2008). Much of Mahalik's (2008) discussion utilized the research results published in an article by Addis (2008) in which Mahalik found a schema for additional research regarding the male gender and psychological stresses. Mahalik's (1999) writings encapsulated what we already know about the expressions of depression in men.

To be culturally responsive is important to grasp the full meaning of cultural competence. In order to gather data regarding cultural diversity and equality in human participants, researchers need to provide accurate data for clinicians to avoid implications of improper treatment (Sue et. al., 2007). Whenever possible, clinicians should seek to solicit information from their clients and their families regarding their perceptions of the etiology of the illness (Lopez et. al., 2006). To address a broad explanation of the Haitian behaviors, psyche and attitudes toward depression, the researcher will examine an overview of the Haitian history and Voodoo religion. It is crucial to understand their perspectives and cultural values that may cause conflict when Haitians attempt seek appropriate treatment. Therefore, it is important to consider more culturally diverse and appropriate skills to better serve the mental health needs of this immigrant population, in

particular, Haitian men (Nicolas et. al., 2007).

Summary

Researchers in the fields of anthropology and psychology acknowledge the impact that society exerts on the development of boys and girls to determine their respective roles as men and women in society (Kleinman & Good, 1985). We are taught, early in our formative years, what is and what is not appropriate male and female behaviors, attitudes, occupations, dress, language, associations, and etc.; according to the constructs of our culture, whether western or non-Western, in particular, our social standing within our respective culture(Jack & Ali, 2010). There is no disagreement among researchers and clinicians that men, from western and non-Western societies, tend to assess medical and mental intervention services much less than do women (Kleinman & Good, 1985). The value of Hammond's (2012) research findings succinctly identified discriminatory practices that place African American men "in a nonclinical sample" at greater jeopardy for depression and poor mental health outcomes (p. 239). According to Hammond (2012), further research is needed to investigate whether African American men's propensity to "take everyday racial discrimination like a man" might provide an explanation of how this stressful biopsychosocial factor "gets beneath the skin" and is vital to causing the disparities that is occur between the health of African American and Caucasian men (p. 239). Creswell (2009) stated that "researchers review the data, make sense of it, and organize it into categories or themes" (p. 175). Social psychologists are aware of the cultural and social implications men, in general, view as a negative consequence of seeking treatment for an emotional or a distressing mental disorder. The

characteristics assigned to the male gender role, ironically similar for both western and non-Western societies, view the men as physically strong, taking charge, dominant, control of emotions, non verbalizations of feelings of sadness, hurt, pain, etc (Addis & Mahalik, 2003). After a thorough reading and analysis of available research studies exploring depression symptomatologies in men and women, from various fields of perspectives including psychological, psychosocial, anthropological perspectives, the data was negligible regarding depression symptomatology in men from a non-Western cultural perspective (Kleinman & Good, 1985). Moreover, there was found no consensus among researchers; anthropologists and psychologists, regarding the definition of depression as being either emotional as opposed to a disorder (Kleinman & Good, 1985). There was little to no research or studies investigating how depression is expressed in an indigenous non-Western cultural environment (Kleinman & Good, 1985). As previously stated, there are hundreds of thousands of Haitian men and women living in the United States and many of them require not only medical intervention but psychological treatments as well (Jack & Ali, 2010). Haitian immigrant men and women arrive here with a multitude of debilitating emotional and psychological disorders that are not appropriately diagnosed and treated. Because of the lack of research regarding Haitian men's depression as expressed in non-Western cultures, in particular cultures of the African Diaspora, clinicians and therapists are less informed with the cultural knowledge essential to interact with and provide appropriate treatment to clients from these non-Western cultures (Destrories & St. Fleurose, 2002). Other researchers report that the MCC “skills” concept examined the skills white mental health professions utilized if and

when they sought assistance with addressing an issue involving cultural diversity or sought to take advantage of multicultural educational opportunities to improve their competency in multiculturalism (Delsignore et al., 2010).With Haitian clients, it is vital to have knowledge and understanding about the client's culture, social status, religion, language and beliefs, as all these factors will powerfully influence the relationship between clinician and client and ultimately, impact the client's willingness to respond positively to therapeutic treatment. The clinicians who work with a diverse population of clients require this cultural knowledge and may include a cultural consultant to facilitate language and other cultural barriers (Nicolas et al., 2006). Since the catastrophic earthquake stuck Haiti in January, 2010, the United States has permitted over 200,000 Haitian immigrants, men, women and children to enter this country on a temporary status (McCabe, 2010). While here, these traumatized Haitian immigrants will need medical and psychological assistance as survivors of such a devastating catastrophe (Mc Shane, 2011). Of course, providing Haitian immigrants with these much needed services presents a tremendous challenge to medical personnel, clinicians and the patients themselves.

As future researchers commence to study non-Western cultural expressions of depression symptomatology; acquire additional data, and conduct studies to explore the aspects of depression as expressed in men in general, and Haitian men in particular, the overall impact of this new knowledge and comprehension will educate clinicians and mental health professionals to better understand, diagnose and provide appropriate therapeutic treatment to Haitian clients. Researchers and clinicians both are challenged to

help Haitian clients resolve mentally challenging questions such as: Why did such a negative situation happen to me? What happened to me as a result of this negative life situation? How would this negative life situation affect how I think and feel about myself? The MRNI-SF subscales, the SMSS, SWBS, and CESD-R will contribute to the stages of change and, in conjunction with the elements of the gender theory, will be used to address the social environment (Korrteet al., 2009). All of these assessment instruments may contribute to a better understanding of the way Haitian men describe symptoms of depression and provide treatment for this population. Therefore, Chapter 3 identified the quantitative approaches that utilized to research this population. The quantitative strategies helped provide a statistical blueprint of the prevalence of depression among Haitian men, ages 20-30 years of age, who live within the U.S. The quantitative approach is the foundation of methodology and is the most appropriate research strategy to answer my research question (Creswell, 2009). In addition Chapter 4 discussed the results, and Chapter 5 provided a summary, a conclusion, and recommendations.

Chapter 3: Research Method

Introduction

The purposes of the quantitative approach was to examine whether cultural concepts of Voodoo had a significant impact on Haitian men's perceptions of depression and their beliefs regarding mental illness, thus providing knowledge of how this population expresses mental distress and trauma. The research involved quantitative approaches to collect relevant data. In this chapter I describe the research design and collection and analysis of data to explore the cultural concepts of masculinity on normative and nonnormative experiences of depression as manifested in Haitian men. I also discuss instrumentation, setting and sample, my role as the researcher, methodology, validity and reliability, protection and participants' rights, and ethical issues. All facets of this research, data collection, and data analysis involved the quantitative approach. Prior to this study, there were no quantitative, qualitative, or multi-method studies that had addressed depression in Haitian men (Nicolas et al., 2007). The findings of this quantitative research design will help practitioners gain general knowledge and understanding of Haitian men's expressions of depression, cultural beliefs (Voodoo), and depression and trauma. Finally, the research will encourage Haitian men to seek mental health services when needed without reservations.

This study addressed the following research questions:

1. Does restrictive emotionality impact Haitian men's beliefs about depression?
2. Does self-reliance impact Haitian men's beliefs about depression?

3. Does subjective masculine stress impact Haitian men's beliefs about depression?
4. Does spiritual well-being associated with Voodoo impact Haitian men's beliefs about depression?
5. What is the effect that time of residency in the United States has on restrictive emotionality among Haitian men?
6. What is the effect that time of residency in the United States has on self-reliance among Haitian men?
7. What effect does length of time in the United States have on subjective masculine stress among Haitian men?
8. What effect does length of time in the United States have on spirituality associated with Voodoo?
9. Can higher levels of spirituality, as related to the practices of Voodoo, predict higher levels of depression for Haitian men?
10. Can spirituality, as related to the practices of Voodoo, affect levels of self-disclosure?

The study used the MRNI-SF subscales (Levant et al., 2013), the SMSS (Wong et al., 2013), the SWBS (Paloutzian & Ellison, 1991-2009), and the CESD-R (Eaton et al., 2004) to further understanding of how Haitian men identify and relate to symptoms of depression (see Appendix I, J, K and L).

After a natural calamity, such as the earthquake experienced in Haiti in January 12, 2010, there would be an expected spike in depression, physical and mental trauma,

increased posttraumatic stress disorder (PTSD), anger over the destruction of personal property, and anxiety, which is a common reaction to such an extreme trauma (Pierre et al., 2010). Haitian men and women were already struggling with the perils of survival in an atmosphere of political, economic, and environmental instabilities. After the earthquake, Haitians were grateful for having survived the great earthquake but also felt an overwhelming grief over the loss of everything, left to survive without any possibility to provide food, shelter, or clothing for themselves or surviving family members. Pierre et al. (2010) reported that men may feel a great loss of masculine status and anger at their reduced ability to provide for their families. For the period covering the time of the 3-year Haitian coup d'état, researchers looked at the number of reported incidents involving domestic violence as well as reported cases of mental issues such as depression. The results showed among those suffering from physical abuse and mental distress, the most frequently cited reasons for both of these life events were: feelings of guilt, mortification, helplessness, emotionally disengaged, or detached from their loved ones and their immediate environment (Pierre et al., 2010).

A quantitative research approach was used to address the research questions based on a questionnaire focusing on factors that may contribute to depression in Haitian men. I specifically examined the impact of cultural factors such as common Haitian beliefs about depression, manifestations of mental distress, religious beliefs, Voodoo practices, and the masculine norms. I explored the cultural impact on masculine norms, male reluctance to disclose distress or seek mental health, and the idiomatic expressions of self-denial. The quantitative data from these investigations were collected and analyzed,

and the results provide statistical data on the number of Haitian men who displayed depression symptomatology.

Research Design

The multiple regression statistical analyses were used to assess the relationship between the MRNI-SF subscales (Restrictive Emotionality and Self-reliance) and the Masculine Subjective Scale to assess traditional masculinity norms around emotion disclosure depression explore the influence of cultural concepts (Voodoo) on how Haitian men manifest symptoms of depression. A multiple regression statistical analysis yielded a more comprehensive analysis of Haitian men's beliefs regarding depression. I used a quantitative approach to garner a descriptive understanding of Haitian men's perceptions of depression symptoms specific to the masculine norms. I chose the survey approach because it was the most appropriate one to provide a numeric description of data to discover answers to research questions. Furthermore, this approach provided empirical data about Haitian men's characteristics, how they express themselves and reveal their attitudes, and their behaviors and cultural belief towards depression. Quantitative method was used to discover if Haitian men's stressors were caused by interpersonal behaviors related to culture, thus affecting men's vulnerability to depression.

Creswell (2009) suggested, "the study may begin with a quantitative method in which a theory or concept is tested, followed by a qualitative method involving detailed exploration with a few cases or individuals" (p. 14). The quantitative statistical analyses assessed the following: the relationship between the MRNI-SF subscales (Restrictive Emotionality and Self-reliance), the SMSS scale to assess traditional masculinity norms

around emotion disclosure depression (CESD-R) and the SWBS scale to explore the influence of cultural concepts (Voodoo) on how Haitian men manifest symptoms of depression (see Appendix I, J, K and L). In this regression model, my dependent variable was the percentage of those Haitian men presenting symptoms linked to depressive symptoms. The dependent variable was measured by the CESD-R (Eaton et al., 2004). My five independent variables were: (a) restrictive emotionality, (b) self-reliance, (c) scores on the SMSS,(d) spirituality as measured by the SWBS, and (e) length of time in the United States. These five variables provided insight into reasons those Haitian men were unwilling to seek help for depressive symptoms. Pallant (2010) reported that an "additional variable (called a covariate) is a variable that you suspect may be influencing scores on the dependent variable" (p. 297). Previous research findings concluded length of time and/or acculturation correlated to poorer psychological functioning and created major distresses on the family system as a whole. Listed below are the covariate and/or confounding variables that were used for the purposes of this study to measure if there was a correlation among Haitian men that impacted their perceptions of depression. Covariate variables may have included age, assimilation, place of birth, and educational level. The confounding variable would be acculturation. The primary focus during the examination of correlations was to determine whether any of the predictors were related to depression. The goal of utilizing a multiple regression was to examine the independent variables to show if there was a link to the dependent variable (Gravetter & Wallnau, 2008). The statistical arrangements are discussed in further detail throughout Chapters 4 and 5.

Embedded in the age range of 20-40 years is the developmental timeframe wherein a male naturally uses to discover and define his own identity within or outside of his cultural background; as well as pursuing, educational, spiritual, and personal and career goals the Independent Variables: age, ethnicity, gender, geographical demographics. The relationship among the variables is subject to the extent to which the participant internalizes and defines himself using primarily his culture as a reference on which he derives his beliefs and perceptions about his own masculinity and whether depression is a malady affecting Haitian men.

One of the purposes achievable through use of a quantitative study is to create and utilize numerical explanations, ideas and supposition regarding observable phenomenon (Gravetter & Wallnau, 2009).The majority of Haitians subscribe to the belief that a curse can cause an individual to become sick (Nicolas et al., 2006). The research hypothesis determined whether Voodoo and culture concepts have a significant impact Haitian men's perceptions of depression along with their beliefs regarding depression and inability to self disclose emotions. By administering the MRNI-SF, SMSS, in conjunction with the SWBS; and the CESD-R the researcher hopes to determine whether culture has shaped their beliefs about depression (Hammond, 2012). The quantitative approach was also appropriate for this study because it provides clinicians with a better understanding of how Haitian men express depressive symptoms. For the purpose of this study, I used quantitative research methods to answer the research questions.

Setting and Sample

The target population for this study is Haitian men, ranging from the ages of 20 to 40 years old, living in the United States. In order to determine the required sample size, a power of .80, and alpha of .05 were combined with estimation to established reliability. A prior power analysis was performed using a full multiple regression of "sample size of 45-59 pair to conservative *p* value of $p < .01$" (Ayalon & Young, 2009, p. 424). Using, GPower3.0.10, a sample size of 90 is needed to detect a "small-to-medium"-size effect, i.e., $(f^2) = .085$, as described in Cohen (1988, p. 413). No previous studies have been reported for this population using a higher or lower effect size measure; therefore a small to medium effect size was chosen.

Sample Size

The sample size consists of 90 participants. A power analysis was conducted to establish the minimum number of participants. The sample was selected from Haitian men throughout United States to evaluate the relationship between the depression disorders, self-denial of depression, externalizes self-perception, and silencing the self. A sample size of 90Haitian men were necessary to examine depression, masculine norms and spirituality associated with Voodoo in order to find the answer to whether Haitian men may or may not be willing to self-disclose or willing to seek mental health services. There are several ways to distinguish characteristic properties of masculinity, normative and nonnormative behaviors placed by society. The psychometric properties of multiple regression power analysis are necessary to evaluate the relationship between the depression disorder and the psychometric properties of the MRNI-SF, the SMSS scale

were necessary to corroborate with the SWBS scale and CESD-R (see Appendix I, J, K and L). I initially contacted a sample of 90 Haitian men via community center and outreach invitations to participate in the research. This included Haitians in the United States. I also collected the variables. Since this is non convenience sampling, it is impossible to complete a list of elements composing the Haitian male population. A clustering procedure is necessary to reach out to the Haitian community for assistance in identifying Haitian men who are suffering from depression or mental disorders and are willing to participate in this research.

Rationale for Age Demographics

The following criteria were used to select Haitian men: The participants were Haitian men, between the ages of 20-40 years old, who reside in the United States. Developed by Rotter in 1945 and expanded by Bandura in 1977, Social Learning Theory explains that individuals learn from others through observation, imitation, and modeling (Bandura, 1977). The age demographics of Haitian men, 20-40 years old, provided a broad range of life events, trauma, accomplishments, personal journeys of maturation and life's commitments. This demographic encompassed the spectrum of Haitian men born in the U S.A came to the U.S.A as a child, or was born in Haiti and came to the U.S.A as a young adult/mature adult. The exclusion of Haitian men under the age of 18years old is based on the cultural tradition that most Haitian males at the age of 18 are considered to be a child and treated as a child as long as they are living at home in a family setting. They are unable to make life decisions and personal choices without consulting their parents. The parents are involved in their personal life and parents make critical life decisions on their behalf. They

cannot develop a resolution during crisis without seeking assistant from their parents. A Haitian male under the age of 18 years has not experienced broad range of life events, trauma, accomplishments, personal journeys of maturation, and life's commitments. Furthermore, Haitian men over the age of 40 were excluded as potential participants in this study because this age demographic of Haitian men are normally settled in their family life. Their identity paradigm relies heavily on assumptions of knowing what is important to them (e.g., their characteristics, career, lifestyles, comfortable with the way their life is progressing and environmental influences). Haitian men over the age of 40 would not be able to provide a real cultural concept of masculinity/manhood. Haitian men over the age of 40 years old have a set pattern of behavior ad constantly guard themselves against the loss of characteristics (e.g., toughness) typically associated with masculinity. Such influences may affect the ability of Haitian men over the age of 40 years old to be flexible beyond the traditional principles of masculinity. The data collection consisted of gathering self administered questionnaires. Haitian participants were contacted by email with a return receipt attached, via the postal service, by a telephone call and subsequent face to face contact. For those participants who were contacted with an initial email (Appendix A) and a follow-up email. (Appendix B) within 5 business days if they have not responded to the email. The survey was administered throughout the Haitian community and/or outreach centers. The participants were asked to sign the informed consent in order to participate.

Role of the Researcher

I solicited Haitian men to participate in the study by reaching out to the Haitian community using multiple avenues of communication. Fliers were distributed throughout the Haitian community in Brooklyn, Queens to seek participants for this study. I also flew to Miami Fort Lauderdale, Florida to personally distribute fliers throughout designated Haitian Community areas. I remained in Miami Fort Lauderdale to personally conduct research with those potential participants who have agreed to take part in the study (see Appendix C). Flyers were also posted in selected locations such as Haitian Markets, barbershops, including a network of community venues within the Haitian communities in Queens, Brooklyn and Miami. I also had access to several Haitian radio programs that allowed me to make a direct appeal to the targeted population (see Appendix G). I responded daily to interested participants via telephone inquiries and contact all of the participants who responded to the flier for the study (see Appendix A and B). During the initial contact, I asked interested participants about their choice of location. By knowing which location is most convenient for the participants, I made arrangements that were suitable accommodations for the potential participant to administer all assessment tools and collect data at stake-holders locations, I scheduled specific days for potential participants from various locations (e.g., Brooklyn ABC Bakery, Queens Golden Touch Auto center & Port Prince Restaurant and Miami Sunrise Bakery). All stake holders agreed to provide a private area on in their premises to accommodate potentials participants for the study. I contacted Haitian men and I conducted all registration, answer all questions related to the study, and I gave instructions to all potential

participants in the study (see Appendix D and H). Haitian men (Creole and French-speaking) origin, persons with English speaking West Indies background was the main focus. These potential participants read and wrote in English based on their training in English as a second language (ESL) at their respective various free public schools services within Brooklyn, Queens and Miami. I asked potential participants whether they have received any training in ESL classes because the participants' questionnaires were written on a ninth grade reading level. This reading level was chosen to ensure that potential participants would able to read and understand the research questions. A continuation of telephone contacts was conducted to obtain the quantitative portion of the study. I rescheduled appointments for any participant who was unable to keep his original appointment. I was responsible for all of the collections of the materials and the analyzing of the study's data. I engaged in the study Haitian men, ages 20-40 years of age, who reside in the U.S., without regards to immigration status. After obtaining the results for the data of my research study my plans are to write a 1 page summary to all the participants and stake holders to share some insight about the research. I provided a brief overview of the study, recruitment phases, data processing and analysis. The summary was also mailed to participants and stakeholders via postal mail services or via emails.

Objectives of the Research

The objectives of the research questions are to hypothesize using a sample of a population so that some correlations can be assumed about descriptive characteristics, attitudes or behaviors in Haitian men between the ages of 20-40 who are experiencing

symptoms of depression (Babbie, as cite by Creswell, 2009). To obtain a gross estimate, a power of .80, and alpha of .05 estimation established reliability was performed using a full multiple regression of sample size. UsingGPower3.0.10, a sample size of 90 is needed to detect a "small-to-medium"-size effect, i.e., (f^2) = .085, as described in Cohen (1988, p. 413). The data collection began after approval by Walden University Institutional Review Board (IRB).The quantitative approach would administer the MRNI-SF subscales, the SMSS, CESD-R and SWBS to obtain a gross estimate (see Appendix I, J, K and L). Participants were selected from Haitian community organizations and social resources in a non-random manner. The gross estimate revealed a range distribution to demonstrate whether Haitian men share similar perceptions and traits in terms of masculine schemas; the Restrictive Emotionality scale which measures men's silence about expressing their feelings and from seeking treatment for depression. Self -reliance scale assesses traditional norms affect on self-sufficiency and independent resolutions to personal crisis. The quantitative approach used open-ended questions to explore Haitian men's concepts of masculinity, the SMSS, CEDS-R, SWBS spiritually associated to Voodoo, and allow the researcher to obtain a numerical description of tendencies set by masculine norms variables by studying the sample of Haitian men.

It is an effective tool that suggested rough estimates of the population of Haitian men manifesting various characteristics inferences concerning their beliefs about depression disorder. It helped provide numerical data regarding the participant's life along with a numerical proportion of Haitian men who admitted to having symptoms of depression, beliefs about depression, and the beliefs and expressions related to gender

role stain (Mahalik, 2008). The quantitative approach focused on using reliable and valid instruments to establish numerical data on the number of men who are not able to verbally express their depression due to their way of life and to the existence of historical and cultural precedents. Data was collected and analyzed to distinguish the occurrence of patterns which may be related to Haitian men's beliefs and attitudes toward depression (Gravetter & Wallnau, 2008). The proposition in this chapter addressed a quantitative research design to explore and analyze responses to the questionnaire.

Instrumentation Questionnaire

The researcher used various quantitative assessment instruments to randomly collect self-reported data from Haitian men's responses to survey questionnaires in order to provide research data on Haitian men's cultural concepts (Voodoo) and beliefs about depression. The survey tested the variables of CESD-R, scale operationally defined with Q-20 items outcomes "ranging from 0 (Not at all or less than one day, to 3 (Nearly every day for 2 weeks)" (Eaton et al., 2004, p. 370). Possible scores ranged from 0 to 80, with higher scores indicating "the category of probable depressive disorder is defined by the presence of dysphoria or anhedonia on any item for nearly every day for 2 weeks, and the presence of symptoms in three or more other groups for 5-7 days in the past week" more depressive symptomatology (Eaton et al., 2004, p. 369).The assessment instruments measured the subjective experiences of depression (Hammond, 2012). In the research, the social demographic was a confounding variable because the social hardships faced daily was identified as a probable confounder that contributed to the "discrimination-mental health relationship" (Hammond, 2012, p. 234).

The majority of participants lived in the south, was single and had temporary jobs. A larger number of participants came from institutions of higher education ranging in ages from 18-29 years old and were younger than participants who enrolled at the barbershops, also single, listed some post high school education, and earned less than $20,000, lived in the north and described higher ranges of symptoms of depression. The barbershop participants who lived in the south accounted for “higher masculine role norms around self-reliance” (Hammond, 2012, p. 234). Those participants aged 40 and older, possessed a partial college education, a college degree or a professional certification, gainfully employed with an income exceeding $40,000, and did not live in the south accounted for a “Mean CES-D scores that were higher among 18-29-year-old men than among men in all other age groups ($P < .001$)”(Hammond, 2012, p. 235).Participants in the CESD-R who self-reported numerous occurrences of racial discrimination and “higher masculine role norms encouraging restrictive emotionality” described additional incidents of depressive symptoms (higher means CESD-R), however, participants describing “higher masculine role norms encouraging self-reliance” described less depressive symptoms (Hammond, 2012, p. 234). Men in the age demographics of 18-29, rather than those in the 40 plus years old, accounted for the highest number of reported daily encounters with racial discrimination ($P = .002$) as well as “higher masculine role norms encouraging restrictive emotionality” ($P = .04$) (Hammond, 2012, p. 235).

The MRNI

Hammond (2012) mentioned “Restrictive Emotionality and Self Reliance subscales of the Male Role Norms Inventory and the Masculinity Norms Salience scale” were combined to understand masculinity (p. 234). The MRNI subscales that address restrictive emotionality expressions or aspects of “traditional masculinity norms around emotion disclosure” of depressions that are determined by externalized self- perception (judging the self by external standards), (inhibiting one’s self-expression and action to avoid conflict and possible loss of relationship). The Self-reliance sub-scales (explored the significant influence of culture in defining characteristics of masculinities, including the dominant hegemonic construct of masculinity) (Hammond, 2012, p. 234). Studies have shown that culture not only gives definition to masculinities but also shapes how men view themselves and their roles as men within their societal milieu (Jack & Ali, 2010). The genesis of the Masculine Norms Salience scale was created from the study to assess the importance of traditional masculinity norms in men using data retrieved from face-to-face interviews (Hammond, 2012, p. 234). The findings of this study on depression in African American men illustrated the idea that both men and women share different fundamental psychological features (Hammond, 2012). Utilizing the MRNI-SF (Levant et al., 2013) assessment helped provide detailed information such as differences in beliefs about depression, masculinity, and Voodoo, which deepened my understanding of the social world from the perspectives of Haitian men. Furthermore, “the Non-Traditional Attitudes sub-scale was dropped. This resulted in seven traditional sub-scales: Avoidance of Femininity, Fear and Hatred of Homosexuals, Extreme Self-Reliance,

Aggression, Dominance, Non-relational Attitudes toward Sexuality, and Restrictive Emotionality" (Levant et al., 2007, p. 87). One hundred and seventy "undergraduate and graduate students (38 men and 132 women)" took the MRNI-R **(**Levant et al., 2007, pp. 83). 107 initial items were narrowed down "to 53 items" through "iteratively analyzing item-to-sub-scale correlations and" removing "items that" showed a low correlation with their relative sub-scale **(**Levant et al., 2007 pp. 86-87). "The final scale includes 22 of the original MRNI items. Improved reliabilities were found for the MRNI-R and its sub-scales, with Cronbach alphas ranging from .73 to .96" (Levant et al., 2007, pp. 87-88). Important differences were evident in regards to the extent respondents agreed with the ideology of traditional masculinity according to the respondent's gender, race and/or ethnicity, thus "providing support for its construct validity". "All of the sub-scales correlate more strongly with the total scale (r= .70 to .87) than they do with each other (r = .38 to .72)" (Levant et al., 2007, p. 88).The outcomes of the updated version of the 53-item MRNI-R provided greater reliability than were the outcomes found using the initial MRNI. How the sub-scales correlate with themselves and with the entire scale indicates they assess various elements across a very similar wide spectrum construct. Additionally, "the MRNI-SF was developed by selecting three of the highest loading items from each sub-scale of the MRNI-R" (Levant et al., 2013, p. 3). I chose to use the MRNI-SF (Levant et al., 2013), in conjunction with CESD-R Inventory, because the MRNI-SF has a concrete and proven "convergent and validity based on the significant correlation of the MRNI-R" connection with CESD-R (Levant et al., 2013, p. 3). The research findings conclude the MRNI-SF mean score for women was considerably moderate "(.75-.79) at

.79)" than for men "(.80-.84) to excellent (.85 and up) with the exceptions of Toughness" (Levant et al., 2013 p. 9). Furthermore, "the revised version of the MRNI-SF is an item "twenty-one item sub-scales" that were used to measure the masculinity philosophy, as the MRNI and MRNI-R norms **(**Levant et al., 2013, pp. 1-12). In the beginning, the MRNI-R was comprised of seven theoretically derived sub-scales. Some of the sub-scale structures lacked the foundation of factor analysis as well as sufficient reliability. Consequently, Levant et al. (2013) developed a more recent version which was a sub-scale consisting of the 21-item MRNI-SF, capable of measuring to what degree the respondents' thinking aligned with traditional masculine gender role norms language and updated sub-scale items (Levant et al., 2013, p. 9). To avoid redundancy, the MRNI-SF entire scale assesses various elements across a similar spectrum construct (Levant et al., 2013). Levant et al., (2013) reported "the resulting set of 21 items was excepted to show a similar seven-factor dimensionality to the MRNI-R" (p. 3). The purpose of this research is to detail the development and the original validation of MRNI-R along with the most recent and revised MRNI-SF (Levant et al., 2013, pp. 1-12). For this purpose the MRNI-SF and the CESD-R assessment tools together provided a greater understanding of the aspects of silencing of the inner voice or self denial impacts Haitian men's ability or willingness to self-disclose (see Appendix I and J).

The SMSS

Finally, the SMSS looked at the similarities and dissimilarities reported by the participants in describing their symptomatology of stressful feelings/personal experiences. The design of the SMSS uses the participant's answers or descriptions of

his/her own perceptions of distressful events to assess the principal symptoms of emotional disorders that correspond to the four major components of masculinity (Wong et al., 2013). How well an assessment tool performs as an effective screening mechanism is commonly measured by four quantitative values: "sensitivity, specificity, and positive and negative predictive values, indicating the relationship between the questionnaire scores and some external criterion" (Pedersen & Karterud, 2004, p. 217). SMSS functioning as a reliable and valuable assessment tool will help decide the symptomatology of psychological levels of distress as these levels relate across diverse normative tradition/cultural divides (Wong et al., 2013). Also, researchers in psychotherapy as well as professionals who provide services in a primary care environment commonly utilize the as a part of SMSS assessment and measurement of outcomes (Wong et al., 2013). The SMSS as an assessment tool helped revealed Haitian men's trauma, physical manifestations of the severity of symptoms distributed across their physical manifestation of traditional masculine that influence men to disclose depression symptomatology.

This research helped healthcare professionals to comprehend the specific ways Haitian men express symptoms of trauma and depression within the Haitian culture. A survey design provided numerical data regarding the participants' differences or relationships connecting variables to assess the current state to determine whether there is a problematic pattern with Haitian men's beliefs and attitudes about depression. Depression was also be addressed in this chapter by administering the CESD-R, a non-experimental research design for assessment of depression; the MRNI-R subscales, the

SMSS and in conjunction with SWBS, a short, “multidimensional self-report inventor designed to detect a wide spectrum of psychological issues, including exploring and analyzing past questionnaire responses” (Brown, Parker-Dominguez & Sorey, 2000, pp. 61-62).

Instrumentation of the Restrictive Emotionality Subscale

The Restrictive Emotionality subscale is a 7-item instrument used to measure the traditional masculinity norms that surround sharing personal feelings (e.g., a man ought to keep his troubles to himself (Hammond, 2012, p. 234).

Instrumentation of the Self-reliance Subscale

The Self-reliance subscale is a 6-item questionnaire designed to measure traditional masculinity norms surrounding keeping everything to one’s self and resolving one’s problems without asking for help (e.g. A man is responsible for making himself successful in the larger community) (Hammond, 2012, p. 234). Hammond (2012) reported “for both the restrictive emotionality and self-reliance subscales, a mean score was computed from responses ranging from 1 (strongly disagree) to 7 (strongly agree). Cronbach’s alphas for these scales were 0.79 and 0.75, respectively” (Hammond, 2012, p. 234).

Instrumentation of the SMSS

The SMSS is a 10 item subscale that measures “the subjective of personal experience of what it means to be a man” (e.g. As a man, I must be the breadwinner and As a man, I believe in the importance of work).Wong et al. (2013) stated, “to describe their personal experience of what it means to be a man by completing by completing the

sentence, As a man…10 times. Respondents then rate their 10 responses on a five-point scale (1=never/Almost) to 5 (Always/Almost always)" (Wong et al., 2013, p. 150). This scale addresses the idea that salience of masculine identity is the factor that helps men to decide whether or not they adhered to the traditional masculine norms especially during times of troubling personal problems/experiences (Wong et al., 2013). Wong et al. (2013) reported (Cronbach's a = 0.88); "indicated greater levels of subjective masculinity stress(e.g. measures of conformity to masculine norms, gender role conflict, and masculine gender role stress)" (Wong et al., 2013, p. 150).

Rationale of Scales to Correlate Ethnicity and Masculinity Norms

There is increased research around the issues of the mental health of men, particularly in regards to how men may express symptoms of depression. However, depression among African American men receives scarce and inadequate attention and does not appear an integral topic in the spectrum of research, writings and discussions about men and mental health. Consider these statistical realities: African American men experience "disproportionate premature mortality from diseases and intentional injuries with high depression comorbidities (e.g. cardiovascular diseases, prostate cancer, human immunodeficiency virus/acquired immunodeficiency syndrome, and homicide)," an alarming increase in suicide among young men, and are most likely to suffer the consequences resulting from lack of access and/or failure to access routine medical examinations or receive treatment from a specific medical care facility (Hammond, 2012, p. 232). Hammond utilizes these scales: "Masculine Role Norms 3 scales, the Restrictive Emotionality and Self-reliance subscales of the MRNI-SF and SMSS scale" in

conjunction with CESD-R to assess important information about the ways in which African American men are impacted emotionally and psychologically by traditional masculine role norms and racial discrimination (Hammond, 2012, p. 234). Hammond's research added to the limited literature on depression in African American men, as well as provides insights into the expressions of emotions, depressive symptomatology, masculinity as differentiated from the perspective of African American men (Hammond, 2012). The perspectives of Black men in America whether Haitian or African American, allowing for a few cultural differences, are more similar than dissimilar. The choice of assessment instruments is appropriate for measuring an ethnic population regarding the expression of emotions (or not), masculine identity and adherence to the traditional masculine norms. The research findings of Hammond (2012) had many relevant cultural and psychological applications for my study of depression among Haitian men.

Beck's Depression Inventory Rationale

Beck (2006), a pioneer in cognitive therapy, first designed the Beck Depression Inventory (BDI). Beck is best known for numerous tests developed to detect symptoms of depression in patients with psychiatric diagnoses (Beck, & Alford, 2009). Beck has been influential in two related but distinct ways. Beck simultaneously developed a schema of how the human mind is organized, how it operates internally, and how human behavior both conditions and results from this particular theoretical understanding (Beck, & Alford, 2009). This led him to favor certain clinical techniques for attempting to help detect, assess, and monitor changes in depressive symptoms among individuals with a psychopathology disorder (Beck et al., 1978-1993). Beck theorized that depression is

developed during the individual's childhood and proceeds throughout adulthood, along with their experiences (Beck et al., 1978-1993). Beck hoped that his inventory would provide a solid scientific basis for measuring the intensity, severity, and the depth of depression symptoms in a primary care setting (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). The goal of BDI was originally developed to detect, assess, and monitor changes in depressive symptoms among people in a mental health care setting. It is also used to detect depressive symptoms in a primary care setting (Beck, & Alford, 2009).

Historically, depression has been described as psychodynamic, resulting from psychological forces that underlie human behavior; emphasizing the interplay between unconscious and conscious driving forces (Kleinman & Good, 1985). The BDI test was developed to describe the relationship to symptoms of depression such as hopelessness, irritability, cognitions such as guilt or feelings of being punish, and which could reflect the intensity or severity of a given symptom (Becket al., 1961). In addition, this phenomenon drew attention to the importance of negative cognitions that often inject intrusive negative thoughts about the self (Beck et al., 1961). In Beck's view, it was the case that these "negative attitude (schemas)" caused depression, rather than being generated by depression (Beck, & Alford, 2009, p. 346).

Although a reliable measure of estimating, the BDI was later revised as BDI-II, published in 1996 (Beck et al., 1961). This assessment tool used by health care professionals, in a variety research settings, as a measurable range of the severity of depression because this tool has two mechanisms: the affective that correlates with mood, as well as physical or somatic factors associated with indication of loss of appetite (Beck,

Steer, Ball, & Ranieri, 1996). The BDI-II reflects this and can be separated into two subscales. The somatic subscale consists of the other thirteen items that present key factors of physical and psychological aspects of depression. The purpose of the subscales is to help determine the primary cause of a patient's depression (DMS-IV-TR, 2001). Analyzing the development of the BDI is an important event in psychiatry along with psychology. It represents a shift in health care professionals' view of depression from a Freudian, psychodynamic perspective, to one guided by the patient's own thoughts (Beck et al., 1996).

On the other hand, the BDI-II was intended to assess the severity of depression in psychiatrically diagnosed adults and adolescents 13 years of age and older (Beck et al., 1996). It is not meant to serve as an instrument of diagnosis, but rather to identify the presence and severity of symptoms consistent with the criteria of the *DSM* (Kelinman & Good, 1985). According to the *DSM-IV-TR* (2000), symptoms are characterized as: the primary dysfunction is "five (or more)" symptoms that have been observable throughout a specific two weeks period that revealed a complete departure from normal routine behaviors, depressed or a sad mood through most of the day, others noticed a lack of "interest or pleasure" in any activity during the day, inability to sleep or oversleeping nearly the whole day, "every day", low energy levels every day, thoughts of being unworthy which may produce irrational feelings of guilt (American Psychiatric Association, 2000, pp. 168 -179).

The research examined the cultural beliefs of Haitian men and the impact of culture on men who sought mental health treatment for depression and mental health

services. The BDI and *DSM-IV-TR* (2000) was not administered to measure depressive symptomatology for several reasons. Haitian men express depression from a non-Western perspective. This assessment did not provide a statistical descriptive analysis of Haitian men's symptoms of depression and how the depressive disorder appears in Haitian men. To assess the variance in the literature on depression symptomatology among Haitian men, the BDI and the *DSM-IV-TR* (2000) did not provide a true statistical measurement of depression because Haitian men embrace traditional masculine norms. Numerous studies have investigated the CESD-R as an instrument to gain insight into culture and masculine norms correlated to depression as applicable to ethnic subgroups.

The CESD-R Rationale

Depression, as a malady, embodies a longer period of chronic psychological pain and agony that can disrupt the ability to carry on daily routine functions (Love & Love, 2006, p. 175). Due to differences in gender socialization, men and women do not express symptoms of depression in similar or identical ways. Furthermore, it may superficially seem the men are less likely to experience depressive symptoms than are women. In addition, Love and Love (2006) reported the findings of Clark et al., (1981) revealed gender differentiation "in item correlations and factor loadings" and finalized their findings that "the CES-D may measure different phenomena in men and women" (Love & Love, 2006, p. 185). Furthermore, the traditional socialization of men makes it more probable that men affirmatively respond to items which do not threaten their sense of masculinity such as: ability to focus, problems at work and somatic expressions, rather than items that hint at femininity weeping and depression (Love & Love, 2006).

The CESD instrument was developed by Radloff (1977), to detect depression symptomatology in racial groups. Eaton et al. (2004) suggested the CEDS-R "of the current scale could retain the advantageous qualities of the measure that has made it valuable to community-based researchers while increasing its generalize ability to current psychiatric understanding" (p. 365). The CESD-R 20 items self-report instrument assessed depressive disorders "in nine different groups as defined by DMS-IV, fourth edition with their associated scale question numbers: (e.g., Dysphoria, Anhedonia, Appetite, Sleep, Thinking / concentration, worthlessness, fatigue, Agitation & Suicidal ideation" (Eaton et al., 2004, pp. 363-377). The CESD simplified the composition of two items changing the response to ("Nearly every day for 2 weeks") which more closely relates to the criteria in the *DSM-IV* (Eaton et al., 2004, p. 365). The two items were revised so that its value would fall within the most intense category in the original CESD ("5-7 days per week") (Eaton et al., 2004, p. 365). The participants are required to specify during the week or weeks how frequently they have behaved or have "felt this way" using a five point scale with a score from "0-4 responses, Not at all or less than 1 day, 1-2 days, 3-4 days, 5-7 days, to nearly every day for 2 weeks" (Eaton et al., 2004, p. 370). Application of the CESD-R possible scores ranges from 0 to 80 (Eaton et al., 2004). In turn, levels of depression (normal, mild, moderate, and severe) as measured by the CESD-R score appeared as the following: less than 16 indicates the absence of depression, a score of 16-21 indicates "subthreshold, possible major depressive episode and probable major depressive episode", and a score of over 21 indicates possibility of major depression (Eaton et al., 2004, p. 370). "Cronbach's alpha value for the CESD-

Rfor the 120 participants was 0.92. The mean CESD-R score was 3.06 (SD=14.7, range= 0-60)" (Eaton et al., 2004, p. 372).The CESD-R provided more validity and reliability to evaluate and assess depression criteria for a non-Western population. Since there is a clear distinction in male and female self-silencing behaviors, for the purpose of this study, the MRNI-SF, the SMSS were necessary to corroborate with the CESD-R and the SWBS scale. In order to determine the required sample size, a power of .80, and alpha of .05 combined with estimation to established reliability. Examination of the information gathered via the survey questionnaire, with the aid of a computer module for quantitative data scrutiny, looked for identifiable models and inclinations correlated to the study inquiries. Because there is no research data describing Haitian men's symptoms of depression, the CESD-R identified factors associated with the causes and links within Haitian men's symptoms of depression. CESD-R identified a range of psychiatric disorders and the level of the mental disorder.

SWBS Rationale

In an effort to answer growing holistic interests, fill a void in psychological writings on the subject, and address quality of life issues, Paloutzian and Ellison (1982-1991) created the SWBS to show the 'perceived spiritual quality of life' (Paloutzian, 1982, manual, p. 2). Some in the field of psychology consider the subject of spirituality too subjective to meet the standards of quantitative assessment. Two subscales, Religious Well-Being (RWB) and Existential Well-Being (EWB), match the authors' interpretation of the two dimensions of spiritual well-being, a conceptualization substantiated by factor analysis on the entire SWBS. Ten items make up each of the subscales, and the two

subscales combine to yield a total score. The RWB items refer to the respondent's view of God and how God is involved in one's life. The EWB items refer to the respondent's sense of the meaning in life and satisfaction with life's present direction. They present straightforward instructions about how the results were scored and acknowledgement that this scale measured the perception of spiritual well-being. The manual summarizes widespread normative data gathered from various religious groups-mainly Christian except for the Unitarian Universalists, clinical samples, and student populations. Unfortunately, the Christian homogeneity raises concern about the scale' representation as a nonsectarian assessment tool which can be applicable with a diverse group of respondents with different beliefs. Further research with more varied religious populations may reduce concern over the apparent ceiling effect observed for the RWB scale among (largely Christian) religious samples. The SWBS instruments examined religious well-being existential and religious domains to address the Haitian men's beliefs, perceptions, and responses to the healing process. Furthermore, culturally speaking, Haitian people embrace a strong belief in "Supernatural" powers whose dominion far exceeds natural laws (Nicolas et al., p. 703). In Haitian culture, the perception is that sickness can be the result of the action of a supernatural power such as: "relationships with God, (b) curses (evil spells), and (c) offended *lwa* (i.e., a powerful spirit or deity in the Voodoo religion" (Nicolas et al., p. 703).

Instrumentation of the SWBS

According to Korrte et al. (2009), the SWBS is a 20-point assessment tool used to measure religious and philosophical thoughts about the meaning of life. The respondent

can answer the questions by selecting the number 1, which means Intensely Agree through number 6, which means Intensely Disagree. The SWBS is a frequently utilized measurement tool with a respected reputation of "psychometric properties, test- retest reliability of .93 and alpha coefficients of .78 to .89 in rehabilitation populations" (Ellison, 1983; McNulty, Livneh, Wilson, 2004, as cited by Korrteet al., 2009, p. 93). Questions are written using the same format where the participant must respond yes or no. The same questioning format is used to compel participants to pay closer attention to the questions and consequently, decrease or avoid partiality in responding to the questions. The SWBS scale was administered independently of the other assessment tools (Appendix K). The SWBS was separated in order to calculate well-being in Haitian men and to investigate whether there is an underlying increased risk for poor well-being due to the significant influence of life pressures they experience. These life pressures have a strong correlation to depression, poor psychological and spiritual health. The belief in the effectiveness of their support resources produced a positive effect on psychological and spiritual health and also served as an inspirational factor in depression. These important research results illustrate the significance of having supportive social relationships that promote well-being and decrease the stress of life's problems. Currently, there are no non-Western measurements that address any psychological or mental behaviors specific to non-White men. The Western scales that were used in this research provided validity and reliability when addressing depression among men in general (Rochlen et al., 2006).

Framework and Stratagem

A small number of researchers have used the individual response survey format to assess the range of mental distress of African American and Caucasian men. There is very little data on the dissimilarities in the expression of distress between these two groups of men (Ayalon & Young, 2009). There are some researchers that report that multiple variables, e.g. inequities and discrimination in education, economics, social status, and opportunities to advance in society, combined with these life stressors, may create the effect of perceived helplessness on the relationship between life's stresses and a sense of well-being (Ayalon & Young, 2009).

The investigation reveals Blacks were more prone to express mental distress through somatic terms, as opposed to Whites who were inclined to express mental distress using cognitive-affective terms (Ayalon & Young, 2009). The correlation connecting what the subjects self-reported as their symptoms and the psychiatric diagnostic scrutiny to determine how well the SCL-90-R functions as a predictor of diagnostic accuracy among these racial groups concluded there were societal and racial variables which explained the differences. Exploring men's self- denial and their attitudes regarding appropriate behavior in relationships may be fruitful in identifying causes or triggers of disorders (Pedersen & Karterud, 2004). According to Pedersen and Karterud (2004), "psychological distress reflected by each subscale score in SCL- 90R appears to be an important feature within several diagnostic categories" (p. 223).The most robust input causes the difference of the subscales was a result of the linked diagnostic cluster, additional diagnostic clusters also showed a distant input toward differences (Pedersen &

Karterud, 2004). Analyses were conducted to evaluate the relationship between the depression disorder and the psychometric properties of the MRNI-R subscales and "the SMSS" scale in conjunction with, CESD-R and SWBS, using the personal descriptive list created with the ability to screen for an extensive range of mental illnesses (Wong et al., 2013, pp. 148-155). Data was investigated to determine schemas theorized to be associated with depression in Haitian men in the United States.

Stratagem

Despite the differences, quantitative inquiries are frequently viewed for dissimilarity with qualitative inquiries. There are differences between the qualitative and quantitative properties of scientific research. One method of quantitative psychology creates psychological hypotheses as mathematics and statistical information descriptive of the number of participants placed in each section of assessment. Qualitative research involves the investigation, logic and explanation of examinations with the goal of uncovering the fundamental significance and logical functions of co-relationships (Creswell, 2009). Although there is clearly a difference usually made between qualitative and quantitative approaches to scientific research, there are clear arguments that both approaches can go hand in hand (Creswell, 2009). There are differences between the qualitative and quantitative properties of scientific research. However, the combination of both quantitative and qualitative methods is called a mixed methods approach and cannot produce a richer comprehension of this research project (Creswell, 2009). The use of the quantitative approach in this investigation appears to be the most appropriate one as the quantitative method provided empirical data about the number of men who remained in

treatment until completion (Creswell, 2009). All documentation results were stored in a locked file. After the five year minimum requirement has been met, all paper documents were shredded, electronic data deleted and audio tapes were destroyed.

Protection and Participant's Rights

Protection of Participants

During the study, one of the most important responsibilities of the researcher is to protect the rights of the participants who are to be analyzed in the study (Creswell, 2009). The initial outreach reached out to the Haitian community through churches, barber shops and organized social functions. I had direct contact with some of the participants through conducting telephone interviews. The potential participants did not having difficulty comprehending the research materials, because potential participants were asked whether they have received any training in ESL. The materials were written at the ninth grade reading level and were validated by the Walden University IRB team. This reading level was chosen to ensure that the potential participants would able to read and understand the research questions, informed consent form, the surveys and/or assessment materials. Participants received and sign an informed consent in order to protect the participant's rights (see Appendix D). Participants were given a synopsis of the study as well as informed of the right to withdraw from the study at any time without penalty. Because it is necessary to have current information regarding protecting the rights of participants in research, I also completed the National Institutes of Health (NIH) participant protections education for research course (Appendix M). Furthermore, the participants' rights were protected by the signing of legal documents that specified no names would used in this

study; instead, the study identified participants by numbers and not names to ensure confidentiality. The relationship between the predictor and criterion were variable and details were provided in Chapter 4.

Participants

I enrolled all of the Haitian men who answered the flier for the study. The participants provided data and resources that aided me to explore how culture, masculinity and religious beliefs impact attitudes about depression. Eligibility for the study on depression in Haitian men was determined using the most inclusive definition of Haitian.

Eligibility for Participation

To avoid bias in our research on depression in Haitian men, we defined any male as Haitian whose parents are Haitian, including first or second generation, born either in Haiti or in the U.S., naturalized citizen or who has permanent resident status, or non-permanent resident status who reside in the U.S.A. My biases was managed by disregarding any information about the participant that is not relevant to this study such as marital or economic status, level of education, sexual orientation, immigration status, or place of birth.

Ethical Issues

Prior to any collection of data, I obtained permission from the Institutional Review Board (IRB) at Walden University (Walden IRB, 2010A). There were no serious risks associated with the study because the data did not include individual's names and an

appendix was provided indicating how data was collected. A mutual agreement specified the precise purposes and limitations of the findings.

Instrument Validity and Reliability

The quantitative surveys for the scales were scored in accordance with scoring manuals. The scoring of all the data analyses and correlation analyses were analyzed using the Statistical Packet for the Social Science (SPSS), "version 18.0 for Windows" to establish reliability and validity related to findings (George & Mallery, 2011, p. 2). The SPSS manual was used as a tool guide to collect all syntax related to the data, including the implementation of a code book to insure identification of participants, variables and open-ended responses for each of the ninety participants. Reliability and validity issues related to correlation and multiple regression findings were explored by examining effect size, the level of significance for each analysis, and power. Effect sizes described the strength of the correlation among the predictors, the level of significance described the likelihood of rejecting the null hypothesis, and the power analysis described the probability of rejecting the null hypothesis. All documents were numerically coded to assure continued confidentially of each participant.

Data Collection

Recruitment Phase

The data collection, the survey instruments, and the agreement between the researcher and the participants and the place where the data was collected are subject to approval by Walden University Institutional Review Board (IRB) before the data analysis can begin (Walden IRB, 2010A). Recruitment phase, as the researcher I solicited

participation in the study by distributing flyers throughout the Haitian community network of venues such as churches, social clubs, barbershops, cultural centers and small stores (see Appendix C). In addition, I also made arrangements to fly to Miami to Fort Lauderdale to personally distribute fliers throughout the Haitian community in these locations. In this phase, if the solicitation for participation in the study, by distributing flyers throughout the Haitian communities, has not been successful, then I had a public service announcement (see Appendix G). The recruitment process continued until 90 Haitian men are identified as potential participants and have agreed to participate. Appointments were rescheduled for any participant who was unable to keep his original appointment. Phase two overview of the study, I responded to interested participants via telephone, face to face contacts and/or via email. If the participant agrees to take part in the study, a cover letter was sent to him informing him of the study, the purpose of the study and the objectives of the study (see Appendix: A & B). I asked interested participants about their choice of location. By knowing which location is most convenient for the participant, I then made arrangements that were suitable accommodations for the potential participants (Brooklyn ABC Bakery, Queens Golden Touch Auto Center, Port Prince Restaurant and Miami Sunrise Bakery). If the participant agrees to take part in the study, I met with that participant according to the location arrangement. By seeking permission from participants on dates and times that would be appropriate to administer all assessment tools and collect data at stake-holders locations, I scheduled on specific days potential participants from various locations such as Brooklyn or Queens. Furthermore, I made arrangements to fly to Miami to conduct research with those

potential participants who had agreed to take part in the study. The participant signed the consent form agreeing to the terms described in the consent (see Appendix D). A demographic survey provided personal and background information about the participants. Information in the demographic survey included items such as: Age, Educational level, Place of birth, Marital status, Employment status, Prior diagnoses of depression and Prior psychiatric diagnoses. The items on the demographic survey used a combination of forced-choice and fill-in the blank response formats. For example, the participants were asked to provide their age and ethnicity. This is an example of a choice from pre-determined categories: (e.g., Haitian, Haitian American, Black /African American, Haitian/Latino or Other). The information in the demographic survey formed the basis of constructing a participant's profile. Some variables addressed the research hypotheses and research questions. The demographic data was entered into the SPSS statistical software program for analysis (Appendix E). The informed consent, the demographic questionnaire and the assessment surveys were collected on site place in a white envelope sealed by the potential participants and collected by me (see Appendix D, E,I, J, K and L).

Phase three is data processing and analysis, the data were collected using the questionnaire and were scored to determine the relationship between treatment attempts and complications in treating Haitian men with depression disorder. All assessment tools such as the MRNI-SF, the SMSS, the SWBS and CESD-R had numbers but no names (see Appendix I, J, K and L). For the protection of the participant's responses at stakeholder's venues and after the survey, the participant used the adhesive envelopes to

seal his responses upon completion. I collected the sealed envelopes from the participant (see picture 9x12 in 22.86 x 30.48 cm). At the end of the assessment, participants were debriefed and provided free information about available mental health services in their locations (see Appendix F). I also informed the participants that I would provide a 1 page summary overview of the study, recruitment phases, data processing and analysis. I asked each participant which method he would like to receive this information and to provide me with a method of contact. The transcribed documents were stored electronically in folder containing quantitative software with a restricted password. All information stored in the computer was protected by a secured password that protected the data from unauthorized access. Backup copies were made of all electronic data and stored in a separate locked cabinet not accessible to unauthorized persons**.** All survey documentation results were stored in a locked file. After the five year minimum requirement has been met, all paper documents will be shredded, electronic data deleted and audio tapes destroyed. Final Phases discussed the results, and Chapter 5 provided a summary, a conclusion, and recommendations.

Data Analysis

The purpose of this study was to explore the impact of masculine norms, SWBS (spirituality associated with Voodoo) on Haitian men's perceptions of depression.

Research Hypothesis

A directional Hypothesis has been established since there are no published research studies that suggest an alternative hypothesis for the study of depression in Haitian men.

Research Questions and Hypotheses

Research Question 1: Does restrictive emotionality impact Haitian men's beliefs about depression?

$H_0$1*:* There is no significant difference in restrictive emotionality in Haitian men's perceptions of depression.

H_a*1:* There is a significant difference in restrictive emotionality in Haitian men's perceptions of depression. Positive correlations to high levels restrictive emotionality would predict increase in levels of depression.

Research Question 2: Does self-reliance impact Haitian men's beliefs about depression?

$H_0$2*:* There is no significant difference in self-reliance in Haitian men's beliefs of depression.

H_a2*:* There is a significant difference in self-reliance in Haitian men's beliefs of depression. Positive correlations to high levels self-reliance would predict increase in levels of depression.

Research Question 3: Does subjective masculine stress impact Haitian men's beliefs about depression?

$H_0$3*:* There is no significant difference in subjective masculine stress in Haitian men's beliefs of depression.

H_a3*:* There is a significant difference in subjective masculine stress and Haitian men's beliefs of depression. Positive correlations to high levels subjective masculine stress would predict increase in levels of depression.

Research Question 4: Does spiritual well-being associated with Voodoo impact Haitian men's beliefs about depression?

$H_0$4*:* There is no significant difference in spiritual well-being associated with Voodoo in Haitian men's beliefs of depression.

H_a4*:* There is a significant difference in spiritual well-being associated with Voodoo in Haitian men's beliefs of depression. Positive correlations to high levels of spiritual well-being would predict increase levels of depression.

Research Question 5: What is the effect that time of residency in the United States has on restrictive emotionality among Haitian men?

$H_0$5: Length of time in the United States is not related to greater restrictive emotionality among Haitian men.

H_a5*:* Length of time in the United States is related to greater restrictive emotionality; the longer they have resided in the United States the more restrictive emotionality they endorse.

Research Question 6: What is the effect that time of residency in the United States has on self-reliance among Haitian men?

$H_0$6: Length of time in the United States is not related to higher self-reliance among Haitian men.

H_a6*:* Length of time in the United States is related to higher self-reliance; the longer Haitian men have resided in the United States the more self-reliance shapes their ability to resolve problems without asking for help.

Research Question 7: What effect does length of time in the United States have on subjective masculine stress among Haitian men?

$H_0$7: Length of time in the United States does not affect masculine stress among Haitian men.

H_a7*:* Length of time in the United States does affect masculine stress among Haitian men. The longer they have resided in the United States the more adherence Haitian men are to the traditional masculine stress.

Research Question 8: What effect does length of time in the United States have on spirituality associated with Voodoo?

$H_0$8: Length of time in the United States does not have an effect on spirituality associated with Voodoo.

H_a8*:* Length of time in the United States does have an effect on spirituality associated with Voodoo. The longer they have resided in the United States the increase levels of spirituality associated with Voodoo effect Haitian men's perceptions.

Research Question 9: Can higher levels of spirituality, as related to the practices of Voodoo, predict higher levels of depression for Haitian men?

$H_0$9: Higher levels of spirituality, as related to the practices of Voodoo, does not predict higher levels of depression for Haitian men.

H_a9*:* Higher levels of spirituality as related to the practices of Voodoo, does predict higher levels of depression for Haitian men. The more spirituality, as related to the practices of Voodoo Haitian men embrace, there is an increase in the levels of depression.

Research Question 10: Can spirituality, as related to the practices of Voodoo, affect levels of self-disclosure?

$H_0$10: Spirituality, as related to the practices of Voodoo, does not affect levels of self- disclosure.

H_a 10*:* Spirituality, as related to the practices of Voodoo, does affect levels of self-disclosure. The more spirituality as related to the practices of Voodoo Haitian men belief in, the more it affects levels of self-disclosure.

What is the effect of residency of time in the United States on restrictive emotionality and self-reliance on Haitian men?

The Rationale of the Hypotheses

To test our hypotheses in this study, I have estimated a sample size comprised of ninety (90) Haitian men between the ages of 20-40 years old to provide answers to the research questions and to explore the effects of culture on perception of depression and mental illness. Key constructs in this study were measured by the MRNI-SF (association with restrictive emotionality, self-reliance), the SMSS scale, SWBS and CESD-R (2004) criteria, scales. Finally, careful attention was given for running separate analyses using appropriated covariate (a variable with the potential to predict a finding) as well as determining and eliminating possible confounding variables (a variable that may be discretely obscured) among independent and dependent variables.

In this research, respondent's demographics may or may not be related to the dependent variables, for example the scores on Restrictive Emotionality, Self-Reliance and SMSS scores. It is assumed that age of the respondent and length of time in the U.S

did impact Haitian men's belief in spirituality associate with Voodoo, but this is unknown and was explored in my statistical analyses. In this investigation, I also assumed that positive correlations to high levels of Restrictive Emotionality and SWBS scores would predict increase in levels of depression and the lower scores would predict lower levels of depression.

Additionally, in this investigation, I further assume based on anecdotal evidence that higher levels of Restrictive Emotionality, Self-Reliance, SMSS and SWBS scores would predict increase levels depression and the lower scores of Restrictive Emotionality, Self-Reliance, SMSS and SWBS would correlate with low levels of depression.

Quantitative Analysis

Statistical Analysis

The statistical analysis proposed to address the primary question under investigation was a simultaneous multiple regression analysis. According to Pallant (2010), "multiple regression is not just one technique but a family of techniques that can be used to explore the relationship between one continuous dependent variable and a number of independent variables or predictors" (p. 148). In this regression model, the response variable depression (y) was the dependent variable. There were five independent variables (x): (a) restrictive emotionality, (b) self-reliance, (c) subjective masculinity stress, (d) spirituality as measured by the SWBS and (e) length of Time in the United States. The statistical arrangement of testing stated the equation that predicted = f (x1, x2, x3, x4, etc) where y = level of depressions and x1 = first explanatory variable etc., identified as follows: x1 =restrictive emotionality, x2 = self-reliance, x3=subjective

masculinity stress, x4 = spirituality, x5 = length of time in the U.S. The primary focus during the examination of correlations was to determine whether any of the predictors are related to depression. The psychometric properties of multiple regression power analysis are essential to assess the relationship between depression and the psychometric properties of the MRNI-SF (subscales restrictive emotionality and self-reliance), the SMSS, SWBS scale, and CESD-R scale. According to Garvetter and Wallnau (2008), "the general purpose of descriptive statistical methods is to organize and summarize a set of scores" (p. 71).This chapter illustrated various steps to test the null hypothesis.

My first step involved identifying data that may be used for the investigation. This step was used to provide information concerning the descriptive for all variables, skew, kurtosis, and standard deviations. The information from survey analyses was to assess three scales the Restrictive Emotionality, Self-reliance and the SMSS. These three scales measured characterizes of the masculinity norms that influences Haitian men's perceptions of depression. The participants' responses in the study measured if there is a correlation between ages of the men who were exposed to masculine norms are hyper-masculinity or if these men were unexposed to masculine norms are hypo-masculinity. The rationale for conducting these scores from the survey determined if there are correlation between age, hypermasculinity and hypo-masculinity that impacted Haitian men's perceptions of depression.

The second step was to examine the matrix patterns of correlation coefficient to determine the relationship between all predictors. Third, I used the multiple regression analyses to test the hypotheses in this study. Such descriptive statistics analyses was used

to identify the relationship of the explanatory's independent variables and the responses dependent variable from the two groups (hypermasculinity men and hypo-masculinity men).The SWBS survey was administered to determine if spirituality, as measured by the SWBS scales, has also shaped Haitian men's beliefs about depressive symptomatology.

Finally, the response variable (y) depression was measured by the CESD-R (Eaton et al., 2004). Once the CESD-R test is administered, the scores were counted by adding all the scores of each column that is assigned to each item, which provided a total score for the respondent to determine a total depression score among Haitian men. CESD-R scores greater than 2 was the statistical cutoff point for positive major depression (Eaton et al., 2004). This descriptive statistics analyses was also used to indicate the levels of depression among Haitian men. The subscale scores of the CESD-R provided various interpretations of Haitian men's emotional well-being and the psychological turmoil surrounding their masculine world, which is marginal (Hammond, 2012). Follow -up, a "one –way analysis of variance" (ANOVA) test was conducted to compare the mean scores of the continuous variable (Pallant, 2010, p. 204). Typically, an analysis of the ANOVA data were: "includes degrees of freedom, sums of squares, mean squares, F ratios, *p* values, and effect size and in addition, means, standard deviations are reported in the text" (Adelheid & Pexman, 2011, p. 51). The primary rationale for using the ANOVA analysis is to measure the mean differences between hypotheses. This analysis was used to measure the hypotheses to establish if there are any significant differences in the Restrictive Emotionality, Self-reliance, and/or SMSS and the SWBS (spirituality associated with Voodoo) on Haitian men's perceptions about depression

symptoms as measured by the CESD-R (Eaton et al., 2004).The main goal is to determine if masculinity and/or spirituality associated with voodoo impact Haitian men's perception of depression.

Power Analysis

In planning to conduct any study it is important to have some sense of cases needed to detect the effect(s) under investigation. With that in mind, a statistical power analysis should be undertaken. In order to do so, however, several parameters must be specified. Two of these parameters are relatively easy to specify: (1) the statistical significance level at which the effect(s) under investigation was tested, i.e., the α level or p value, and (2) the power probability with which the investigator wishes to be able to correctly reject a false null hypothesis. More simply stated, the power probability determines how likely it is that if the effect(s) hypothesized really exits, the study was able to detect them. These two parameters are conventionally set to (α) = .05, 2-tailed and (power =) .80, respectively. The third parameter, the effect size (f^2), is almost always more problematic. Sometimes prior research or pilot studies are available to provide some guidance as to the magnitude of the focal effect(s) under study, but, more typically, the effect size has to be "guess-timated" (Cohen, 1988, p. 12).

For the purpose of conducting this power analysis, the statistical significance level and the power probability have been set to the conventionally accepted levels of .05 and .80, respectively (Cohen, 1988). With regard to the effect size associated with the focal independent variable, and using Cohen's effect size terminology, it has been assumed that this parameter was in the "small-to-medium"-size range, i.e., f^2 = .085 (Cohen, 1988, p.

413). Lastly, we assume that this effect was tested in the context of a multiple regression model with five additional predictors which, together with the focal independent variable, comprise the multiple regression model(s) to be estimated. These additional predictors are expected to account for approximately 25% of the variation the dependent variable. Given these specifications, the total number of cases required for the study is (n =) 90.When the participant completes the surveys, descriptive statistics was used to compute age, ethnicity, immigration status, diagnosis of depression (if known) or if previous treatment attempted, and the means, medians, modes plus frequencies score were sorted for each of the variables in the study (Gravetter & Wallnau, 2009).The scales were scored in accordance with scorings manuals. Means scores were computed for all variables, slopes and graphs were used to clarify the significant interactions of all predictors. For the statistical analysis, the Statistical Packet for the Social Sciences (SPSS) version 18.0 was used Scoring of all the data analyses and correlation analyses were analyzed. When completed, I ran a multiple regression analysis and a power analysis to establish the differences between the variables. To compute statistical analyses of the all variables in a simultaneous multiple regression, I started with the predictors, examine B and beta weights accordingly and the maximum *p* values (Pallant, 2010). To ensure accuracy, I counted the power for the multiple regressions to address the findings from data. I ensure that the data is entered correctly and measure the effects of the significance level of the analyses accurately. Reliability and validity issues related to correlation and multiple regression findings were explored by examining effect size, the level of significance for each analysis, and power. Effect sizes described the strength of the correlation among the

predictors, the level of significance described the likelihood of rejecting the null hypothesis, and the power analysis described the probability of rejecting the null hypothesis. Next, I am going to check my data for possible errors by a read-through of variables scores that appeared out of range (Pallant, 2010). Then, I cleaned up my data by identifying when the errors took place from the data folder. Also, I looked for outliers values that appeared outside the data's range (Pallant, 2010). After that, I rectified the error which appeared in the data folder or remove the data value (Pallant, 2010). In conclusion, to achieve the above goals, I analyzed the multiple regressions as well as the statistical findings which were reported and presented in the documents.

The following assessment tools were used to determine if Haitian men's life stressors are caused by interpersonal behaviors related to culture; affecting men's vulnerability to express depression: the Restrictive Emotionality subscale, the Self-reliance subscale, SMSS and the SWBS. The SMSS was also used to separately monitor individual responses, evaluate the individual as communally based and is reflective of communal institutions/ traditional (Wong et al., 2013, p. 148). The SWBS, which is a 20-item assessment tool that helped Haitian men to identify if their cultural beliefs are linked by their shared views on spirituality (God) or supernatural forces (Voodoo). Preliminary analysis included exploring procedures to obtain descriptive information about the sample such as: information about the participants, the MRNI-SF**,** the SMSS contributions to schemas; social maladaptive behaviors which are external factors and the outcomes. Analysis addressed schemas that govern interpersonal maladaptive behaviors that prevent men from seeking mental health services, due to social inequalities in daily

interactions that may cause depressive symptoms in men. I also examined the correlation patterns between MRNI-SF, the SMSS scale SWBS and CESD-R scores. Analyses included treatment attempts and were explored prior to testing the hypotheses and conducting reliability analyses. The cleaning procedures included monitoring data for any errors in transcription before the data is entered into the research database. Corrections, as well as errors, were documented and retained until the study is completed. The screening procedures used ninety Haitian men, between the ages of 20-40 years old, who live in the United States, were used for the purpose of this study to evaluate if there is a relationship between the aspects of culture that impact their perceptions of depression. The age demographics of Haitian men, 20-40 years old, provided a broad range of life events, trauma, accomplishments, personal journeys of maturation and life's commitments were detailed in the chapter 4 results.

Summary

The entire chapter 3 provided a breakdown of multiple methods that were used to answer the research hypotheses of the study. The correlation and regression analyses were used to determine the relationship between all predictors. The researcher utilized appropriate quantitative assessment tools in this study to obtain a descriptive analysis of Haitian men's spirituality associated with the religion of Voodoo and their beliefs about depression. The MRNI-SF, in conjunction with the SMSS, explored schemas for Haitian men's inability to self-disclose. A spiritual belief in God plays a major role in Haitian men's ability and willingness to express themselves and their thoughts about mental health. Another important assessment tool that was vital in this research is the CESD-R

for two important reasons. The primary reasons are the CESD-R is frequently used because of its validation among non-Western populations and has the capacity to identify psychological symptoms such as trauma and somatic characteristics that are associated with symptoms of depression. The secondary reason is the capacity of the CESD-R to identify somatic characteristics. Creole, the language spoken by the majority of Haitians, does not contain familiar Western psychological words therefore, psychological symptoms, i.e. depression, are expressed by Haitians in somatic terms.

A simultaneous multiple regression analysis was appropriately utilized to compile data about key factors to test the hypotheses to support the research findings. The researcher organized a "codebook" containing a number assigned to each participant (Pallant, 2010, p. 11). Also, construct columns for all the variables, responses including coding for open ended responses by integrating abbreviations, letters and colors with the variables that correlated to each of the ninety participants. The SPSS manual was used as a tool guide to collect all syntax related to the data, including the implementation of a codebook to insure identification of participants, variables and open-ended responses. Chapter 4 addressed the results from the research study and Chapter 5 provided a summary of the results, recommendations, and implications for future social change.

Chapter 4: Results

This chapter begins with a discussion of the sample from which the data were derived. Analysis of the quantitative surveys was conducted using SPSS software version 18.0 for Windows. The relationship between depression and the five predictor variables was examined using quantitative techniques, including descriptive statistics. The quantitative approach consisted of analyzing the results and providing statistical data and outcomes to discover the levels of depression among Haitian men. The quantitative materials were written at the seventh and ninth grade reading levels and were approved by the IRB at Walden University. The findings from the quantitative sections of the research are presented in this chapter. The purpose of this quantitative analysis was to find out if the relationship between levels of depression in Haitian men, as a dependent variable, related to five other independent variables: (a) restrictive emotionality, (b) self-reliance, (c) subjective masculine stress, (d) spiritual well-being, and (e) length of time in the United States. The research questions and hypotheses were as follows:

Research Question 1: Does restrictive emotionality impact Haitian men's beliefs about depression?

$H_0$1*:* There is no significant difference in restrictive emotionality in Haitian men's perceptions of depression.

H_a*1:* There is a significant difference in restrictive emotionality in Haitian men's perceptions of depression.

Research Question 2: Does self-reliance impact Haitian men's beliefs about depression?

$H_0$2*:* There is no significant difference in self-reliance in Haitian men's beliefs of depression.

H_a2*:* There is a significant difference in self-reliance in Haitian men's beliefs of depression.

Research Question 3: Does subjective masculine stress impact Haitian men's beliefs about depression?

$H_0$3*:* There is no significant difference in subjective masculine stress in Haitian men's beliefs of depression.

H_a3*:* There is a significant difference in subjective masculine stress and Haitian men's beliefs of depression.

Research Question 4: Does spirituality associated with Voodoo impact Haitian men's beliefs about depression?

$H_0$4*:* There is no significant difference in spirituality associated with Voodoo in Haitian men's beliefs of depression.

H_a4*:* There is a significant difference in spirituality associated with Voodoo in Haitian men's beliefs of depression.

Research Question 5: What is the effect that time of residency in the United States has on restrictive emotionality among Haitian men?

$H_0$5: Length of time in the United States is not related to greater restrictive emotionality among Haitian men.

H_a5*:* Length of time in the United States is related to greater restrictive emotionality; the longer they have resided in the United States the more restrictive emotionality they will endorse.

Research Question 6: What is the effect that time of residency in the United States has on self-reliance among Haitian men?

$H_0$6: Length of time in the United States is not related to higher self-reliance among Haitian men.

H_a6*:* Length of time in the United States is related to higher self-reliance; the longer Haitian men have resided in the United States the more self-reliance shapes their ability to resolve problems without asking for help.

Research Question 7: What effect does length of time in the United States have on subjective masculine stress among Haitian men?

$H_0$7: Length of time in the United States does not affect masculine stress among Haitian men.

H_a7*:* Length of time in the United States does affect masculine stress among Haitian men. The longer they have resided in the United States the more adherence Haitian men are to exhibiting traditional masculine stress.

Research Question 8: What effect does length of time in the United States have on spirituality associated with Voodoo?

$H_0$8: Length of time in the United States does not have an effect on spirituality associated with Voodoo.

H_a8*:* Length of time in the United States does have an effect on spirituality associated with Voodoo.

Research Question 9: Can higher levels of spirituality, as related to the practices of Voodoo, predict higher levels of depression for Haitian men?

$H_0$9: Higher levels of spirituality, as related to the practices of Voodoo, does not predict higher levels of depression for Haitian men.

H_a9*:* Higher levels of spirituality as related to the practices of Voodoo, does predict higher levels of depression for Haitian men.

Research Question 10: Can spirituality, as related to the practices of Voodoo, affect levels of self-disclosure?

$H_0$10: Spirituality, as related to the practices of Voodoo, does not affect levels of self- disclosure.

H_a10*:* Spirituality, as related to the practices of Voodoo, does affect levels of self-disclosure.

Sample Selection

The process of selecting and recruiting participants for this study began on September 11, 2013, after approval by Walden University IRB (approval number 09-11-13-0156133). I reached out to all participating stakeholders via telephone to inform them that I had approval from the IRB to start my research study. The following data collection sites were approved by the IRB: Brooklyn, New York; Queens, New York; Cambria Heights, Queens, New York; and Fort Lauderdale, Florida. Then, I distributed 250 flyers throughout the Haitian community (see Appendix I). I solicited potential participants

from the IRB-approved survey sites as discussed in Chapter 3. I conducted all facets of registration of potential participants for the study and answered all of their questions related to the study. I had a public service announcement, also approved by the IRB, which was used for 3weeks with two common Haitian radio stations and included my contact information, including telephone number and e-mail address. This information was available to targeted populations across a large geographical area. I responded to interested participants via telephone and face-to-face contacts. I scheduled potential participants to take part in the survey once they agreed to participate in the study. From all these measures, I obtained 90 participants. I collected 90 completed surveys and they were included in the analysis below.

Description of the Sample

The sample size for this study was set for 90 Haitian male participants between the ages of 20 and 40 years old who lived in the United States. The participants filled out a demographic survey that provided information regarding their personal and professional characteristics. The demographic characteristic information is included in Tables 1 and 2.

Table1

Descriptive Statistics – Age of the Participants/Length of time in the United States

					Range	
	N	*M*	*SD*	*Median*	*Minimum*	*Maximum*
Age	90	30.98	6.1	31	20	40
Length/US	90	21.39	8.74	22.5	2	40

Table 2

Frequency Distributions-Demographic Characteristics (N = 90)

Characteristics	*Number*	*Percentage*
Place of Birth		
U.S	45	50.0
Haiti	45	50.0
Years in the United States		
0-10	32	28.8
11-20	25	22.5
21-40	33	29.7
Education		
Elementary	2	1.8
≤ High school	7	6.3
High school/Technical	67	60.3
≤College/College graduate	13	11.7
Missing	1	1.0
Employment		
Unemployed	15	13.5
Employed	73	65.7
Missing	2	2.0
Personal Relationship		
Single	42	37.8
Married/Cohabiting	48	43.1
Clinical Characteristics		
Diagnose with depression/TX	90	100.0
Psychiatric diagnosis	90	100.0
Attempts psychiatric	89	99.0
Missing	1	1.0

Note. There were 90 participants. However, there were missing data for some participant characteristics. Data on education, employment, and attempts psychiatric treatment were missing for 1.1%, 2.2%, and 1.1%, respectively.

Findings

Quantitative Results

Table 3 provides the descriptive statistics for all quantitative measures and presents results of these analyses.

The results from the CESD-R had a mean score of 16.43 (*SD* = 9.40), with a median score of 17.5. Actual scores ranged from .00 to 57.00. The Cronbach alpha was (α = .81) signifying good internal consistency. The 4-point Likert scale ranged from 0 on the scale which indicated not at all or less than 1 day of depression, to a score of 5-7 days on the scale which indicated depressive symptoms nearly every day for 2 weeks. As seen in Table 3, the mean of the CESD-R (2004) was slightly greater than the threshold of "clinically meaningful" depression, (i.e., 16 as reported by the author of this measure (Eaton et al., 2004).

The MRNI-SF is comprised of two subscales. The Restrictive Emotionality (RE) subscale had a mean score of 18.47 (*SD*=4.87), with a median score of 21. Actual scores ranged from 3.00 to 21.00. The Cronbach alpha was .95. The second subscale from the MRNI-SF was the Self-Reliance (SR) subscale which had a mean score of 19.44 (*SD*=3.16), with a median score of 21, and actual scores ranging from 5.00 to 21.00. The Cronbach alpha was .88 signifying the Self- Reliance subscale has good internal consistency. While there were no corresponding clinical cut-offs for Restrictive Emotionality or Self-Reliance, the median values of both of these measures were, in fact, their maximum possible scores (21). Higher scores of self-reliance indicated Haitian men were experiencing higher dominant hegemonic traits of masculine norms around the

ability to self-disclosure emotions. Haitian men who show higher scores on restrictive emotionality tend to “keep everything to one’s self” and resolving one’s problems without asking for help.

Subjective Masculine Stress Scale showed excellent internal consistency, Cronbach alpha of .97. The 5-point Likert scale ranged from 1 (never/almost never) to 5 (always/almost always). The Subjective Masculine Stress Scale (SMSS) mean score was 4.65 (*SD*= .80), with a median score of 5.00, and scores ranging from 1.20 to 5.00. While there were no corresponding clinical cut-offs for the Subjective Masculine Stress Scale, respondent scores corresponded to the maximum possible score. Higher scores indicated Haitian men were experiencing greater levels of subjective masculinity stressors.

The SWBS has a good internal consistency, Cronbach alpha was .76. The 6-point Likert scale ranged from 1 (strongly agree) to 6 (strongly disagrees). The SWBS mean score was 41.40 (*SD*=12.66), with a median score of 40 and actual scores ranging from 20 to 69. The mean value of the Spiritual Well-Being Score corresponds to what the author of the measure characterizes as a sense of “moderate spiritual well being”, (Ellison & Paloutzian, 1982-1991). Higher scores indicated greater spiritual well- being and a positive relationship with God.

Table 3

Descriptive Statistics – Scaled Measures

Scaled Measure	*N*	*M*	*SD*	*Median*	*Skewness*	*Kurtosis*	*Range* *Minimum*	*Maximum*
CESD-R	*90*	16.43	9.40	17.5	.754	2.95	.00	57.0
MRNI(RE)	*90*	18.47	4.87	21.0	-1.92	2.40	3.00	21.0
MRNI(SR)	*90*	19.44	3.16	21.0	-2.49	6.18	5.00	21.0
SMSS	*87*	4.65	.801	5.00	-2.89	7.91	1.20	5.00
Missing	*3*							
SWBS	*90*	41.40	12.66	40.0	.261	-.841	20.0	69.0

Note. Four scaled were measures above CESD-R= Center for Epidemiological Studies of Depression Scale Revised, two dimensions of masculine role norms, restrictive emotionality (RE) and self-reliance (SR) were examined using the subscales of The Male Role Norms Inventory (MRNI), the Subjective Masculinity Stress (SMSS) and Spiritual Well-Being Scale (SWBS). Data on SMSS were missing for 3.3%respectively.

Ten research questions and related hypotheses were created for this current study. Each question and hypothesis was tested utilizing statistical analyses. Descriptive statistical analyses were used to address each research question and to test the hypotheses. The findings of the statistical significance resulted from utilizing a criterion alpha level of .05

The essential question in this investigation was to find out if the relationship between depression dependent variables in Haitian men is related to five other independent variables: (a) restrictive emotionality, (b) self-reliance, (c) subjective masculine stress, (d) spiritual well-being and (e) length of time in the United States.

Research Question 1: Does restrictive emotionality impact Haitian men's beliefs about depression?

$H_0$1: There is no significant difference in restrictive emotionality in Haitian men's perceptions of depression.

H_a1: There is a significant difference in restrictive emotionality in Haitian men's perceptions of depression.

Table 3 presents the correlation matrix among the dependent and independent variables. Before presenting the findings from this bivariate analysis it should be noted that three of the predictors, restrictive emotionality, self-reliance, and subjective masculine stress were negatively skewed (see Table 3). Given that fact, these three variables were transformed to at least mitigate, if not entirely eliminate, the negative skewness. Because these three variables were negatively skewed, the raw scores for each variable were first subtracted from their (maximum values + 1). This first operation converts negatively skewed variables into positively skewed variables at which point the skewness can be reduced, and possibly eliminated, by applying a natural log transformation which comprises the second step of the transformation process. In the third step of transforming these variables, the log scores were reverse-scored so that the final, transformed scores were in the same order as the original, untransformed scores. That is, lower scores in the original raw score metric also correspond to lower scores in the transformed metric. Similarly, higher scores in the original, raw score metric had higher scores in the transformed metric. The transformed versions of the original variables were used in the bivariate correlation matrix immediately below as well as in the multiple regression models to follow.

Three of the variables, restrictive emotionality, self-reliance, and subjective masculine stress were negatively skewed (see Table 3), and these. Given were transformed. Because these three variables were negatively skewed, the raw scores for each variable were first subtracted from their (maximum values + 1). This first operation converts negatively skewed variables into positively skewed variables at which point the skewness can be reduced, and possibly eliminated, by applying a natural log transformation which comprises the second step of the transformation process. In the third step of transforming these variables, the log scores were reverse-scored so that the final, transformed scores were in the same order as the original, untransformed scores. That is, lower scores in the original raw score metric also correspond to lower scores in the transformed metric. Similarly, higher scores in the original, raw score metric were higher scores in the transformed metric. The transformed versions of the original variables were used in the bivariate correlation matrix.

As seen in Table 4, there was a statistically significant relationships between restrictive emotionality ($r = .29$, $p < .05$), self-reliance ($r = .31$, $p < .05$), subjective masculine stress ($r = .33$, $p < .05$) and depression. Based on Cohen's (1988) effect size standards for correlation coefficients, (i.e., $r = .10$ is "small", $r = .30$ is "moderate", and $r = .50$ is "strong"), these correlations can be characterized as of moderate strength. However, there was no significant correlation between spirituality associated with Voodoo and depression ($r = .01$, $p = .96$). Similarly, the anticipated positive relationships between age and depression were not significantly correlated ($r = -.16$, $p = .14$). On the other hand, Haitian men who have been in the United States for a longer period of time

showed a significant correlation to depression than their counterparts who have been in the United States for a shorter period of time (r = .22, p< .04). Tables 5, present the results of restrictive emotionality, self-reliance and subjective masculine stress. As seen in Table 5, the correlations between restrictive emotionality, self-reliance and subjective masculine stress are all positive and strong (r>= .60, p< .05). In fact, the correlations among these three measures are possibly too strong to be accommodated in the multiple regressions. A particular concern is the correlation between restrictive emotionality and self-reliance (r = .87, p< .05). As reported, the correlation, r = .87, is significant at p< .001.The correlation between restrictive emotionality and self-reliance *(r = .87)* is so strong that the regression analysis might not be able to reliably separate their effects on depression. Correlations of this magnitude suggest that the "net", the separate, effects of these two predictors on depression in the regression model to follow may be "collinear" (Pallant, 2010, p. 158). This possibility was further evaluated below.

Three one-way analyses of variance (ANOVA) were also conducted to examine the relationship between age (trichotomized) and: restrictive emotionality F (2, 87) = 0.34, p = .72, self-reliance F (2, 87) = 0.81, p = .45 and subjective masculine stress F (2,84) = 0.39,p = .68.The sample was divided as closely as possible into three age subgroups as follows; 20-27 (n=30) 33% of the sample, 28-34 (n=29) 32% of the sample and 35-40 (n=31) 34% of the sample. Consistent with the correlations reported in Table 4, the overall F tests from each of these three analyses of variance were not statistically significant (= 0.39, p> .05) thereby age of Haitian men was not found to be related to restrictive emotionality, self-reliance, and subjective masculine stress.

Table 4

Pearson Correlations between Depression and Other Study Measures

Variables	*N*	*r*	*p*
Age	90	.16	.14
Length of time in the United States	90	.22	.04*
Restrictive Emotionality	90	.29	.01*
Self-Reliance	90	.31	.003*
Subjective Masculine Stress	87	.33	.002*
Spiritual Well-Being	90	.01	.96

* $p < .05$
** $p < .01$
*** $p < .001$

Table 5

Standardized Results of Restrictive Emotionality, Self-Reliance and SMSS

Variables	*N*	*R*	*p*
Restrictive Emotionality	90	.60	.001*
Self-Reliance	90	.60	.000*
Subjective Masculine Stress	87	.60	.000*

* $p <= .05$

Research Question 5: What is the effect that time of residency in the United States has on restrictive emotionality among Haitian men?

$H_0$5: Length of time in the United States is not related to greater restrictive emotionality among Haitian men.

H_a5: Length of time in the United States is related to greater restrictive emotionality; the longer they have resided in the United States the more restrictive emotionality they endorse.

Research Question 6: What is the effect that time of residency in the United States has on self-reliance among Haitian men?

H_06: Length of time in the United States is not related to higher self-reliance among Haitian men.

H_a6: Length of time in the United States is related to higher self-reliance; the longer Haitian men have resided in the United States the more self-reliance shapes their ability to resolve problems without asking for help.

Research Question 7: What effect does length of time in the United States have on subjective masculine stress among Haitian men?

H_07: Length of time in the United States does not affect masculine stress among Haitian men.

H_a7: Length of time in the United States does affect masculine stress among Haitian men. The longer they have resided in the United States the more adherence Haitian men are to the traditional masculine stress.

Research Question 8: What effect does length of time in the United States have on spirituality associated with Voodoo?

H_08: Length of time in the United States does not have an effect on spirituality associated with Voodoo.

H_a8: Length of time in the United States does have an effect on spirituality associated with Voodoo. The longer they have resided in the United States the increase levels of spirituality associated with Voodoo effect Haitian men's perceptions.

HaitianmenwhohaveresidedintheUnitedStatesforlongerdurationsexhibit a tendency to report greater restrictive emotionality (r=.19, p<.07) and greater self-reliance (r=.20, p<.06), but these associations were not statistically significant. With regard to subjective masculine stress, there was no association between this variable and the length of time in the United States (r=.10, p>.05). However, contrary to expectation, younger Haitian men rather than older Haitian men reported significantly greater levels of spirituality associated with Voodoo (r=-.37, p<.05). Table 6 also presents results of this analysis.

Research Question 9: Can spirituality, as related to the practices of Voodoo, predict levels of depression for Haitian men?

$H_0$9: Higher levels of spirituality, as related to the practices of Voodoo, does not predict higher levels of depression for Haitian men.

H_a9*:* Higher levels of spirituality, as related to the practices of Voodoo, does not predict higher levels of depression for Haitian men.

As shown in Table 6, younger Haitian men reported significantly greater levels of spirituality as related to the practices of Voodoo (r=-.37, p<.05). Because of the void in the literature, there is a dire need for more study of Haitian men's general beliefs about depression, the practices of Voodoo, and their willingness to seek help for depression.

There is no data on depression among Haitian men compared any data from a study from either a Western or a non-Western point of view. These limitations are addressed in chapter 5.

Table7 also presents results of this analysis. As displayed in this table, the five predict or variables, age, length of time in the United States, MRNI-SF, subjective masculine stress and spiritual well-being, together are significantly related to depression (R^2 = .18, F = 3.48, df= (5,81), p<.01).With regard to the individual predictors, subjective masculine stress is significantly and positively related to depression (β=.27,p=.04). For example, when the other predictors in the regression model were controlled, length of time in the United States was not statistically significant related to depression (β = .20, p = .06). As stated above, none of the other predictors–age, masculine norms, and spiritual well-being–exhibited any relationship to depression.

Research Question10: Can spirituality, as related to the practices of Voodoo, affect levels of self-disclosure?

$H_0$10: Spirituality, as related to the practices of Voodoo, does not affect levels of self- disclosure.

H_a*10:* Spirituality, as related to the practices of Voodoo, does affect levels of self-disclosure.

As seen in Table 6, younger Haitian men reported significantly greater levels of spirituality, as related to the practices of Voodoo (r=-.37, p<.05).

Table 6

Analysis of Transformed Results of Measures

Variables	*N*	*R*	*p*
Length of time in the United States	*90*	*.10*	*.05**
Restrictive Emotionality	*90*	*.19*	*.07*
Self-Reliance	*90*	*.20*	*.06*
Spiritual Well-Being	*90*	*.37*	*.001**

* p< =.05

Table 7

Standardized Result of Model Predicting Depression

Variables	B	*SE B*	*β*	*t*	*P*
Age	-.278	.170	-.181	2.68	.11
Length US	.211	.111	.199	3.63	06
MRNI-SF	.436	1.268	.046	.118	.73
SMSS	6.453	3.108	.270	4.31	.04*
SWBS	-.038	.080	-.052	.225	.64

* p< =.05

Summary

The quantitative research analyses provided knowledge to better understand the levels of depression among Haitian men. The quantitative responses from the survey presented a descriptive statistics analyses that measure subjective stress, masculine norms and depression, for example. These findings, from multiple sources of quantitative research analyses, provided an opportunity to discover the population in terms of depression and mental health. These findings also helped to examine aspects of the

Haitian masculine norms and provided insights into a topic that has long needed to be addressed (Nicolas, 2011).

Ten research questions and related hypotheses were created for this study. A multiple regression model and statistical analyses were used to address each of the research questions to test the hypotheses to determine whether these variables are related to depression. There were five standardized measures which were used in this study. The correlation and regression analyses were used to determine the relationship between all predictors. The categorical variables were coded for their use in regression analyses of the variables that correlate to each of the ninety participants. Internal consistency reliability coefficients (Cronbach α) using a criterion alpha level of .05 were calculated for each of all these measures. Research Question 1 examined the relationship between MRNI-SF**,** the SMSS scale and the SWBS (spirituality associated with Voodoo) that impact Haitian men's perceptions of depression symptoms as measured by the CESD-R (2004). Pearson correlation reported that men who showed greater levels of restrictive emotionality and subjective masculine stress reported greater levels of depression. Conversely, Haitian men who reported greater levels of spirituality associated with Voodoo do not report increased levels of depression. Additionally, Haitian men who have been in the United States for a longer period of time reported more levels of depression than their counterparts who have been in the United States for a shorter period of time. This finding is supported by several other studies that examined length of time. For example, acculturation causes poorer psychological functioning and creates major

distress on the family system as a whole (Desrosiers and St. Fleurose, 2002; Gopaul-McNicol, Benjamin-Dartigue, and Francois, 1998; as cited by Pierre et al., 2010).

Chapter 5 further discussed, in greater, the findings and critique this study. The researcher examined and presented some of the Social and Educational Implications of this study. Chapter 5 also included a discussion on the limitations of this study and introduces recommendations for additional studies of this subject.

Chapter 5: Discussion, Conclusions, and Recommendations

Discussion

This purpose of this dissertation was first to examine the relationship between the predictor depression, as measured by the CESD-R, and its relationship to age, length of time in the United States, restrictive emotionality, self-reliance, subjective masculine stress, and spiritual well-being. This research permitted me to explore new concepts and address what was previously unknown about Haitian men and how depression symptoms may be manifested within their cultural experience. The driving force for this study was inspired while working as a psychiatric clinician in New York. I was part of the staff that provided mental health services for a Haitian family that entered this country on a temporary status after the catastrophic earthquake struck Haiti in January 2010. At this time, I could not find any empirically researched studies that either addressed depression among Haitian men from a cultural perspective or addressed aspects of masculinity and culturally relevant stressors that may contribute to depression symptoms in Haitian men.

The multivariate regression models were used to determine the relationship between all predictors and depression. The first three hypotheses were supported by the MRNI-SF subscale scores because Haitian men who reported greater levels of restrictive emotionality, self-reliance, and subjective masculine stress reported greater levels of depression. Respondents who reported greater levels of spirituality associated with Voodoo and/or as related to the practices of Voodoo did not show greater levels of depression.

With regard to the effect that length of residency in the United States had on restrictive emotionality and self-reliance, both hypotheses were supported by participants' responses. This revealed that restrictive emotionality, self-reliance, and length of time in the United States correlated with significant levels of depression. On the other hand, the length of time in the United States, that is, a proxy for the process of assimilation/acculturation, did not have an effect on or influence the current levels of subjective masculine stress and/or spirituality associated with Voodoo and spirituality, as related to the practices of Voodoo. Correlations between spirituality and depression measures were statistically significant. Younger Haitian men, rather than older Haitian men, reported significantly greater levels of spirituality, although younger Haitian men did not report greater levels of depression. Levels of spirituality, as related to the practices of Voodoo, showed no effect with levels of self-disclosure.

Interpretation of Findings

Quantitative Interpretations

As noted in Chapter 2, I examined several theories of the role of the male socialization process and how this may relate to depression. Previous findings reported that socialization of men connected to understanding the issues surrounding men seeking help for depression and other mental health problems (Mahalik, 2008). The debate of codified behaviors was discussed at length in numerous studies, which provided the descriptions and implications on the power of codified behaviors that have become "social proof" of normal (acceptable) and nonnormal (unacceptable) behaviors in society (Mahalik, 2008, p. 175). This codified social context as nonnormative male behavior

restricted men from expressing symptoms of depression such as crying and seeking help. Those mainstream dominant powers that are viewed as “social norms” motivate men to choose to “conform to the norm” rather than risk exclusion or negative identification as “aberrant” (Mahalik, 2008, pp. 175-176). These normative and nonnormative descriptions of masculine norms are powerful, not allowing men to express exceptions to the established norms. Failure to comply with these societal masculine norms may cause a man to be subjected to marginalization within his social, professional, and personal circles. I also found correlations between restrictive emotionality, self-reliance, and subjective masculine stress scales to be significantly related to depression

However, there is a possible exception when gender socialization processes interact with environmental disasters such as the storm in Haiti. When a large-scale event such as a natural catastrophe or a political state of emergency occurs, men have the opportunity to observe the responses of other men to the catastrophic or emergency situation. In such situations, men were freed from the societal stoic masculine norm expectations and did openly express their feelings of sadness, rage, hopelessness, or depression around this incident. In the literature review, the discussion among Haitians, particularly men, revealed a reluctance to disclose problems of depression or to seek psychological help. In general, Western and non-Western societal norms stigmatize men more strongly than women because seeking help in a mental health clinic/hospital is perceived as a woman’s environment and not an environment for men (McCusker & Galipo, 2011). The role of men in society further explains that men are significantly

impacted by societal messages via public media and portrayals of descriptive, injunctive, and cohesive characteristics of masculine norms (Mahalik, 2008).

From the survey, a significant relationship was found between restrictive emotionality, self-reliance, subjective masculine stress, and depression. This study revealed the Western societal forces were similar to non-Western societal norms because both cultures' definition of the masculine gender role constrained men to be emotionally restrictive. There were no distinctions between Western and non-Western social perspectives that addressed normative as well as nonnormative male behaviors. This study revealed that Haitian men were reluctant to express their emotions due to the influence of their traditional indigenous masculine roles. Characteristics of traditional Haitian concepts of masculinity inhibited Haitian men from freely expressing emotions and also internalizing depression. The findings indicated Haitian men were likely to suffer from depression if they continued to suppress their emotions and adhere to a stoic posture in alignment with their traditional masculine norms.

Another significant relationship was depression among Haitian men. All 90 of the participants denied ever having been diagnosed with depression, denied having received any prior psychiatric diagnoses, and also denied any attempts to engage in psychiatric or therapeutic treatments. Using the CESD-R results, 57.8% of the study participants qualified for a diagnosis of depression (e.g., a CESD-R score ≥ 16). There was also a significant relationship between the perceptions relating to stigma associated with shame toward depression. Forty-one Haitian men reported they did not know anyone who had suffered from a mental illness such as depression. Forty-nine Haitian men reported that

they would avoid association with an individual who had mental illness. Although 52 of the 90 participants qualified for a diagnosis of depression, this group was least likely to disclose that they were experiencing symptoms of depression. This group of men expressed concern about discrimination as the major disincentive to seeking therapy and treatment for symptoms of depression. This result was supported by previous literature that indicated men in general who had depression often did not seek counseling support.

Next, an additional significant relationship was found in respondents who reported greater levels of spirituality associated with Voodoo and/or as related to the practices of Voodoo and those who did not show greater levels of depression. Younger respondents, rather than older Haitian men, reported significantly greater levels of spirituality associated with the practices of Voodoo. Throughout previous chapters, the cosmo-centric culture illnesses are viewed as inharmonious with the universal energy (WHO & PAHO, 2010). Regardless of whether they were born in Haiti or born in the United States, the participants' quantitative survey responses highlighted factors that were important to the prediction of depression symptoms. The majority of the men had resided in the United States for more than 20 years, yet Haitian men continued to consult with traditional medical practitioners. According to the results of the CESD-R, the quantitative data did reveal 52 of the 90 participants reported symptoms fitting a diagnosis of depression. When addressing depression among Haitian men, there is a pertinent link that connects among non-Western cultures, namely that these non-Western cultures conceptually have no equivalent word in their vocabulary that defines the malady of depression (Kleinman & Good, 1985). Further research is needed to understand and

describe their meaning of the word depression, to provide details on how Haitian culture influences life choices, and to provide explanations of beliefs about Voodoo, masculinity, sickness, and health.

Restrictive Emotionality, Self-Reliance, and Subjective Masculine Stress

As men strive to exemplify the hegemonic Western cultural masculine gender role norms, they increase the likelihood they will encounter difficult and challenging consequences including a higher probability of dysfunctionality in their ability to emotionally connect to and sustain a meaningful relationship with family, friends, or an intimate partner (Wong et al., 2013). Although the results of this study were not strictly replicated of Wong et al, researching both studies indicated masculine gender role norms impacts a man's likelihood to suffer from depressive symptoms and seek help. The literature also supported the findings in this study by providing an understanding of the stigma attached to individuals who seek psychological help for depression may be more strongly pronounced if that individual is a male living in the United States. The literature revealed that men who voluntarily seek psychological help for mental problems are perceived as not masculine, fragile, and lacking personal fortitude (McCusker & Galipo, 2011). Men who have been socialized from a hegemonic or traditional concept of masculinity can encounter gender conflict when they seek psychological help (McCusker & Galipo, 2011). Men experiencing gender role conflict seem to manifest characteristics of depression and conceal pessimistic thoughts about asking for psychological intervention. Consequently, men who stigmatize themselves are also not inclined to disclose themselves or seek psychological help in contrast to men who do not stigmatize

themselves thus, they are able to self-disclose (McCusker & Galipo, 2011). A plethora of research studies have concluded that men have a more negative attitude than women towards seeking help for mental issues; therefore, men rarely seek or accept psychological help for depression or other mental distresses (McCusker & Galipo, 2011). This theory is supported by the finding that restrictive emotionality, self-reliance, and subjective masculinity stress, was positively related to increase depression scores.

Spirituality Associated with Voodoo, Depression, and Cultural Norms

To examine the correlation between the religious practices of Voodoo and symptoms of depression, a multiple regression analysis was conducted to investigate the relationship between spirituality, as related to the practices of the religion of Voodoo and levels of depression. The regression model was not significant. This study revealed spiritual well-being is not significantly related to depression. The relationship between spirituality and level of self-disclosure of depression are discussed in the section of the findings below.

The findings of the study indicated that when participants were asked whether they had ever received treatment for depression, received a prior psychiatric intervention or treatment for mental disorder during the last six months, the outcomes were overpowering. All ninety of the participants stated that they have never received mental health intervention for depression, nor have taken a psychoactive drug for depression, or have participated in any psychiatric treatments for depression (see Table 2). Although the statistical analysis on this research question for this study was not significant, there was essential information that would be helpful in the understanding of depression among

Haitian men. The Haitian people do not have a Western cultural concept of depression, therefore, Haitian people do not understand mental illness as a medically treatable malady. Thus, they usually look for indigenous resources within their culture to address their mental issues (Jack & Ali, 2010).

Previous literature substantiated that Haitian culture has a multiplicity of rationalizations for maladies which are grounded in cultural, religious, and social beliefs. These explanatory theories often govern if and when a Haitian will seek help. Within the Haitian culture, Voodoo functions as a dual religious and a health care system because Voodoo embodies healing practices, health advocacy, prevention of maladies, and improvement of personal well-being (WHO & PAHO, 2010). I did not determine statistical significance regarding the religion of Voodoo and its relationship to levels of self-disclosure related to depression. It is important to note, there is a lack of research pertaining specifically to the impact spirituality associated with Voodoo and levels of self-disclosure has on Haitian men related to depression symptoms. The findings of the study did not determine any statistical significance regarding the ability to self-disclose depression symptoms and the impact self-disclosure has on Haitian men. These discrepancies open many avenues for future research in the area of depression among Haitian men.

Strengths and Weaknesses of the Study

A substantial asset to the outcomes of this study was the use of the surveys, MRNI-SF (restrictive emotionality and self-reliance), the SMSS, and the SWBS. These surveys effectively allowed the participants to identify and self-evaluate the specific

types of social maladaptive distress he had experienced. The spiritual well-being scale refers to the respondent's view of God, how God is involved in one's life and the respondent's sense of the meaning in life and satisfaction with life's present direction. The researcher found that these scales and surveys were user friendly; allowing the participants to easily identify the stress factors and to complete the surveys in a timely manner.

A weakness of this study is related to the void in literature on the subject of depression among Haitian men. Because of the void in literature on the subject of depression in Haitian men, there were no available descriptive statistical analysis data to compare my study results. Another weakness is it was assumed that positive correlations to high levels of restrictive emotionality, self-reliance, and subjective masculine stress would predict an increase in levels of depression. Future studies would answer many questions and increase understanding and treatment of depression among Haitian men. A final weakness of this study was the exclusion of Haitian men younger than 20 years old and older than 40 years old. I made a decision to specify the age spectrum for this study based on an assumption that Haitian males younger than 20 years old would not be included because they traditionally have not experienced a broad range of life events, trauma, accomplishments, or achieved a significant level of independence. Furthermore, I excluded males over 40 as Haitian men in this age demographic are often settled in their way of life and can be unwilling to change. Another unknown is to what degree Haitian men is influenced to self-disclosure. What we know from this study is that Haitian men preference to internalize depressive symptom and affirmatively respond to items which

do not threaten their sense of masculinity. What I found from this study is that Haitian men prefer to internalize depressive symptom and affirmatively respond to items which do not threaten their sense of masculinity. What I also found from this study is that Haitian men stigmatize an individual who has or had mental illnesses.

In Chapter 1, I made an assumption that the participant's age and length of time in the United States would impact the traditional masculinity role and spirituality associated with Voodoo. This assumption of response bias is considered a weakness of the study of Haitian men between 20-40 years old who reside in the United States. Scores from this study may be a misrepresentation of the Haitian men's true level of distress. Again, an unavoidable weakness of this research was the lack of any existing measurement tools designed to assess depression in males from the Diaspora or a non-Western culture. Finally, relying solely on the use of self-reported measures was a limitation of the study. The self-reported data is subjective because if a participant feels that his responses may not remain confidential, he may skew the answers to make himself look better in the eye of the researcher.

Recommendations for Future Studies

Based on the results from this study, the following recommendations were suggested for possible studies in the future. The recommendations listed below were formulated based on the void within the literature, outcomes of this study, and the researcher's experience as a mental health clinician.

- Future empirical studies would benefit from addressing depression among Haitian men that reside in Haiti to gain a clearer understanding of the perceptions and behavior manifestations associated with depression.
- Additional research should utilize case studies to examine the precise and diverse symptoms by which Haitian men manifest depression.
- Future studies should examine how Haitians, in general and Haitian men in particular, respond to treatment for depression from an indigenous cultural and holistic perspective.
- Future studies would benefit from addressing depression among Haitian adolescents to gain a clear understanding of their perceptions and manifestations associated with depression.
- Future studies would benefit from addressing why men deny their symptoms of depressions and suffer in stoic silence.
- Additional research should address the subject of depression within the social context of non-normative and normative male behaviors.
- Future studies would benefit from addressing the impact spirituality associated with Voodoo and levels of self-disclosure have on Haitian men related to depression symptoms.
- Future studies would benefit from addressing depression among Haitian men from a qualitative approach to provide deeper explanations of Haitian men's behavior, details of the participants' personalized points of view, and attitude towards depression.

Social Change Implications

The implications for social change are threefold. Most of all, this study added to the research in the mental health literature on Haitian men and depression where previously there was very little. Mental health providers now have some information on how to best approach Haitian men by incorporating their Haitian indigenous cultural understanding of depression. Furthermore, this study helps educate mental health professionals about the myths and half-truths promoted through movies about Haitian culture. Last but not least, this study assists in helping Haitian men seek help and diminish the stigma attached to doing so.

The critical ethical facts that professionals in the field of helping people need to understand are the cultural constructs of the people they are trying to provide help. Without this cultural foundational knowledge and understanding, there is a very high probability of unethical and ineffective treatment including potentially negative charges and violations of human rights (Sue et al., 1992). An implication is the myth of Western perspective, of misrepresentation and misunderstanding that surround Voodoo. For example, from a Western perspective, Voodoo is most frequently thought of as an evil concoction of spells, hexes, and the working of black magic to accomplish some dastardly deed (McAlister, 2002). This Western perceptive may impact healthcare professionals and prejudice their understanding of the potent interrelationship between Haitian people and their spiritual devotion to the religion of Voodoo. Quite the contrary, for Haitian people, religion serves a critical role in all levels of Haitian life. Voodoo is more than just a religion combined of West African traditions and Catholicism; it

functions as a health care system for Haitians people utilize when and if they seek help for a physical or mental condition. The findings of quantitative data reveal that Haitian men reported significantly greater levels of spirituality, as related to the practices of Voodoo also spirituality associated with Voodoo have no significant correlation with depression. The literature findings described Voodoo as a religion to communicate with the ancestors and the spirit world to restore harmony where there was disharmony. Haitians are culturally conditioned to accept Voodoo ideologies about physical and mental illnesses, interventions, and corrective prescriptions to modify an individual's malady. The literature findings reveal that most Haitians would seek help from a Voodoo priest (spirituality as related to the practices of Voodoo and spirituality associated with Voodoo) when they cannot find any medical explanation for their malady.

Another implication is a lack of comprehension of cultural concepts related to the person's values, and religion differences from one individual to another. Many Haitians ascribe to a humoral theory of wellbeing and sickness. Heat and cold must maintain a balance within the body to prevent sickness. These cultural and spiritual beliefs are authentic and essential to recognize in order to comprehend how deeply embedded these beliefs impact Haitian people regardless of whether they were born in Haiti, in the United States or their religious affiliation. The lack of balance between heat and cold as well as the balance between the mental and the physical is thought to cause sickness. Haitians believe the ancient theory of humoralism which is based on the individual's own unique humoral makeup. Physical and mental distresses are essentially caused by influences that affect the individual's ability to perform routine activities. Haitians frequently use a

combination of approaches to resolve issues of sickness and maintain a sense of wellbeing. Health can be restored through “herbal teas, regulated diet, compresses, baths, and massages” (Pierre et al., 2010, p. 24). Balance is restored by reversing the direction of the disequilibrium (Miller, 2000; Nicolas et al., 2006). In cases where tests reveal no evidence of a medical diagnosis related to the patient's complaints of being sick, the next step is to find a resolution to the malady from a non-Western source (WHO & PAHO, 2010). Clinician evaluations of non-Western clients with depressive disorders should include valuable cultural information that informs the clinician of the client's cultural perspectives, religious and secular beliefs, customs, social status, and how the client views his or her illnesses (APA, 2002). The layers of complexity are revealed when compared with non-minority patients, especially when the patients have a different ethnic background from the clinician (Sue & Sue 2008). These complexities are obstacles that continue to exist within culturally competent assessment such as lack of acknowledge that there are many ethnicities, economic classes, and cultures differences among non-Western people.

Recommendations for Action

I formulated several recommendations derived from the results of this study on depression among Haitian men. These recommendations were developed to promote much needed knowledge and understanding about the malady of depression, its affects, and how it is manifested among Haitian men living in the United States. Haitian men trying to live without seeking help for depression would greatly benefit from changes in the mental health system that reach out to this neglected demographic. Additional

research with Haitian men could foster a better understanding about depression among them and lessen the cultural stigma of seeking and adhering to treatment. Some of the conclusions resulting from this pioneering study could be publicized using social media, radio, printed materials and Haitian personalities to connect with Haitian men around their cultural definition of depression and raise their awareness of available resources within their communities. Numerous public service announcements are needed within the global Haitian community in (Kreyòl) to encourage men of African descent to become involved in acknowledging their mental health issues and to seek help for depression. More than half of these participants revealed that they knew someone who has suffered from a mental illness such as depression. The same participants also stated that their opinion of that individual changed after they found out the individual suffered with a mental illness such as depression. These public service announcements should also be conducted at different levels by encouraging the family as an integral part of the support system. These public service announcements should show involvement and support of family members, thereby encouraging those individuals who are suffering with depression to participate in their own mental health recovery. The clients will not feel isolated, but rather feel supported as they seek the help that they need.

Conclusion

While working as a psychiatric clinician in New York, I became acutely aware of culturally sensitive issues within the staff and client populations. As a clinician, I must explore my own cultural identity and acknowledgement of my identity issues and how these issues affect values, beliefs, and skills of others I encounter. Empowering people to

understand their lives and make the necessary changes to improve their lives is part of the goals of the mental health profession. In order for me to identify with someone from a different culture, I have to understand my culture. I have to be aware that there are other cultures and there are differences within various cultural groups. As I become more culturally competent, I am less likely to unintentionally impose my cultural beliefs and values on a client. As I reflected upon my journey as a researcher, I realized that this study took me to throughout New York City's culturally diverse five boroughs and Florida. This journey provided me with the opportunity to meet and have a dialogue with some very intriguing male participants. I had the rare opportunity to address the topic of depression among men which is not a subject discussed in Haitian society.

The acculturation process of most immigrants is usually accompanied by considerable stress and value system clashes when trying to assimilate into mainstream Western culture especially among recent immigrants who wish to maintain their own ethnic cultural values. The written interviews as well as the individual interviews cannot reflect the terms of endearment the Haitian men showed through their facial expressions or the tone of their voices. These men demonstrated such compassion to help me to comprehend the events unfolding around these inter-related topics of voodoo, emotion, self-reliance and depression. Many of these men stated that their ethnic identity, particularly the racism encountered as a major problem for the black immigrant, especially those that are from countries where English is not the first language. It is very hard and unrealistic for Haitians to forget their long struggle to free themselves from slavery and the role of slaves that shaped the eastern section of Hispaniola. Hispaniola

was the name Christopher Columbus gave to the island when he landed in 1492.From that time, Haiti was colonized and enslaved by several colonial powers: Spain, France, England and the United States. Haiti (Hispaniola) was rich in sugar cane, cocoa, coffee, indigo, plantain and all of the tropical fruits. The Haitian Revolution was the result of a spiritual ritual practiced in the religion of Voodoo. The ritual was performed by an ougan priest named Dutty Bookman on August 14, 1791. During the ritual, participants drank the blood of a black pig and spoke the names of the leaders in their African languages. Haitians credit Dutty Bookman with success of the Haitian Revolution. The Haitian Revolution gave these former slaves independence, brought in mass mobilization, socialism, and economic change. Haitian slaves were the first in the Western Hemisphere to free themselves from their owner and declare themselves free men and women.

The American culture places great emphasis on individualism, and a strong sense of self-importance (Wong et al., 2013). This concept of the importance of the self can be disconcerting to indigenous people such as Haitians who subscribe to a cosmos-centric way of thinking. Haitians do not conform to these behavior patterns of individualism which tends to disrupt their belief systems, masculinity norms, and spirituality. There was a survey question about the correlation of spirituality and its relationship to predicting depression. The findings of this study indicated that younger respondents, when compared to older Haitian men, reported significantly greater levels of spirituality related to knowledge and the religious practice of voodoo. There were no previous literature data for comparison or to examine any significance results. Many of these younger men emphasized the significance of spirituality as a powerful force over which they have no

control. Thus, Haitian men would be more open to seek help for their depression/sadness/mental health problems if the professional personnel offering them psychological assistance approached this population with cultural competency and with an unbiased attitude. Culturally competent mental health professionals can assist Haitian clients without discrimination, biases, and stereotypical ideas popularized by Western cultural perspectives.

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Appendix A: Notification E-mail for the Study

This e-mail will be sending to any participant who provided the researcher with an email account as a primary method of contact.

Attention: Would you like to join a research group?

My name is Darlyne Richardson and I was born in Haiti. I am doing this research study to earn a PhD in Clinical Psychology from Walden University. To complete my research, I am looking for 90 Haitian men, ages 20 to 40 years old, living in the United States. I am trying to examine what Haitian men believe about depression, cultural beliefs, religion and what it means to be a Haitian man living in the United States. Your personal information that you share during this study will be kept private.
This means that what you tell me, as the researcher, will not be used outside of this research study.

To take part in this research, I will ask you to complete the following forms: Inform consent and a series of surveys. These questionnaires will ask you to talk about things you have experienced and your cultural beliefs about depression. Some questions will ask about you and other questions will ask about others you may know about. I will talk with you face to face.

Thank you for considering participating in this very important research study.

Sincerely,
D. Richardson

Appendix B: Follow-up and Reminder E-mails to the Participants

Follow up e-mail to volunteered participants.

Hello XXXX,

Thank you so much for volunteering to join in this study. I value your personal time and your being a part of this research study. If you have any questions or concerns, please feel free to e-mail me at drichardson@gmail.com.
If you need a duplicate copy of the consent form for your record, I will send it to you, just send a request by e-mail.

Thanks so much,

D. Richardson, M.S.W

*Reminder e-mail to volunteered participants.

Hello XXXX,

Thank you so much for joining in this study. Again, I highly value your personal time and your taking part in this research study. If you have any questions or concerns, do not delay to email me at drichardson@gmail.com.

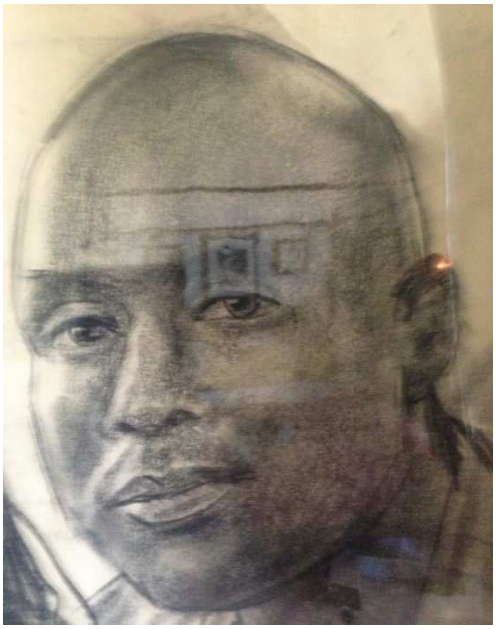
Thanks again,

D. Richardson, M.S.W

Appendix C: Recruitment Flyer for Participants

DEPRESSION: REAL MEN TALK ABOUT IT!

Are you a Haitian man, between the ages of 20- 40 years old, and you live in the United States? I am asking you to take part in a research study I am doing on Haitian men from the age of 20 to 40 years old. You must live in the United States. My name is Darlyne Richardson and I am student at Walden University.



The study involves answering survey questions to the best you can about Haitian beliefs, sad feeling over a long period of time, your understanding of God. Also, you will be asked questions about what you think it means to be a Haitian man living n America. If you want to help me in this important study, please get in touch with me at my address below.

E-mail: DRichardson@gmail.com

Appendix D: Informed Consent Form

Understanding Distinctive Beliefs and Perceptions about Depression among Haitian Men

A Quantitative Study

You are invited to join in a study on Haitian men. There as on I am doing this study is to record what Haitian men think or believe about believe feelings of sadness that last a long time. I want to record what you think it means to be a Haitian man living in the United States. You can help me do this study if you are open and willing to talk to me and to answer questions the best you can. This form is called 'Informed Consent'. I have to give it to you so that I can be sure you understand what I am asking you to do in this study before you decide to take part in it. Are you a Haitian man, between the ages of 20-40 years old? Do you live in the United States? Are your parents Haitian, including first or second generation, born either in Haiti or in the U. S.? Are you a naturalized citizen? Do you have permanent resident status or non-permanent resident status in the U.S.? If you answered YES to anyone of these questions, I welcome you to help me in my research study.

My name is Darlyne Richardson and I am doing this research study. I am also Haitian and I am completing my PhD in Clinical psychology at Walden University.

Background Information:

The idea for doing this study came about because I could not find any literature on Haitian men and what they think, feel and believe when it comes to issues like sadness, happiness, and how to cope with life's ups and downs. I could not find any information where Haitian men speak for themselves. The truth is, there was nothing written on Haitian men at all! The reasons I am doing this research study is to record what Haitian men living in the United States think and believe about sad feelings that last a long time. What do you think and believe about what boys are taught as you grow in to a man. Do you believe in the Voodoo religion? Does the Voodoo religion help you to cope with your life and your feelings of sadness? If you were feeling sad, how would you show it?

Procedures

If you agree to be in this study, you will be asked to:

- Respond to the study questionnaires which should take about 1 hour 15 minutes to complete. This information will help me as the researcher to learn more about you as the participant.

- The demographic data questions will take 10-15 minutes to answer. These questions will ask your age, occupation, income, in which country were you born, religion, educational level, prior psychiatric diagnosis and marital status.
- There are four questionnaires and these questionnaires will take you about 45 minutes to complete. These questionnaires will ask you to think about events you have experienced and what you think/believe about depression. Some questions are directly and other questions are indirectly. These surveys will ask you questions about your definition of what it means to be a man.
- The first survey should take about1 0 minutes. It will ask you about your opinions. For example: A man should know how to repair his car if it should break down. The second survey should take about 15 minutes to complete. It will evaluate your experiences as a man. For example: (Please describe your personal experience of what it means to be a man by completing the following sentence, "As a man..."10 times).The third survey looks at your Spiritual and/or religious view points. These questions should take about10 minutes to answer. The fourth survey looks at your feelings and the questions should take about 10 minutes to complete. At the end of the surveys, I will offer you free information about available mental health services in your area.

Time Commitment:

- Approximately maximum of 1 hour 15 minutes
- (15 Min) for Informed consent
- One (1) hour to complete 6 surveys

Voluntary Nature of the Study

Your participation in this study is of your own free will. This means that everyone will respect your decision to join or not to join in this study. No one at Walden University will treat you differently if you decide not to be in the study. Furthermore, if you decide to join the study now, you can still change your mind during the study. Finally, if you feel stressed during this study, you may stop at any time. You may skip any questions that you feel are too personal.

Risks and Benefits of Being in the Study

In this study, Haitian men will face no physical harm or danger or feel any mental stress. All information I get from Haitian men will be guarded and protected for total privacy. All study information that show your will answers will be kept private. During this study, you have the right to not answer any questions during the study and you can take breaks at any time during the study. You always have the right to stop answering questions and simply leave the study. I will not question why you are leaving the study. However, if

you choose to go on answering the questions, it is very important that I tell you that you might feel uncomfortable answering questions and talking about something you are not used to talking about with anyone. Remember, whatever you say to me or write in your answers, your identity will never be reported to anyone. A toll free number is available below for mental health services in Brooklyn, Queens and Miami.

The results I find in this of the study will give mental health workers and healthcare professionals a better understanding of how Haitian men express feelings of sadness. The information I will get from your being honest and willing to talk and answer study questions will help me, there searcher, to document how Haitian men understand and express themselves when they are sad over a long period of time. I will also describe the types of experiences that may cause Haitian men to become sad. I could not have done this study without your help and the valuable time you spent with me during this study. I am very grateful for all your help. Thank you.

Compensation

I will not be able to pay you in any way for your time and help during this study. I am asking you to volunteer your time as a participant in this study.

Confidentiality

No one will know your name or what you said during this research study. Whatever you tell me, there searcher, will not be used outside of this research project. Also, the researcher will not include your name or anything that could identify you in any reports of the study. As a participant, I ask you to keep to yourself any information you told me during your individual interview.

Contacts and Questions

You may ask any questions you have now. Or, if you have any questions later, you may contact the researcher at D.Richardson@gmail.com. If you want to talk privately about your rights as a participant, you can call Dr. Leilani Endicott at 1-612-312-1210 or1-800-925-3368 extension (3121210). She is the Walden University representative who can discuss this with you. Walden University's approval number for this study is 09-11-13-0156133 IRB will enter approval number here and it expires on IRB will enter expiration date on September 10, 2014.

If you feel you would like to speak to a professional counselor in your area, below is the contact information for free/low cost counseling:

Brooklyn: Crisis interventions Service NYC Department of Mental Health 93 Worth street New York, NY 10013 (for Manhattan & Queens) 1800-LIFENET
Queens: Long Island Consultation Center 97-29 64 Rd Rego Park NY 113741 (718) 896-3400

Mobile Crisis List: Medical team will make a home visit in case of psychiatric emergencies and evaluate for hospitalization service below are subject to a sliding fee scales, accepts Medicaid and other medical plans.

Manhattan: 212-290-3240 (Visiting Nurses), 212-939-3016/3331(Harlem Hospital) Social Worker's Office 212-939-3330

Brooklyn: 718-935-7284(Interfaith Medical Center) &718-946-2600 (South Beach Psychiatric Center)

Queens: 718-779-1234 (Catholic Charities), 718-464-7500 Ext.3350 (Creedmor Hospital)

Miami Free Clinics: 954-467-4700 Broward County Health Department, University of Miami Hospital 305-689-4444 and Borinquen Health Care Center, Inc 305-576-6611
The researcher will give you a copy of this form to keep.

Statement of Consent:

I have read the above information and I feel I understand the study well enough to make a decision about my participation. By Insert signing below or clicking here I am agreeing to the terms described above.

Printed Name of Participant

Date of consent

Participant's Signature

Researcher's Signature

Electronic signatures are regulated by the Uniform Electronic Transactions Act. Legally, an" electronic signature" can be the person's typed name, their email address, or any other identifying marker. An electronic signature is just as valid as a written signature as long as both parties have agreed to conduct the transaction electronically

Appendix E: Demographic Questionnaire

Please respond to the following questions: *You may leave blank, any item(s) that you do not wish to answer.*

English

1. How old are you?___years old
2. Where were you born?_____
Your state_____
Your country of residence_____

3. What is your ethnic origin/race?(Only choose one)

(a)Haitian
(b)Haitian American
(c)Black/African American
(d)Haitian/Latino
(e) Other

4. Can you describe to me what it means to you to be Haitian or other?
5. Your religion
(a)Christian
(b)Muslim
(c)Protestant
(d)Catholic
(e)Methodist
(f)Baptist
(g)Buddhist
(h)Other (specify)
(i)None

6. Your highest level of education
(a)Elementary
(b)Middle School
(c)Some high school
(d)High school graduate
(e)Technical school graduate
(f)College graduate (bachelor's degree)
(g)Graduate degree (master's or doctorate)

7. What is your marital status?(Only choose one)
(a)Single

(b)Married

(c)Separated
(d)Divorced
(e)Widowed
(f)Living with a girlfriend/partner

8. What is your living arrangement?(Only choose one).
(a)Live with a family member(s)
(b)Live alone
(c)Live with a roommate
(d)Other

9. Do you have any children? Yes__ No__

9a. Howmanychildren?_____

10. Do your children live with you?___Yes No____

10a.Where_____

11. How many people live with you?___

12. Which best describe your current employment status?(Only choose one)

_Fulltime, more than50 hours a week

_Fulltime, more 40 hours a week

_Part time

_In-school

_Unemployed or laid off and looking for work

_Unemployed and not looking for work

_Disabled, not able to work

13. Do you have family currently residing in Haiti?___Yes No___

14. Have anyone one diagnose you with depression? _Yes No_

15. Have you had prior psychiatric diagnosis? _Yes or No_

16. Have you ever attempts psychiatric treatments? _Yes or _No

Appendix F: Debriefing Statement

Thank you so much for joining in this study! You can be sure that I will never use your name or any other information you gave during this study. I will not use your name on anything. Instead, I will use a random letter or number when I analyze the data. All research records have either letters/numbers and no names to make sure no one will know who you are. I will be responsible that everything will be kept private. Your personal information that you talked or wrote about for this study will be kept secret. The information you provided to me, the researcher, will not be used outside of this research project.

It is critical that you take good care of yourself, pay attention to your own health, and seek support from your family and community, as well as professional help whenever you feel it is necessary. However, it is very important that you know that you might feel uncomfortable, especially while discussing with me something you don t usually discuss with anyone. A toll free number is available below for mental health services in Brooklyn and Queens, NY, and Miami Fort Lauderdale.

If you feel you would like to speak to a professional counselor in your area, below is the contact information for free/low cost counseling:
Brooklyn
Crisis interventions Service NYC Department of Mental Health

93Worth Street New York, NY 10013 (for Manhattan & Queens)

1-800-LIFENET

Queens

Long Island Consultation Center

97-2964 Road Rego Park, NY 11374

(718)896-3400

Mobile Crisis List: Medical team will make a home visit in case of psychiatric emergencies and evaluate for hospitalization service below are subject to a sliding fee scales, accepts Medicaid and other medical plans.
Manhattan:

212-290-3240 (Visiting Nurses)

212-740-7287 (Columbia Presbyterian)

212-238-7313(Gouverneur Hospital)

212-939-3016/3331(Harlem Hospital) Social Worker's Office 212-939-3330

Brooklyn:

718-935-7284 (Interfaith Medical Center)

718-946-2600 (South Beach Psychiatric Center)

Queens:

718-464-7500 Ext.3350 (Creedmor Hospital)

718-526-8400 (Transitional Services)

718-779-1234 (Catholic Charities)

718-896-9090 (Jewish Community Services)

Miami Free Clinics

Broward County Health Department

University of Miami Hospital

2421SW 6th Ave, Fort Lauderdale, FL 33315
1400 NW 12th Avenue Miami, FL

Near South Fort Lauderdale 33136 for free initial assessment
(954)467-4700 call (305) 689-4444

Borinquen Health Care Center, Inc

3601Federal Highway, Miami, FL, 33137 **(305)576-6611**

Appendix G: Public Broadcast Announcement

Attention: Haitian Men ages from 20 to 40 years old throughout the United States. I need you to take part in a quantitative research to address Haitian men's life difficulties in the United States. Real men talk about depression so get involved, Help eliminate the stigma surrounding your cultural beliefs about Haitian Men and Ayiti. It time to stand up! Let the world hear your voice and participate in this pioneering research by breaking the code of silence on depression among Haitian men.

You are cordially invited to participate in this ground breaking work! Let us work together and make a difference in mental health for our people. The cost: Absolutely free! Come join with me. Let us talk about real depression and break that code of silence on depression.

Appendix H: Data Recording Log for Data Collection Site

Data Recording Log

Coded Number Study's Site Participant's Identifiers

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This sheet will be **stored** in a locked cabinet with other research data and will be destroyed after five years.

Appendix I: The Center for Epidemiological Studies Depression Scale Revised

Center for Epidemiologic Studies Depression Scale – Revised (CESD-R)

Below is a list of the ways you might have felt or behaved. Please check the boxes to tell me how often you have felt this way in the past week or so.	Last Week				Nearly every day for 2 weeks
	Not at all *or* Less than 1 day	1 - 2 days	3 - 4 days	5 - 7 days	
My appetite was poor.	0	1	2	3	4
I could not shake off the blues.	0	1	2	3	4
I had trouble keeping my mind on what I was doing.	0	1	2	3	4
I felt depressed.	0	1	2	3	4
My sleep was restless.	0	1	2	3	4
I felt sad.	0	1	2	3	4
I could not get going.	0	1	2	3	4
Nothing made me happy.	0	1	2	3	4
I felt like a bad person.	0	1	2	3	4
I lost interest in my usual activities.	0	1	2	3	4
I slept much more than usual.	0	1	2	3	4
I felt like I was moving too slowly.	0	1	2	3	4
I felt fidgety.	0	1	2	3	4
I wished I were dead.	0	1	2	3	4
I wanted to hurt myself.	0	1	2	3	4
I was tired all the time.	0	1	2	3	4
I did not like myself.	0	1	2	3	4
I lost a lot of weight without trying to.	0	1	2	3	4
I had a lot of trouble getting to sleep.	0	1	2	3	4
I could not focus on the important things.	0	1	2	3	4

REFERENCE: Eaton, W. W., Smith, C., Ybarra, M., Muntaner, C., Tien, A. (2004). Center for Epidemiologic Studies Depression Scale: review and revision (CESD and CESD-R). In ME Maruish (Ed.). *The Use of Psychological Testing for Treatment Planning and Outcomes Assessment* (3rd Ed.), Volume 3: Instruments for Adults, pp. 363-377. Mahwah, NJ: Lawrence Erlbaum.

Appendix J: The Male Role Norms Inventory-Short Form Scale

MRNI-SF

Please complete the questionnaire by circling the number which indicates your level of agreement or disagreement with each statement. Give only one answer for each statement.

Strongly Disagree	Disagree	Slightly Disagree	No Opinion	Slightly Agree	Agree	Strongly Agree
1	2	3	4	5	6	7

1. Homosexuals should never marry.
   1 2 3 4 5 6 7
2. The President of the US should always be a man.
   1 2 3 4 5 6 7
3. Men should be the leader in any group.
   1 2 3 4 5 6 7
4. Men should watch football games instead of soap operas.
   1 2 3 4 5 6 7
5. All homosexual bars should be closed down.
   1 2 3 4 5 6 7
6. Men should have home improvement skills.
   1 2 3 4 5 6 7
7. Men should be able to fix most things around the house.
   1 2 3 4 5 6 7
8. A man should prefer watching action movies to reading romantic novels.
   1 2 3 4 5 6 7
9. Men should always like to have sex.
   1 2 3 4 5 6 7
10. Boys should prefer to play with trucks rather than dolls.
    1 2 3 4 5 6 7
11. A man should not turn down sex.
    1 2 3 4 5 6 7
12. A man should always be the boss.
    1 2 3 4 5 6 7

Strongly Disagree	Disagree	Slightly Disagree	No Opinion	Slightly Agree	Agree	Strongly Agree
1	2	3	4	5	6	7

13. Homosexuals should never kiss in public.
    1 2 3 4 5 6 7
14. A man should know how to repair his car if it should break down.
    1 2 3 4 5 6 7
15. A man should never admit when others hurt his feelings.
    1 2 3 4 5 6 7
16. Men should be detached in emotionally charged situations.
    1 2 3 4 5 6 7
17. It is important for a man to take risks, even if he might get hurt.
    1 2 3 4 5 6 7
18. A man should always be ready for sex.
    1 2 3 4 5 6 7
19. When the going gets tough, men should get tough.
    1 2 3 4 5 6 7
20. I think a young man should try to be physically tough, even if he's not big.
    1 2 3 4 5 6 7
21. Men should not be too quick to tell others that they care about them.
    1 2 3 4 5 6 7

Appendix K: Spiritual Well-Being Scale

SWB Scale

For each of the following statements circle the choice that best indicates the extent of your agreement or disagreement as it describes your personal experience:

SA	= Strongly Agree	D	= Disagree
MA	= Moderately Agree	MD	= Moderately Disagree
A	= Agree	SD	= Strongly Disagree

1.	I don't find much satisfaction in private prayer with God.	SA	MA	A	D	MD	SD
2.	I don't know who I am, where I came from, or where I'm going.	SA	MA	A	D	MD	SD
3.	I believe that God loves me and cares about me.	SA	MA	A	D	MD	SD
4.	I feel that life is a positive experience.	SA	MA	A	D	MD	SD
5.	I believe that God is impersonal and not interested in my daily situations.	SA	MA	A	D	MD	SD
6.	I feel unsettled about my future.	SA	MA	A	D	MD	SD
7.	I have a personally meaningful relationship with God.	SA	MA	A	D	MD	SD
8.	I feel very fulfilled and satisfied with life.	SA	MA	A	D	MD	SD
9.	I don't get much personal strength and support from my God	SA	MA	A	D	MD	SD
10.	I feel a sense of well-being about the direction my life is headed in.	SA	MA	A	D	MD	SD
11.	I believe that God is concerned about my problems.	SA	MA	A	D	MD	SD
12.	I don't enjoy much about life.	SA	MA	A	D	MD	SD
13.	I don't have a personally satisfying relationship with God.	SA	MA	A	D	MD	SD
14.	I feel good about my future.	SA	MA	A	D	MD	SD
15.	My relationship with God helps me not to feel lonely.	SA	MA	A	D	MD	SD
16.	I feel that life is full of conflict and unhappiness.	SA	MA	A	D	MD	SD
17.	I feel most fulfilled when I'm in close communion with God.	SA	MA	A	D	MD	SD
18.	Life doesn't have much meaning.	SA	MA	A	D	MD	SD
19.	My relation with God contributes to my sense of well-being.	SA	MA	A	D	MD	SD
20.	I believe there is some real purpose for my life.	SA	MA	A	D	MD	SD

Appendix L: The Subjective Masculinity Stress Scale (SMSS)

PsycTESTS®

doi: 10.1037/t21427-000

Subjective Masculinity Stress Scale
SMSS

Items

The following questions are about *gender* issues. Please describe your *personal experience* of what it means to be a *man* by completing the following sentence, "As a man . . ." 10 times. Just give 10 different responses. Respond as if you were giving the answers to yourself, not to somebody else. There are no right or wrong responses. Don't worry about logic or importance, and don't overanalyze your responses. Simply write down the first thoughts that come to your mind.

1. As a man . . .
2. As a man . . .
3. As a man . . .
4. As a man . . .
5. As a man . . .
6. As a man . . .
7. As a man . . .
8. As a man . . .
9. As a man . . .
10. As a man . . .

Please refer to your responses above. For each "As a man . . ." response, indicate how OFTEN this experience is STRESSFUL for you.

	Never/Almost never	Rarely	Sometimes	Often	Always/Almost always
"As a man . . ." Response 1	1	2	3	4	5
"As a man . . ." Response 2	1	2	3	4	5
"As a man . . ." Response 3	1	2	3	4	5
"As a man . . ." Response 4	1	2	3	4	5
"As a man . . ." Response 5	1	2	3	4	5
"As a man . . ." Response 6	1	2	3	4	5
"As a man . . ." Response 7	1	2	3	4	5
"As a man . . ." Response 8	1	2	3	4	5
"As a man . . ." Response 9	1	2	3	4	5
"As a man . . ." Response 10	1	2	3	4	5

Appendix M: Certification of Completion NHI

Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Darlyne Richardson** successfully completed the NIH Web-based training course "Protecting Human Research Participants".

Date of completion: 03/11/2010

Certification Number: 414539

Darlyne Valcin-Richardson, Ph.D.

Curriculum Vitae

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ACADEMIC EXPERIENCE

2009-2014 Doctor of Philosophy – Clinical Psychology, ***Walden University,*** *Minneapolis, Minnesota*

2006-2007 Master of Social Work – Counselor Education: Mental Health Counseling, ***Stony Brook State University Of New York,*** *Stony Brook, L.I., NY*

2003-2006 Bachelor of Science – Social Work, ***York College, City University Of New York,*** *Jamaica, New York*

RELEVANT PROFESSIONAL EXPERIENCE

2010-2012 ***Senior Intern Trainer/Manager (full-time)***
Holliswood Hospital; Hollis Queens NY

Responsible for identification and counseling of patients identified as high risk; attendance tracking; curriculum development; development and facilitation workshops; supervision of general population in group setting/education; observation and evaluation of adolescents in hospitalization and adults in the programs of Partial Hospitalization (PHP); problem resolution.

2007- 2011 ***Psychiatric Clinician (Full-time)***
The Child Center of New York (QCCNY)

Responsible for intakes; diagnosis of mental and emotional disorders under supervision; treatment planning; individual counseling with children, adolescents and adults; crisis intervention; Provide a setting that promotes growth, increased

efficiency and overall product quality for various disciplines and topics in accordance with the agency policies. Handles core functions in the lecture, groups sessions and communicate effectively with students/clients of diverse backgrounds. Implementing a safety locality to intervene and address sexual violation for children/family. Analyzes processes to ensure maximum availability through revolutionize the problem/ management reviews change effecting complete implementation and test. Educate patients to utilize the art therapy process organize thoughts and feelings, contain impulses and allow for non-verbal means of expression. Educate and explore alternatives safe and healthy coping skills and behavior which could aide in prevention of relapse or re-hospitalization.

2006-2007 ***Analyst Social Worker (full-time)***
State Legislator Jack Eddington 7th District Suffolk County, New York

Responsible for operations of a $10M political administrative center to sustain, assess and identify Laws that directly and indirectly strengthens our cultural society. Responsible for identifying gaps in laws and make objective recommendations to state legislator. Forensic Interviewing conducted for division law/operation. Involve in program development, Compliance with State and Federal Laws. Identify and implement opportunities for program improvements policy affective and include all minorities.

1996- 2002 ***Medical Claims Manager (Full-time)***
USI Administrators, Melville, New York

Responsible for intakes; medical data to accurate for billing purpose not limited to overseeing collections processing, insurances per-authorizations and verification, tracking payment and payment plans. Supervise teams of medical coders and billers who compile patients' medical recorders and assign codes for procedures and diagnoses to generate bills for reimbursement to appropriated healthcare provide

1994-1995 ***Claim Adjustment Coordinator/Team Leader***

ADVICA Health Resources

Responsible for intakes; managing day to day activities of the district worker' compensation, filing claims accordingly; Functional capacity as an evaluation (FCEs) to assisting with allotment/financial /budgetary duties; Familiar with all aspects of daily business operations including: HIPPA, OSHA compliance, Contract Negations. Implemented interpersonal and communication skills when assisting staff with difficult callers. Determined relapse periods and premium refunds when applicable.

ASSOCIATED PROFESSIONAL EXPERIENCE

2011-2012 ***Intern Student***
Holliswood Hospital

Responsible for intakes; diagnosis under supervision; treatment planning; individual counseling with children, adolescents and adults; charting and report writing; crisis intervention; development and implementation of group for agoraphobia.

2010-2011 ***Practicum Student***
Responsible for intakes; diagnosis under supervision; treatment planning; individual counseling with children, adolescents and adults; charting and report writing; crisis intervention; development and implementation of group for agoraphobia.

2006-Prsent ***Play Therapist***
Responsible for intakes; diagnosis under supervision; treatment planning; individual counseling with children, adolescents and adults; charting and report writing; crisis intervention; development and implementation of group for agoraphobia.

2007-Present ***Forensic Interviewer***
Responsible for intakes; diagnosis under supervision; treatment planning; individual counseling with children, adolescents and adults; charting and report writing; crisis intervention; development and implementation of group for agoraphobia.

2004-Present ***Suicide Prevention Counselor***
Responsible for intakes; diagnosis under supervision; treatment

planning; individual counseling with children, adolescents and adults; charting and report writing; crisis intervention; development and implementation of group for agoraphobia.

COMMUNITY SERVICE AND CONSULTING EXPERIENCE

2008 *The Recreation Center, Clinical Consultant, Suffolk County, New York*

2004 *Freshman Center, Social Work Consultant BFCU School District Suffolk County, New York,*

PROFESSIONAL ORGANIZATIONS

American Psychological Association, Student Membership

Caribbean Regional Conference of Psychology (CRCP).

Haitian Studies Association, University of Massachusetts Boston, Student Membership

HONORS AND AWARDS

2011 *Recognized* as APA International Conference Travel Grant for Caribbean Regional Conference of Psychology (CRCP). Nassau Bahamas

2009 *Recognized as Academic Excellence* for PSI CHI Walden University *Minneapolis, Minnesota*,

2007 *Recognized as Suicide Prevention with Youth and Older population School of Social welfare, Stony Brook*

2007 *Recognized as Forensic Interviewing of Children The National Children's Advocacy Center Huntsville, Alabama*

2003 *Recognized as Academic Excellence, York College University, New York*

PUBLICATIONS

Richardson, D. (2014). Understanding Distinctive Beliefs and Perceptions about Depression among Haitian Men.

CLINICAL/RESEARCH INTERESTS

Men Studies; Haiti; Haitian men; Spirituality; Men and depression; Minority issues and Self-Esteem; Role of attribution styles in the development of learned helplessness in adult male, minorities identified as high-risk

REFERENCES

Dr. Brain Ragsdale, Professor of Psychology, Walden University
Dr. Guerda Nicolas, Professor of Psychology, University of Miami
Dr. Peterson, Professor of Department of social science, City University New York, York College,