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Haitian American Caregivers' Experiences Caring for Family Members Battling Substance Abuse

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This is to certify that the doctoral dissertation by

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Walden University
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Abstract

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MS, Walden University, 2016

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Dissertation Submitted in Partial Fulfillment

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General Research Psychology

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Abstract

Immigration issues, acculturation, and identity processes are risk factors identified for the development of substance abuse among Haitian Americans. While the problem of substance abuse within the Haitian American population has been identified, little research has been conducted on Haitian American caregivers who have cared for a loved one battling substance abuse. The purpose of this interpretative phenomenological analysis (IPA) was to explore how Haitian American caregivers experienced the phenomenon of caring for a family member battling substance abuse and to understand how caregivers coped with this demanding task. Carver et al.'s concepts of coping and Pargament's theory of religious coping constituted the theoretical basis for this study. Semistructured interviews with 10 participants constituted the data for this study. Data were analyzed using the principles of IPA. Results indicated that the caregiving journey was long and arduous, and it was filled with adversity and heartache. Participants expressed being distraught and overwhelmed. They adjusted physically, mentally, financially, and spiritually to endure the hardships of caregiving, yet they reported reluctance to receive assistance, which they only received when they felt overwhelmed. They used various means to cope with the stress of caregiving, but they showed proclivity toward implementing religious and spiritual coping. These results have the potential for positive social change by informing and enhancing mental health workers' competencies regarding how to assist Haitian American mental health services in conjunction with spiritual care.

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Dedication

This body of work is dedicated to the legacies of my late parents, Gregoire Ronald Chery (1953-2010) and Myrtho Saint-Elien (1959-2021). May this body of work be a small representation of the selfless and tireless work they did in their respective careers and communities to empower and enrich the lives of all they encountered.

Je t'aime.

Acknowledgments

It has certainly been quite the journey to attain this milestone and the fruition of this achievement would not have been as feasible without the consistent support of those who have I been blissed to cross paths within this lifetime. Whether it was through a fleeting moment of encouragement or being present through the entirety of my journey, every instance, thought and positive intention have contributed to sustaining me on this path, and for that, I am eternally appreciative and grateful.

For the duration of this journey, I have been met with extreme and insurmountable challenges, but through the amazing support I have received, I have been sustained and have been able to remain steadfast upon this path. Maintaining and cultivating the knowledge that God has and continues to guide and order my steps despite the adversity I face, by placing choice individuals in my life to hold space for me, has been a constant comfort.

To commence my venture into gratitude, I would first like to acknowledge the amazing faculty I had the pleasure of working with from Walden's General Research Psychology Department who offered me the opportunity to advance my skills and further my development as an agent of positive social change. I would like to extend my deepest and most heartfelt gratitude to Dr. Amy Sickel, the Program Director, Dr. Susana Verdinelli, my Dissertation Chair, Dr. Jane Lyons, my Second Committee Member, and Dr. Susan Marcus, my URR, who, through their amazing guidance, have allowed me to flourish under their tutelage. Their patience and constant advocacy for me throughout this

entire journey have been unparalleled and have provided me with the space to learn, grow and mature into the scholar I am today.

To my precious family and friends, I thank you for uplifting me in positive intentions when the burden became a bit difficult to bear. Thank you all for always being a constant source of support, love, and strength. Your unwavering encouragement has meant the world to me and has assisted me in reaching this point in my journey.

To my mother, Myrtho Saint-Elien, and father, Gregoire Ronald Chery, who have both ascended into glory, thank you for the unwavering love, support, and guidance you showered me with each and every day of your earthly existence and continue to provide me with in the transcendent realms. The foundation you have laid for me continues to sustain me in my most difficult moments. Thank you for always uplifting me and showing me that my dreams were always just within my reach. I dedicate this body of work to you, and I honor the sacrifices you have made to assist me in bringing my vision into fruition. It is on your shoulders that I proudly stand, and it is in my work that your legacy will be continued. *Je t'aime toujours et toujours, je t'aimerai.*

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Chapter 1: Introduction to the Study

The recovery process from substance abuse to wellness is a collaborative effort that impacts both the individual battling substance abuse and their support system (Jules & Maynard, 2016). However, the resources available to the individuals who comprise the support system may be relatively limited, and the needs of the support system for individuals battling substance abuse are often overlooked (Liddle, 2015). Therefore, more research is needed to address the needs of those who provide care to family members of substance abuse patients (Brenda, 2013). This need for more research is further apparent when looking at the experiences of Haitian and Haitian American caregivers who provide care to a family member battling substance abuse (Marcelin et al., 2005). Currently, the chief methods of coping for this population are through religious and spiritual means (Marcellin et al., 2005). The Haitian and Haitian American population tends to lean towards family, folk healers, and spirituality when facing medical or mental health issues (Khoury et al., 2012). According to the current literature, Haitians and Haitian Americans do not favor treating their mental health problems within the medical system, and they tend to use spirituality to deal with them (Jacobson, 2004); however, there is limited research on how caregivers experience the phenomenon of taking care of a family member with substance abuse issues and how they cope with the challenges.

This chapter provides a foundation to understand the experience of Haitian American caregivers and the methods they implement to cope with and care for an individual battling substance abuse. In this chapter, I outline the theoretical and conceptual basis for this study and describe the chosen methodology to explore the key

concepts of this research. Additionally, I present the scope of this research as well as the delimitations and limitations. Finally, the significance of this study is presented.

Background

The literature on this subject matter is centered around the general and conventional coping styles implemented by caregivers to cope with the psychological stressors that they encounter while providing care to a loved one. The literature has addressed issues associated with providing care for a family member, Haitian American substance abuse and health-related beliefs, and the use of spirituality or religion (S/R) as a coping strategy in substance abuse; however, researchers have not explored the coping styles available to and implemented by caregivers in the Haitian and Haitian American population with regard to caregiver coping styles while caring for a loved one battling substance abuse. Scholar practitioners remain unclear as to how the Haitian and Haitian American populations cope with psychological stressors, particularly the stressors of providing care to a loved one battling substance abuse (Dieujuste, 2016; Khoury et al., 2012).

The literature foundation for this study centered on articles related to issues associated with providing care for a family member, Haitian Americans' cultural beliefs regarding mental health issues, caregivers' coping strategies, and the use of S/R as a coping strategy. Exploring coping styles prevalent within the Haitian and Haitian American cultures may enrich the discussion and knowledge of caregiving and coping styles. Furthermore, this study may inform the academic and applied practice sectors by providing insight on this population's coping strategies.

Problem Statement

Substance abuse is a problem that impacts the Haitian American community (Marcellin et al., 2005). Immigration issues, acculturation, and identity processes are risk factors identified in the development of substance abuse among Haitian American youth (Marcellin et al., 2005). Although the problem of substance abuse in the Haitian American population has been identified (Douyon et al., 2005; Marcellin et al., 2005), little research has been conducted on the caregivers of Haitian American individuals who suffer from substance abuse.

Providing care for a family member battling substance abuse issues is associated with devastating consequences for the caregiver's physical, mental, emotional, and socioeconomic well-being (Mannelli, 2013). Individuals battling substance abuse illnesses negatively impact their family members' quality of life, financial security, mental health wellness, social life, and levels of functioning (Mannelli, 2013). This is because, while attending to an ailing loved one, caregivers must also contend with maintaining their quality of life, time, resources, and energy (Dodge & Kiecolt-Glaser, 2018; Griva et al., 2016; Shapiro et al., 2007).

Although caring for an individual battling substance abuse may cause a myriad of issues for the caregiver (Mannelli, 2013), the problem is compounded for the Haitian American population, a population with a severe mistrust of the medical sector. Haitian American caregivers of individuals battling substance abuse may be reticent to seek counseling or medical attention due to cultural beliefs (Khoury et al., 2012; Marcellin et al., 2005). Furthermore, the topic of mental illness is seldom discussed in the Haitian

American population due to fears of stigmatization, discrimination, and perceived humiliation inflicted on the ailing individual (Allen et al., 2013; Dieujuste, 2016; Goodman, 2005; Keys et al., 2015). The aforementioned factors contribute to the reluctance and reticence that Haitian Americans maintain with regard to seeking medical assistance. Further compounding the addressed concerns, issues due to language barriers, mistrust of the medical system, and difficulties navigating the mental health care system discourage individuals from this population from procuring medical services when needed (Allen et al., 2013).

Purpose of the Study

The purpose of this qualitative study was to explore how Haitian American caregivers experience the phenomenon of caring for a family member battling substance abuse and to understand how caregivers cope with this demanding task. Because Haitian Americans tend to favor S/R as a primary means of dealing with stressful situations (Khoury et al., 2012), I also address how Haitian American caregivers use religion and spirituality as a coping strategy.

The criteria for participation in the study were intended to accommodate the time period in which substance abuse for the target population began. During the 1980s, there was both an influx of Haitian immigrants and widespread use of cocaine in the Southeast of the United States (Mohl, 1985; Rose, 1989), particularly in South Florida, where many Haitian Americans reside and where the sampled population was pulled from. Most Haitian Americans who were sampled for the study were either first generation (through birth or naturalization) or descendants of immigrants who migrated to the United States

during the late 20th century with varying cultural, religious, and spiritual beliefs, traditions, and influences. The various cultural, spiritual, and traditional beliefs are in large part due to diverse Haitian cultural history, in which many mores and civilizations had an influential impact on the Haitian culture (Hood, 2018). Thus, the Haitian culture is an amalgamation of European and African cultures and can credit its language, music, and religion to these cultures (Hood, 2018). One of the staples of the Haitian culture consists of religious/spiritual beliefs. Religious demographic data reflect that Haiti is a predominantly Christian country, with 80% ascribing to the Roman Catholic faith and 16% ascribing to Protestantism. The rest of the population that professes a religious belief consists of Hindus and Muslims (FACTfile, 2019). However, one would be remiss to neglect the fact that the practice of Voodoo exists in the Haitian culture. Most Haitians who indulge in Voodoo state that it is done in a syncretic or blended fashion with their core religious beliefs, and this will be further explored in later sections.

Research Questions

The research questions (RQs) and subquestion (SQ) for this study were the following:

RQ1: How do Haitian American caregivers describe the experience of caring for a family member battling substance abuse?

RQ2: How do Haitian American caregivers cope with caring for a family member battling substance abuse?

SQ1: How do Haitian American caregivers use S/R to deal and cope with a family member battling substance abuse?

Theoretical Framework

Carver et al.'s (1989) concepts of coping and Pargament's (1997) theory of religious and spiritual coping constituted the theoretical framework for this study. One of the leading components of both of these theories is psychological stress. *Psychological stress* is defined as a relationship between people and their environments in which people deem their environments to be demanding and challenging or exceeding their resources and potentially presenting risks that endanger their well-being (Lazarus & Folkman, 1984). This was a consideration as to the theories that I utilized for the study, as the participants in the current study were likely to have experienced psychological stress while witnessing their loved one battling substance abuse. Individuals who have experienced psychological stress may find that they have difficulty coping with their loved one's substance abuse.

Lazarus and Folkman (1984) defined *coping* as "constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (p. 141). In this definition, there are two general ways in which an individual might cope with psychological stress: problem-focused coping and/or emotion-focused coping (Lazarus & Folkman, 1984). *Problem-focused coping* is defined as utilizing problem-solving skills to manage a stressful situation by doing something to alter the source of the stress elicited (Carver et al., 1989). When considering this approach, Carver et al. (1989) postulated that problem-focused coping is comprised of the following facets: active coping, planning, suppression of competing activities, restraint coping, and seeking of instrumental social support.

Conversely, *emotion-focused coping* is defined as the endeavor to reduce or manage the emotional distress associated with a stressful situation (Carver et al., 1989). Carver et al. (1989) argued that this approach is chiefly composed of the following tenets: the individual's seeking of emotional social support, positive reinterpretation, acceptance, denial, turning to religion, focus on and venting of emotions, behavioral disengagement, and mental disengagement. This framework, which includes a broad range of coping strategies grouped into problem focused and emotion focused, is an appropriate scheme to understand the different ways in which Haitian American caregivers handle the stress of caring for a loved one battling substance abuse.

One of the coping strategies described in Carver et al.'s (1989) framework refers to turning to religion as a way of coping. Considering that the Haitian American population tends to cope with psychological stress via emotion-focused coping (Kudadjie-Gyamfi & Magai, 2008) and S/R coping (Khoury et al., 2012), Pargament's (1997) theory of religious and spiritual coping was also used as a theoretical framework in this study. Pargament acknowledged that people will often rely on religion when endeavoring to cope with stress for two reasons: its accessibility and its appeal. Pargament's theory of religious coping is based on the premise that an individual's chosen coping style is the one that is most accessible and feasible. In the Haitian culture, S/R are widely accessible and are used to bring forth healings and restoration. The practice of congregating and communing with individuals who have a shared experience enables someone to feel as though they are not alone in a moment of adversity. Thus, S/R

coping is an integral part of the human psyche and is a fundamental component of survival (Sampson & Laub, 2003).

Pargament's (1997) theory has been used in research to assess and explain people's proclivity to use religion and spirituality to cope with adversity. Pargament's theory puts forth that S/R methods are used as complementary alternatives to conventional medicinal practices (Galindo, 2016). Furthermore, Pargament's theory indicates that religion and spirituality may assist people in making changes, including letting go of anger, overcoming bitterness, or becoming more forgiving (Pargament et al., 2000). As caregivers need to adjust to the overwhelming task of caring for an individual battling substance abuse, the use of religious and/or spiritual methods and interventions, especially when already native to their cultural practices, may assist in making the needed adjustments for their balance. Given the context and central aim of this study, Carver et al.'s (1989) concepts of coping and Pargament's theory were applicable to the study and were used to understand what coping strategies are used among Haitian American caregivers and how they processed the initial stress of having a family member battling substance abuse.

Nature of the Study

The interpretative phenomenological approach (IPA) was the research design utilized in this study (Smith et al., 2009). The use of the phenomenological approach allows a researcher to examine the personal lived experiences of an individual to explore the possibility of shared meaning across individuals. For the intent of this research, the core phenomena examined were the coping strategies and the experiences of caregiving

among Haitian American caregivers who care for a loved one battling substance abuse. Previous research on the path of a caregiver indicated that being a caregiver is associated with high psychological stress (Belizaire & Fuertes, 2011). Kudadjie-Gyamfi and Magai (2008) noted the Haitian and Haitian American populations tend to deal with and cope with psychological stress via emotion-focused coping, via religious and/or spiritual methods. Therefore, an exploration of how this population uses spirituality and religiosity to cope was also conducted. As the study explored the lived experiences of the participants, IPA was the best and most appropriate approach to examine how Haitian American caregivers interpret their experiences.

Participants in the study were Haitian American caregivers of family members who had battled substance abuse and identified as (a) being naturalized or Haitian-born U.S. citizens; (b) having lived in the United States for a minimum of 15 years to ensure acculturation into American customs to demonstrate a level of experience in the endeavor to integrate the culture of origin with the new culture (Schwartz et al., 2010); (c) being adults 35 years or older; (d) having attained at least an eighth grade education to have a grasp of the study; (e) having a command of the English language; and (f) having cared for at least one loved one with a history of substance abuse in the last 10 years. A family caregiver is typically defined as a parent, husband, wife, partner, or sibling who attends to the personal needs of someone who is incapable of providing care to themselves (Pam, 2013); however, the study included those who provided care for members of their extended families (such as aunts, uncles, and cousins). The data for the study were collected via semistructured interviews. The information obtained from the narratives of

the participants was then analyzed using various qualitative means, as discussed in further detail within Chapter 3.

Operational Definitions

The following terms are operational definitions and were implemented throughout the scope of this research and dissertation. It is for this reason that I have included a list of terms and their definitions for the convenience of the reader. Please refer to the below-placed definitions.

Caregiver: A family caregiver is typically a parent, husband/wife/partner, or sibling who attends to the personal needs of someone who is incapable of providing care to themselves (Pam, 2013). In the context of this study, participants were family caregivers, including individuals of the extended family such as aunts, uncles, nieces, nephews, and cousins.

Coping: Coping refers to an individual's adaptation and change of their cognitions and behaviors in an endeavor to manage specific external and/or internal demands that may be deemed insurmountable to the individual (Lazarus & Folkman, 1984).

Haitians: Indigenous people from Haiti, the Caribbean Island that occupies two-thirds of Hispaniola. According to Jacobson (2004), the Dominican Republic occupied two thirds of the island until the Spaniards conceded one third of their occupation to the French following a colonial war. There are two languages spoken in Haiti: French and Creole, which became official in the 1990s. Creole, an amalgamation of the French, Spanish, and Dutch languages, is considered to be the chief dialect; however, Creole became recognized as a language with its own written grammar and linguistic syntaxes.

Haitian Americans: Individuals who either immigrated to the United States by way of emigration from Haiti or individuals who were born to Haitian parents and raised in the United States.

Hopelessness: Feelings involving despair, powerlessness, depression, and perceived ineptitude that may negatively impact one's self-image, competence, and ability to cope (Moreselli, 2017).

Religiosity: Religiosity is a comprehensive sociological term that refers to expressing one's involvement or interest in participation in an organized system of beliefs (adopted by a particular culture or sect) in which traditions are upheld and celebrated to inspire dedication and belief in a traditional and organized manner (Cornwall et al., 1986).

Self-efficacy: An individual's ability to face adversity by making sound decisions and taking proactive steps to enact change and yield effective results (Williams & Rhodes, 2016).

Social support: A collective support system that extends beyond the patient or client. Social support often encompasses family members, friends, colleagues, healthcare professionals, spiritual survivors, and social services that assist the patient or client in coping with medical and/or psychological adversities (Barrera, 1986).

Spirituality: Reber (1995) defined spirituality as a system of faith that provides an individual with inspiration, comfort, solace, and guidance. Spirituality refers to an individual's personal and intimate connection with their higher source. Pargament (1997) differentiated religiosity and spirituality by stating that spirituality is the "search for the

sacred." Two key terms in this definition are *sacred* and *search*. The term *sacred* is not limited to concepts of God and higher powers but is inclusive of other aspects of life that are believed to be manifestations of the divine or "imbued with divine-like qualities, such as transcendence, immanence, boundlessness and ultimacy. Beliefs, practices, experiences, relationships, motivations, art, nature, war—virtually any part of life, positive or negative, can be endowed with sacred status" (Hill et al., 2000). The term *search* refers to an ongoing journey that begins with the discovery of something sacred and is followed by an attempt to form a relationship with that which is revered as sacred. This pursuit can be done in traditional and nontraditional ways and is not contingent on a religious belief or devotion (Hill et al., 2000).

Substance abuse: A condition in which a person engages in the use of chemicals for which the rewarding effects provide a compelling incentive to repeatedly pursue the behavior despite detrimental consequences (Ball & Ross, 2012).

Syncretism: The blending of religions within the culture (Olmos & Paravisini-Gebert, 2011). Syncretism was essential to this study, as those who utilize religious and/or spiritual means to cope will inevitably be implementing a syncretic form of religious or spiritual traditions. Haitian culture is an amalgamation of both European and African cultures and can credit its language, music, and religion to these cultures (Hood, 2018).

Task-oriented coping: Coping mechanisms that occur when an individual does not face an issue but instead immerses themselves in activities unrelated to the phenomenon (Kariv & Heiman, 2005).

Task-oriented emotions: Emotions that are conveyed when an individual attempts to cope with personal concerns using emotions as opposed to facing the reality presented by the facts (Kariv, & Heiman, 2005).

Assumptions

For the conduct of this study, I assumed that the participants were honest and forthcoming about their experiences. Moreover, I assumed that the participants of the study possessed enough self-cognizance to accurately respond to the queries of the study. I also assumed that the participants were able to accurately recall the events and emotions surrounding the phenomenon during the interviewing process. Finally, I assumed that the participants of the study bore commonalities amongst themselves because of their shared experiences and culture. However, each participant is an individual in their own right and coped with the phenomenon in their own way, and although they may have had similar responses to how they responded to stress, each individual had their own subjective experience that did not completely mirror those of others.

Scope and Delimitations

In this study, I sought to examine how Haitian Americans implement religious and spiritual methods of coping when encountering traumatic stress attributed to a loved one's substance abuse. This focus was primarily chosen because it was anticipated to be time efficient and require a limited number of resources. The targeted sample encompassed any Haitian American over the age of 35 who had the experience of providing care to a loved one who had battled substance abuse. This age was set to accommodate the rise and continuation of substance abuse within this population in

America. I recruited from a local parish that provides religious and spiritual services to the Haitian American community and a local nonprofit organization that provides social assistance to the Haitian and the Haitian American communities, both in Miami, Florida, where I reside. In the case that I needed additional participants, I planned to implement snowball sampling, where interested parties would inform their networking circle of the opportunity to participate in the study. I expected to recruit 10–12 participants for this study. I anticipated the data collection process to last 2 months; however, due to unforeseeable personal circumstances, the data collection process took a total of 6 months to complete.

In order to ensure transferability of this study, careful documentation of participants' context, coding of data interviews, analyses, and documentation of themes were done to demonstrate enough depth, breadth, and detail in the data description (Lincoln & Guba, 1985; Shenton, 2004). The sample size for this research was carefully chosen, and data collection focused on contextually based, deep, and rich individual descriptions. This thick contextual description allowed for the comparison to other contexts and similar populations.

Limitations

A limitation that also served as a strength for this study was that I have an "insider's perspective," being that I am Haitian American and know the customs and traditions of the culture. While this may be perceived as a strength because of my intimate knowledge and access to the population, it was a potential limitation as my insider and intimate knowledge could have increased the risk of researcher bias and put at

risk the credibility and dependability of the data collection, analysis, and interpretation. To ensure that this potential limitation was addressed, I implemented procedures that guaranteed the trustworthiness of my study, such as actively journaling my experiences, taking detailed notes during my review of the interview transcripts, keeping awareness of my biases and reactions, writing memos throughout the data collection and analysis processes, and maintaining constant communication with my committee to ensure that personal biases did not interfere in the data analysis process (Lincoln & Guba, 1985; Shenton, 2004).

Significance of the Study

Research has shown that members of the Haitian American community are reticent to receive psychological assistance, which is further compounded when substance abuse is added into the equation (Carson et al., 2010; Nicolas et al., 2009). This research study described the experiences of providing care to a loved one battling substance abuse within the Haitian American community and the methods that individuals utilize to cope with the psychological stressors of being a caregiver to a loved one battling substance abuse. Understanding the manner in which this population copes with psychological stressors assists in filling the current gap in the literature and advances the ongoing discussion in the mental health field.

The potential contributions of this study may also lead to better training dealing with cultural sensitivities, education, and interventive and preventive programs to assist this population. Due to the significant presence of Haitian Americans in South Florida and abroad, this study may provide the community and practitioners with information

that will cultivate practices able to service this population, thereby enacting social change within this community. Knowing how this population copes with adversity and knowing the reticence and apprehension present with this population provide practitioners with the necessary historical context for the issue to enact positive change. This knowledge may lead to a discussion that will eventually lead to practitioners overcoming these barriers and being able to service this population. By having a better understanding as to how spirituality and religiosity are implemented within this community, practitioners will be able to integrate conventional means of therapy and better serve this population as the demand for psychological services is dire for these families.

Insights garnered from this study will raise awareness for practitioners in understanding the needs and apprehensions of this community. Moreover, this study will assist practitioners in integrating this population's cultural beliefs into clinical therapeutic practices to assist them in coping. Because of the stigmas surrounding substance abuse within the Haitian American community, most are reticent to seek out therapeutic assistance. However, understanding and supporting the manner in which they cope with this phenomenon will begin to bridge the gap and eradicate harmful stigmas present in society. It was my ultimate hope that, through the dissemination of this research effort, the scholarly community may garner a more profound understanding of religious and spiritual coping so that it may be integrated into conventional therapy to serve this population better. This integration may lead to more engagement within the community and piqued interest into partaking in traditional therapeutic options.

Garnering a comprehensive idea regarding how the Haitian American community implements spirituality and religiosity via their various means of spiritual and religious engagement to facilitate healing within the substance abuse arena will begin to fill the gaps present within the literature regarding cultural uses of religion and spirituality. One of the main means of implementing religiosity and spirituality for this population is through the use of music. As research has indicated, music, spirituality, and religiosity have long been pillars of this community and have been used to celebrate, commiserate, and heal many aspects of people's lives (Pierre et al., 2017). Thus, understanding the manner in which this community implements such integral components of its culture will provide a basis to understand how this culture utilizes music, spirituality, and religiosity to bring healing and restoration.

Substance abuse creates financial, mental, and physical distress for individuals and their families (Terry, 2018). Family caregivers of substance abusers are negatively affected in their quality of life and may be at risk of developing mental health problems (Dodge & Kiecolt-Glaser, 2018; Mannelli, 2013). Caregivers' inability to cope can result in anger, depression, and anxiety, causing guilt and embarrassment (McCann & Lubman, 2018). Understanding how Haitian caregivers of people with substance use disorders cope with the demands of caring can provide an understanding of how they manage these stressors.

Recognizing, describing, and explaining the strategies of coping that Haitian caregivers use have the potential to assist counselors, church leaders, and Haitian caregivers of loved ones battling substance abuse. Because Haitians tend to mistrust the

mainstream health system (Allen et al., 2013) and tend to use folk healing or religion when confronted with mental health issues (Khoury et al., 2012), the results yielded from this study have the potential to inform counselors and mental health workers on how to address this population's beliefs.

Implications for Social Change

Through this study, I intended to produce a work that would augment the extant literature available to mental health providers about culturally relevant patient support and immediate and extended care for those indirectly suffering the effects of substance use disorder. Moreover, this study addressed supplementary and alternative healing practices that could be incorporated into the standard modalities of care for this population. It is hoped that the results of this study can provide guidance to providers via additional avenues to assist their clients in cultivating and fostering successful coping styles. The results from this study may improve the quality of care provided to clients which will, in turn, improve the quality of life for clients by empowering the clientele of this community and providing practitioners with a baseline in understanding the culturally relevant methods implemented by this population to combat psychological and emotional stress. Thus, this study yielded options that may benefit the mental health care field and clientele, thereby creating positive social change for future generations.

Summary and Transition

Substance abuse is a debilitating issue that affects not only people battling substance abuse, but also the family and friends of substance abusers. It makes incredible demands on all parties involved psychologically and emotionally and causes all subjected

parties to make daily adjustments in order to cope with the devastation associated with substance abuse. Through this dissertation, I ventured to explore the religious and spiritual methods employed by the loved ones of individuals battling substance abuse to cope with the stress incurred from their loved one's substance abuse. Chapter 2 surveys the literature surrounding substance use and abuse, its effects on surrounding support systems, and the manner in which these support systems help people cope with loved ones' substance abuse using spirituality and/or religiosity. I present past studies on surrounding topics and briefly discuss the studies' findings. Moreover, Chapter 2 addresses pertinent theories that are later used to explain the results. The highlights of Chapter 2 are the discussions on the literature search strategy, past studies, theoretical foundations of the study, and prior studies that are relevant to this current research endeavor.

Chapter 2: Literature Review

Substance abuse has negatively impacted the Haitian American community in the United States for decades (Marcelin et al., 2005). Acculturation and acclimation are risks that contribute to the use of controlled and uncontrolled substances among Haitian American youth (Marcellin et al., 2005). Although the issue of substance use within the Haitian American population is acknowledged in literature (Douyon et al., 2005; Marcellin et al., 2005), there has been less substantive research conducted to explore the manner in which substance abuse impacts the families and loved ones of people battling substance abuse within the Haitian American population.

The role of a caregiver can often have devastating effects on the individual's physical, emotional, mental, and socioeconomic well-being (Mannelli, 2013). One neglected population not explored within the study conducted by Mannelli (2013) consists of the caregivers of people who battle substance abuse. Substance abuse gravely impacts caregivers' quality of life, financial security, mental health wellness, social life, and various levels of functioning (Mannelli, 2013). These caregivers work to maintain quality of life while expending time, resources, and energy on their caregiving duties (Dodge & Kiecolt-Glaser, 2018; Griva et al., 2016; Shapiro et al., 2007).

The task of providing care for an individual battling substance use and abuse is a taxing vocation that requires psychological and emotional fitness garnered through efficient coping skills, often learned through therapeutic practices (Tanner et al., 2013). The problem of caregiving becomes further compounded for the Haitian American population because of the prevailing reticence to seek counseling or medical attention due

to cultural beliefs (Khoury et al., 2012; Marcellin et al., 2005). This reticence stems from the stigmatization placed around illness and disease and is further propagated because of existing barriers, mistrust of the medical system, and difficulties navigating the health care system (Allen et al., 2013).

Thus, in Chapter 2, I present the literature search strategy implemented to explore the current literature surrounding coping, caregiving, substance use disorder, and the Haitian American community. I provide an explanation of the search strategy and the theoretical framework that I used as the theoretical foundation for this study. I also provide a general overview of the following topics: perceptions of mental health in the Haitian and Haitian American communities, Haitian American substance abuse in the United States, Haitian American means of coping, the role of spiritual and religious practices in Haitian culture, the role of a caregiver, and the effects of substance abuse on the loved ones and families of substance abusers. Finally, I conclude the chapter by highlighting the gaps in the literature and reaffirming the need for further research to be conducted in this subject area.

Literature Search Strategy

I conducted the literature search for this study at Walden University's online library databases. I used the following databases during the literature search: PsycInfo, PsycARTICLES, PsycNet, Psychology: A SAGE Full Text-Collection, Psychiatry Online, EBSCOHost, and SocINDEX. I also used Google Scholar to search for pertinent articles otherwise not identified in the listed databases.

I used the following keywords: *Haitian*, *Haitian American*, *spiritual psychology*, *transpersonal psychology*, *holistic psychology*, *religious psychology*, *spirituality*, *religion*, *coping*, *forgiveness*, *substance use*, *substance abuse*, *family therapy*, *continual therapy*, *spiritual mechanisms*, *spiritual coping methods*, *spiritual well-being*, and *psychological well-being*. I explored the following topics in the literature review: (a) mental health and Haitians/Haitian Americans, (b) Haitian American caregivers' cultural beliefs around mental health issues, (c) the role of religiosity and spirituality in the Haitian American culture, (d) issues associated with providing care for a family member, (e) issues associated with being a caregiver, (f) caregivers' coping strategies, (g) the use of spirituality and religion as a coping strategy in substance abuse, and (h) the effects of substance abuse on loved ones.

I used only English language resources for the literature search. Articles no more than 7 years old made up the majority of the articles chosen in the review, with the exception of influential research studies related to Haitian and Haitian American experiences and the manner in which these populations heal ailments. While conducting this search, I discovered documented instances of the reticence to obtain mental health treatment within the culture, which compelled me to delve deeper into the literature. This further exploration led me to articles that addressed the implementation of holistic and all-natural means within the culture to heal physical and mental ailments, which are further discussed.

Theoretical Framework

Carver et al.'s (1989) concepts of coping and Pargament's (1997) theory of religious coping constituted the theoretical basis for this study. Lazarus and Folkman (1984) defined coping as "constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (p. 141). One theory directly applicable to this concept and this study is Pargament's theory of religious coping. Pargament stated that the use of religion allows an individual to successfully process a traumatic event and cope with the consequences of said event. In conjunction with Pargament's theory of religious and spiritual coping, Carver et al.'s concepts of coping pertain to the various coping strategies beyond religion that Haitian Americans use to overcome the challenges of caring for a loved one battling substance abuse.

Religious Coping

As previously mentioned, the aim of this research endeavor was to explore the manner in which members of the Haitian American population cope with a loved one's substance abuse. One of the facets of coping is gaining the ability to forgive. The notion of relying on religion when facing adversity is widely accepted within Western societies. More notably, this phenomenon has been cited as bearing a positive relationship between religious coping and forgiveness when facing a trauma (Prati & N Pietrantoni, 2009).

Pargament (1997) acknowledged that people will often rely on religion when endeavoring to cope with stress for two reasons: its accessibility and its appeal. Thus, Pargament's theory of religious coping is based on the premise that an individual's

chosen coping style is the one that is most accessible and feasible. The assessment speaks to the manner to which religion, as a system, has permeated and dominated Western cultures. Pargament's theory of religious coping also speaks to the extent to which religion has become significant in how one perceives the world and their ability to cope with the realities of this world. Religion provides people with a viable solution in that it facilitates the opportunity for people to orient themselves to their realities. This orientation provides two-fold relief in that it assists people in processing and coping with their traumas (Pargament, 1997). Thus, individuals who have implemented religion as a coping mechanism believe it to be the ultimate facilitator of coping and emotional healing (Pargament, 1997).

Spiritual Coping Within the Context of Religious Coping as It Applies to the Study

Within the concept of religious coping is the inherent implication of spiritual coping. For many cultures, such as the Haitian and Haitian American cultures, there is a clear separation between religious traditions and spiritual practices (Hill et al., 2000). Although Pargament did not make the clear distinction between religious and spiritual coping, I made a distinction between religious and spiritual coping for the purposes of this study as the participants made clear delineations between their senses of religiosity and spirituality. Sheridan (2004) offered a definition of religiosity and argued that while religiosity may be conceptualized as the manner in which an individual experiences a transcendent being, as influenced by their community, spirituality is an individual quest for "meaning, purpose, and connection with self, others, the universe, and ultimate reality, however one understands it, which may or may not be expressed through

religious forms or institutions" (p. 10). Therefore, the experience of spirituality may occur sans religious cultures, traditions, or practices.

A significant area of Pargament's (1997) theory of religious coping indicates that a person's method of coping is directly influenced by the convenience afforded by their orienting system. The same concept may be applied to spiritual coping. For instance, the practice of congregating and communing with individuals who have a shared experience enables someone to feel as though they are not alone in a moment of adversity. Thus, spiritual coping is an integral element of the human psyche and is a fundamental component of survival. Another notable part of Pargament's theory of religious coping indicates that an individual will employ religion as a means of coping and managing stress if it is an appealing and compelling method. Again, the same principle can be applied to spiritual coping if it helps the individual process the trauma or adversity that they are encountering.

Major Assumptions of Pargament's Theory of Religious Coping

There are seven defining assumptions or characteristics of religious and spiritual coping that are used to explore the variety present within the manner in which individuals implement and utilize religion to cope (Pargament & Raiya, 2007).

Religion Comes in Many Shapes and Sizes. One of the foundational tenets of the theory of religious coping is the acknowledgment of the variety of religious beliefs and cultures. For a considerable period of time, religion was regarded by medical professionals in a negative light and was considered by mental health professionals to be an avoidant coping mechanism that was based in denial to buffer against anxiety

(Lindeman, 2011). While religious passivity and denial are noted in the literature (Lindeman, 2011), it is important to give credence to the use of active religious coping to assist in surmounting life's adversities. In fact, empirical studies suggest that when implemented in therapeutic settings, religious coping is more consistently linked to active rather than passive coping styles (Lindeman, 2011).

Religious Coping Does Not Operate in a Vacuum. The second foundational tenet of the theory of religious coping is in regard to the pervasiveness of religion in an individual's life. Religious coping is not a method that most are unaccustomed to implementing. People will tend to defer to religious solutions to issues from a generalized orienting system composed of well-established beliefs and paradigms, aspirations, and values. Thus, religious coping is often triggered by an individual attempting to cope with an adversity beyond their general scope of understanding.

Religious Coping Has Spiritual, Psychological, Social, and Physical Implications. The theory of religious coping is also used to explore the multidimensionality of religious interventions and methods to induce coping. The implementation of religious coping incorporates physiological and psychological components that lead to anxiety reduction, which may positively contribute to an individual's overall sense of self-control and self-efficacy. Further, the utilization of religious coping may cause an individual to explore their own sense of spirituality and their connection to the inner and higher self.

Religious Coping Can Be Both Helpful and Harmful. The fourth assumption of the theory of religious coping is used to explore the dualistic nature and potential

outcome present within the implementation of religious coping. The usage of religious coping can be either constructive or destructive, and it is the implementation of the user that determines its effectiveness or ineffectiveness. Because of its complex nature, explorations delving into the helpful and harmful ways to use religious coping should be examined in conjunction with the individual's needs, desires, aspirations, situations, and social context.

Religious Coping Is a Better Predictor of Outcomes Than More General Religious Orientation. The fifth assumption of the theory of religious coping is used to explore the implementation of religious coping rather than the religious orientation or affiliation of the individual utilizing religious coping. As a mechanism, religious coping is a concretized manifestation of a somewhat obscure concept during difficult and stressful situations. The use of religious coping allows the individual to work in a collaborative nature with their higher power to bring about a resolution to their adversity, under the benevolence of an omniscient and omnipotent benefactor.

To Study Religion, Multiple Research Methods and Tools Are Needed. The sixth assumption of the theory of religious coping is used to explore the complexities of studying religious coping. In order to develop a comprehensive perspective on religious coping, the implementation of diverse research methods and tools must be implemented by the researcher or practitioner. Further, in order to garner a sense of how religious coping is utilized, it is necessary to approach the data gathering stage in a qualitative-like fashion where interviews are conducted to know and understand how the participant's life and faith have impacted their ability to overcome their obstacles.

Religion Can Be More Fully Interwoven Into Efforts to Help People. The final assumption of the theory of religious coping is related to the implementation and inclusion of religious interventions into conventional forms of assistance. Oftentimes, clinicians will avoid the topic of religion within their professional relationships. However, by confronting their own discomfort surrounding religion, the clinician may be able to better assist the individual by utilizing the coping mechanism already implemented and comfortable for the client.

Prior Application of Pargament's Theory of Religious and Spiritual Coping

Research conducted within the last 20 years has shown a considerable marked interest in the manner in which individuals facing adversity utilize religious coping to manage the psychological stressors that accompany obstacles. Studies conducted by Pargament et al. (2000), Keefe et al. (2001), Tepper et al. (2001), and Pendlton et al. (2002) are instrumental in understanding the significance and value of religious coping and the manner in which it decreases physiological and psychological symptoms of stress, deepens one's sense of spirituality and interconnectedness, instills hope, and improves overall and holistic well-being. The implementation of religious coping demonstrates a marked improvement in the individual's quality of life by improving on the aforementioned arenas. The use of Pargament's theory of religious and spiritual coping serves as a guide to the manner to which religious coping assists and benefits varying populations who otherwise use this method as the chief and only means of coping with life's difficulties (Keefe et al., 2001; Pargament et al., 2000; Pendlton et al., 2002; Tepper et al., 2001).

Relevance of Pargament's Theory of Religious Coping to Current Research

Pargament's (1997) theory of religious coping was applicable to the study in that it was used to understand the manner in which religious coping influenced the participant's ability to cope with the psychological and emotional stressors of providing care to their loved one who was battling substance abuse. The list of interview questions had sections dedicated to the exploration of the following categories: (a) exploring the hardship and adversity the participants faced consequent to their loved one's substance abuse, (b) the manner to which the participants processed the psychological and/or emotional stress they experienced during this time, (c) the degrees of stress experienced and (d) the manner to which religion and/or spirituality assisted in mitigating stress and facilitating the participants' ability to cope. The means to which religious coping was measured was church attendance and support, prayer life, the reading of religious materials and counsel from religious leaders. As evidenced by Pargament's (1997) theory of religious coping, the aforesaid activities can be regarded as religious facilitators for coping and forgiveness, which has been linked to overall wellness.

Pargament's theory of spiritual coping was applicable to the study in that it was used to assess the extent to which spiritual coping was a direct contributor to forgiveness and the individual's resilience. As noted, the list of interview questions explored the manner to which the participants processed and coped with the psychological and emotional stress of providing care to a loved one battling substance abuse. However, for the purposes of this study and the applicability of this theory, Pargament's theory of spiritual coping was utilized to explore the implemented methods of coping from a

focused spiritual perspective. The means of spiritual coping were meditation, prayer, chanting, and music. Based on Pargament's theory of spiritual coping, the aforesaid activities can be regarded as facilitators for coping and can lead to mitigation of the effects of psychological stress.

Carver et al.'s Concepts of Coping

Carver et al. (1989) theory of concepts of coping has its foundation in the definition of coping offered by Lazarus and Folkman (1984). Lazarus and Folkman (1984) define coping as a conglomerated variety of cognitive and behavioral interventions that individuals implement to manage psychological stress. Folkman and Lazarus (1980, 1985) compartmentalized the idea of coping by distinguishing between two major coping styles: problem-focused and emotion-focused. As previously mentioned, problem-focused coping refers to an individual's ability to solve a stressful situation by doing something to alter the source of the stress elicited (Carver et al., 1989). Carver et al. stated that problem-focused coping is comprised of the following distinct facets: active coping, planning, suppression of competing activities, restraint coping and seeking social support for instrumental reasons. Conversely, emotion-focused coping is regarded as the endeavor to reduce or manage the emotional distress associated with a stressful situation (Carver et al., 1989). Carver et al. maintained that this approach is chiefly comprised of the following tenants: behavioral disengagement, mental disengagement, positive reinterpretation, denial, acceptance, turning to religion and focus on and venting of emotions. Carver et al. noted the significance of these two coping-style dimensions. Using these dimensions and the distinctions that Carver et al. made with

regards to coping, they were able to devise the COPE inventory. The COPE inventory is an assessment tool that measures the associations with approach and avoidance motives and positive and negative traits. It incorporates several tenets that assess and evaluate the most used and understood concepts of coping.

Major Tenets of Carver et al.'s Concepts of Coping

There are eleven defining tenets attributed to coping that include active coping, planning, suppression of competing activities, restraint coping, seeking social support for instrumental reasons, behavioral disengagement, mental disengagement, positive reinterpretation and growth, denial, and acceptance.

Problem-Focused Coping Styles.

Active Coping. Active coping is defined as the process of taking and making active and deliberate steps towards trying to remove or evade the stressor, or an attempt to mitigate its effects. Active coping incorporates the initiation of direct action, the increase of one's efforts and the attempt to execute a coping mechanism in a progressive fashion.

Planning. Planning is regarded as the individual's use of strategy to devise ways to cope with stressors. Planning involves formulating action strategies and considering different approaches to best handle a situation.

Suppression of Competing Activities. Suppression of competing activities refers to the manner to which an individual will compartmentalize and prioritize the issue by evading any involvement in competing activities or suppressing the processing of

competing channels of data. This method is generally used when an individual's predominant occupation is on the present challenge or threat.

Restraint Coping. Restraint coping is an active coping mechanism that refers to one's ability to delay action until an appropriate opportunity to act is presented. The act of self-restraint can be considered to be both an active and passive strategy in that the individual is actively focusing their behavior and intention on effectively managing the stressor while passively exercising restraint until the proper opportunity for resolution presents itself.

Seeking Social Support for Instrumental Reasons. Seeking social support for instrumental reasons refers to actively seeking advice or assistance. Seeking social support for emotional reasons entails receiving moral support, sympathy and understanding from an outside party. Because of its proactive nature and emotional undertone, seeking social support can be regarded as both a problem-focused and emotion-focused style of coping. However, Carver et al. (1989) caution that the implementation of this method can be perceived in either a positive or negative persuasion, contingent on the manner to which an individual implements the use of social support. If this method is implemented for the means of developing a co-dependent relationship, it could be to the detriment of the individual utilizing this coping mechanism. However, utilized for the purpose of collaboratively combating an issue, social support, as a means of coping, can reassure an individual who was otherwise insecure or intimidated by the stressful event.

Emotion-Focused Coping Styles.

Behavioral Disengagement. Behavioral disengagement, which likens itself to hopelessness, refers to an individual's attempt to reduce effort expended on dealing with a stressor, even to the point of relinquishing their aspirations to attain goals that the stressor may have interfered with.

Mental Disengagement. Mental disengagement can be seen in an array of differing activities that an individual will engage in to distract from thinking of a goal set to which the presenting stressor is interfering with. The most notable associated tactics with mental disengagement include engaging in alternative activities to distract from the presenting issue, daydreaming, and escapist tactics, achieved usually through sleep and media immersion.

Positive Reinterpretation and Growth. Lazarus and Folkman (1984) regarded this concept as an emotion-focused coping style that is aimed at managing the distressful emotions rather than directly dealing with the presenting stressor.

Denial. The concept of denial has been discussed and postulated upon for decades. While some researchers argue that denial may be useful due to its ability to minimize distress thereby facilitating coping (Breznitz, 1983; E Cohen & Lazarus, 1973; Wilson, 1981), contrasting opinions maintain that denial only contributes to the presenting issues unless the stressor could be profitably ignored. That is, the denial of the reality of an event only facilitates the further gravity of the event, thereby making the inevitable coping process more difficult (Matthews et al., 1983). A third perspective held by other researchers is that denial may be useful in the early stages of a stressful

situation; however, the continual usage of denial may impede on one's ability to cope with the phenomena later in the process (Levine et al., 1987; Mullen & Suls, 1982; Suls & Fletcher, 1985 as cited in Carver et al., 1985).

Acceptance. Acceptance is considered as a relatively functional coping response in that the individual faced with a stressor accepts the reality of the stressful event and is engaged in any endeavor to deal with the situation. The concept of acceptance serves a dual purpose in the coping process. The first purpose is the acceptance of the stressor, which generally occurs in primary appraisal. The second purpose is the acceptance of the absence of active coping skills, which occurs in secondary appraisal.

Turning to Religion. Turning to religion refers to the manner to which an individual will defer to religion or religious resources when facing stress for an array of reasons that include but are not limited to: religion serving as an emotional support, religion serving as a conduit for positive reinterpretation and growth, or religion being used as an active coping mechanism to combat a stressor.

Focus on and Venting of Emotions. Focusing on and venting of emotions refers to an individual's ability to ventilate and verbalize their emotions during a distressful or upsetting period. This method of coping may be advantageous in difficult situations, such as the loss of a loved one.

Prior Application of Carver et al.'s Concepts of Coping

The theory of the concepts of coping is founded on the premise that there exists a variety of methods one can incorporate to manage and handle psychological, emotional and physiological stress. Research conducted examining the concepts of coping within

the past 25 years has explored how coping strategies have been implemented in a variety of arenas to influence and optimize self-efficacy regardless of the adversity one faces. Studies conducted by Riolli and Savicki (2010) and Gudjonsson and Sigurdsson (2003) are instrumental in garnering a sense for the varying coping styles implemented by diverse demographics within varying contexts. In their study, Riolli and Savicki (2010) cited the effectiveness of different coping strategies and the impact of coping diversity among soldiers engaged in the Iraqi and Iranian wars. Through the conducted study, Riolli and Savicki (2010) found that positive reinterpretation, emotional social support, and humor were most strongly correlated to lower psychological symptoms, whereas venting emotions, denial, mental disengagement, behavioral disengagement, and alcohol and drug use were correlated to higher levels of psychological symptoms. In the second study, Gudjonsson and Sigurdsson (2003) found that low self-esteem and denial coping were the best predictors to the levels of compliance present in men and women through the usage of the COPE scale. The study cited significant variances on all three scales with women demonstrating lower levels of self-esteem than their male counterparts, being more compliant and implementing different coping strategies when faced with stressful situations. Both of the presented studies cited the significance of how garnering an understanding as to how the concepts of coping are implemented across varying demographics serves as a guide to understanding how coping is conceptualized globally and implemented to assist with the psychological stress brought on by trauma and hardship.

Relevance of Carver et al.'s Concepts of Coping to Current Research

Carver et al.'s (1989) concepts of coping are applicable to the study in that they were used to examine the different methods this population uses to cope. Caregivers need to adjust to the overwhelming task of caring for a family member battling substance abuse; and making these changes are necessary for their balance. This theory was applicable to the study as it was used to gain a better understanding of the coping strategies used among Haitian American, how they process the initial stress of caring for a family member battling substance abuse, and what they do to mitigate stress and facilitate coping.

Literature Review Related to Key Concepts

The previous section explored the theories of religious and spiritual coping (Pargament, 1997) and the theory of the concepts of coping (Carver et al., 1989). In addition to the aforementioned theories, the following topics were discussed and synthesized to provide a foundational basis for this research endeavor: (a) mental health issues associated with the Haitian American population, (b) Haitian American substance abuse in the United States, (c) the role of the caregiver, (d) issues associated with providing care for a family member, (e) effects of substance abuse on loved one and (f) the use of spirituality and religiosity as a coping strategy for substance abuse.

Mental Health Problems Among Haitian Americans

Although scarce, there have been a number of articles that speak to how mental health is perceived within the Haitian American community. Those who identify as Haitian American belong to a unique category in that they are often struggling to

maintain the traditions of their ancestral roots while trying to acclimate into the perceptions, customs, and traditions of their host country's culture (Douyon et al., 2005). To highlight the perceptions of behavioral health issues, Douyon et al. (2005) explored the concept of acclimation and assimilation in the context of mental health perceptions in amongst Haitian Americans. Through their study, Douyon and colleagues (2005) sought to characterize the behaviors exhibited by Haitian American youths that have been deemed undesirable by Haitian parents to determine the relationship between traumatic experiences with the behaviors exhibited in the troubled population. The mixed methods study cited data from 292 Haitian youths in Miami-Dade County, Florida, USA by exploring how trauma has negatively affected the sampled population. Douyon et al. found that traumatic experiences did not bear a direct correlation to the mental health outcomes among children. Further, Douyon et al. found childhood victimization among Haitian children does not appear to be directly related to undesirable behaviors associated with unsupervised youths.

With regards to the importance of making mental health programs accessible to Haitian and Haitian American communities, Jean-Louis et al. (2000) examined the receptiveness to engage in a community-based agency providing psycho-educational counseling to Haitian immigrants living with HIV/AIDS in Boston, Massachusetts. The qualitative study cited data from 67 Haitian adults living with HIV/AIDS, with 28 females and 29 males ranging from the ages of 19 to 63 (Jean-Louis et al., 2012). With those who participated, Jean-Louis et al. found that the CCHER project implemented was able to identify complex mental health issues, such as substance use disorder issues, that

allowed the agency to address said issues among Haitians and plan culturally appropriate educational, outreach, and counseling strategies for Haitian substance use disorders and community members.

To further the advancement of Jean-Louis et al. (2000) and explore the mental health issues with the Haitian and Haitian American communities, Fawzi et al. (2009) conducted a quantitative study that cited the prevalence of depression and PTSD among Haitian immigrant students and examined the factors associated with depression and PTSD to identify potential areas of intervention that may enhance psychosocial health outcomes among immigrant youth from Haiti in the United States. The data for this study was extracted from 168 Haitian immigrant youths after stratified random sampling had been conducted on a student population in Boston, MA. Utilizing general descriptive statistics, bivariate analyses, chi-square statistics and multivariate logistic regression, Fawzi et al. (2008) found that significant levels of PTSD and depression were present within the population. The depression and PTSD experienced from the population was attributed to the stressors associated to immigration and concerns for safety. The authors suggested that reducing such stressors and enhancing access to social support and appropriate mental health services may improve educational attainment and psychosocial health outcomes in the Haitian youths.

Further examining mental health in the Haitian and Haitian American communities Nicolas et al. (2007) examined clinical depression as presented in Haitian immigrant women living in the United States. Specifically, this paper cited three distinctive types of depression and explained the symptomologies by providing case

examples. Data for this longitudinal study was extracted over a period of 7 years from 55 Haitian immigrant women living in the United States. Nicolas et al. found that depression among Haitian women often takes on varying forms and the expression and depictions of depression vary from their Western counterparts. Because of their varying perspectives, Haitians' experience, describe, and present with depression differently than how Eurocentric cultures conceptualize it. Within the Haitian culture, maladies have been historically thought to be the production of and punishment from deities (Jacobson, 2004). Thus, the manner to which illnesses, including mental health issues, are approached, conceptualized, and managed vary and have cultural and spiritual components (Jacobson, 2004). It is for this reason that, as Nicolas et al. noted, clinicians and researchers put forth an earnest effort to understand the culture and the conceptualization of mental illness from Haitians' perspective to identify and implement effective treatments.

The final study considered to provide a literary foundation for this dissertation was a quantitative study conducted by Allen et al. (2012) that examined the associations between indicators of familial and social connectedness as they related to generalized anxiety disorder, depression and physical and mental health for Haitian American and non-Haitian Americans living in Miami during the 2010 Earthquake in Haiti. Data for this study was extracted via survey questionnaires administered to adults attending continuing education classes at Barry University in Miami Shores, FL. The sample size for the study was 114 participants, of whom: persons (42 Haitians and 1 non-Haitian) who had family or friends in Haiti during the earthquake and 71 persons (1 Haitian and

70 non-Haitians) reporting having no family or friends in Haiti on that date. Utilizing univariate descriptive statistics, bivariate associations, ANOVA, Likert-type scales and conducting assessments that screened for Generalized Anxiety Disorder, Major Depressive Disorder, physical and mental ailments, the researchers found that familial and social connectedness during the earthquake impacted and elicited empathetic responses from Haitian American survey participants. Social connectedness among expatriates is a constant in the Haitian community. The diaspora still maintains a strong sense of social ties and are a source of support to Haitians living in Haiti and the psychological stressors transcend distance and time.

In sum, this section highlighted mental health issues as they are experienced by Haitian Americans. The featured authors of this section provided a synopsis on how mental health is perceived by Haitian and Haitian Americans as well as the current findings in research that demonstrate assimilation and acculturation factors contribute to mental health concerns within the community. The authors featured also provided research demonstrating the importance of integrating an understanding of how the community perceives illness into treatment modalities to encourage participation and cohesion between the community and health care providers.

The Perception of Mental Health in the Haitian and Haitian American Communities

The pervasive stigma of mental health within the Haitian and Haitian American community has contributed to the reticence experienced within this community towards seeking professional and medical assistance when needed (Jacobson, 2004). A notable instance to which attention was brought to Haitian and Haitian American mental health

occurred during the 2010 Earthquake in Haiti. On January 12, 2010, an earthquake claimed a total of more than 300,000 lives (Bilham, 2010). This catastrophic event elicited professionals and laypersons alike to aid the impoverished country (Bilham, 2010). However, the reticence present within this population made offering assistance, even in dire straits, an insurmountable task. Studies such as the two mentioned and presented, cited examinations of the perceptions, attitudes, and stigmas surrounding mental health and professional intervention (Bilham, 2010).

Research efforts, such as the ones conducted by Wagenaar et al. (2012) and Kaiser et al. (2014) offer insight into how the Haitian and the Haitian American communities perceive mental health. Wagenaar et al. examined attitudes surrounding depression and suicidal ideations in the wake of the 2010 Earthquake. Wagenaar et al., extracted data from 408 adult participants in Haiti's central plateau. Results of this study indicated that a large population of Haitian's suffered with suicidal ideations that were strongly linked to alcohol usage, visitations to a Voodoo priest and lacking healthcare if ill. Further, Wagenaar et al. found that these participants refused psychological assistance due to their distrust in the systems. Similarly, Kaiser et al. conducted a mixed methods study in which they sought to examine the psychological implications associated with overthinking in the Haitian population and the rumination of ideas associated with vast overthinking. The qualitative portion of the study was extracted from 31 participants who were asked to speak on the depression and anxiety they were experiencing as a result of the 2010 earthquake, while the quantitative component of the study cited its data from 405 participants who were administered the Beck Depression Inventory and the Beck

Anxiety Inventory surveys. Utilizing the ethnographic methodology and the implementation of semi-structured interviews coupled with the assessments administered, Kaiser et al. found that overthinking can cause one to isolate themselves, which may result in material deprivation and is closely linked to failure to achieve one's goals and cause a lack of productivity. When it persists for extended periods of time, overthinking may lead to psychosis. Kaiser et al. also found that familial and communal support may alleviate the symptoms; however, there are enduring social and structural inequalities that lie at the root of the syndrome and that are more difficult to address.

Dieujuste (2016) further explored the plight of caregiving within the Haitian American community by reporting an analysis of the concept of the stigma of mental illness within the Haitian American community. Data were extracted from electronic databases and manual searches of scientific journals. The method used for this concept analysis was useful in clarifying the meaning of the stigma of mental illness and examining its attributes and characteristics. The goal of this concept analysis was to increase understanding of the stigmas of mental illness and provide nurses with information about how these stigmas may be manifested in Haitian American patients. Dieujuste found that the Haitian population attributes physical ailments to spiritual maladies and suggested that this cultural belief contributes to the reticence within the community.

To further corroborate the aforementioned studies, research efforts by Vornax (2007, 2011) provide insight as to how this population implements their cultural and religious beliefs to heal mental maladies. Vornax conducted a study in 2007 that focused

on primarily gathering perceptions of the Haitian people on illness and examining the dominant attitudes in Haiti surrounding voodoo and illness. Data for this article were extracted from two anthropological perspectives that analyzed illness in Haiti. A systematic review was conducted on the prevalent perceptions of illness within the Haitian culture. Vornax argued that garnering a more comprehensive understanding of the nature of the perceptions of illnesses will assist in deconstructing the stigmas applied to this culture with regards to treating illnesses. In conclusion, Vornax argued that professionals must take on a comprehensive micro- and macro-social lens when attempting to assist this population as both concepts provide meaning to the understanding of how illness is perceived and the complexity of the phenomenon in Haiti.

In a consequent study, Vornax (2011) furthered the previously conducted study by examining the manner to which voodoo was perceived and revered by the Haitian people. Through a qualitative study, data was provided by Haitian professionals (voodoo practitioners, therapists, and church officials) from 21 voodoo practitioners and 20 therapists and church officials. Vornax found that voodoo is perceived to be the over-arching healthcare system for Haitians living in rural areas for four main reasons. First, voodoo is an organized, coherent system that is socially and culturally embedded in a given society. Second, it is made up of (a) practitioners recognized as healers and consulted as such; (b) treatment sites where practitioners meet with the sick, treat them, and suggest ways of dealing with their problems; and (c) practices, techniques, protocols, and specialized knowledge that are learned and shared by healers and are used to foster health, treat disease, and prevent illness. Third, voodoo offers theories on illness, as a

health care system does. Fourth, it plans therapeutic, preventive, and care-giving practices in keeping with those theories. And finally, it suggests behavior for preventing illness. In summation, both of these articles have been presented because they provide context to the reverence bestowed upon the Voodoo culture and religion.

The Cultural Beliefs of Haitian American Caregivers Regarding Mental Health Issues

Several studies have explored the cultural beliefs surrounding providing care for someone battling a mental disorder. Khoury et al. (2012) discuss the plight of being a Haitian/ Haitian American caregiver. Khoury et al. conducted a mixed methods study in which they sought to examine the adversities associated with providing care to a relative with Alzheimer's disease or progressive dementias. Data were collected from 31 semi-structured interviews, 10 focus group discussions (FGDs) and four case studies. They found that the Haitian and Haitian American populations tend to seek out and implement alternative interventions, methods and approaches to combat mental health impediments, such as spirituality and religiosity.

Additionally, Firbank and Johnson-Lafleur (2007) conducted a study that sought to examine the attitudes surrounding caregiving and cohabitation for the elderly in the French Quebec and Haitian communities in Canada. Data were extracted from the French Quebec and Haitian population of the elderly (65 years and older) residing with an adult child for at least a year and the main child caregiver. Utilizing the interpretive descriptive qualitative method of inquiry, Firbank and Johnson-Lafleur found that cohabitation and

providing care for elderly and ailing parents within this culture was broadly normalized and considered to be necessary transitions for the elderly and adult children.

Both of the above-mentioned studies cited demonstrations that Haitians and the Haitian Diaspora value the implementation of holistic religious or spiritual means to combat illness. When confronted with medical or mental issues, the Haitian American population tends to resort to family, folk healers, and spirituality (Khoury et al., 2012). Religion and spirituality are linked to the use of music (Butler, 2002; Wilcken, 2005), which becomes a source of comfort and trust when health issues arise. This can again, be traced back to their ancestral roots and heritage in that the belief of any misfortune was brought on by a deity and was to be purged out or cleansed through certain rituals and traditions (Jacobson, 2004). Understanding the beliefs of this community and incorporating these beliefs into psychotherapeutic modalities will assist the community in pursuing assistance and care to combat mental health illnesses.

Discussion of the Targeted Population and Migratory Trends

During the 1970s and 1980s, the migration from Haiti came from the more rural areas where the socioeconomic status of the people was considerably lower than their counterparts in the urban areas of the island. It is in these areas where complementary means of medicinal wellness and medical systems were sought. Haitian migration within the past three decades has been comprised of individuals hailing from different socioeconomic strata who decided to settle in the metropolises of the United States. Although the Haitian immigration trend has been steady for the past twenty years, there was a particular influx of Haitians relocating to the United States during the early 1970s

into the 1980s. This migratory wave coincided with the cocaine era occurring in the metropolitan regions of the United States. This particular wave of immigrants were families seeking to provide a more optimistic future for their children, within the prepubescent and adolescent ages. Because of their lifestyles in Haiti, these families had limited educational opportunities afforded to them or "no primary school literacy or bilingualism" (Portes & Grosfoguel, 1994). Naturally, when the Haitians of this socioeconomic class emigrated to the United States, they maintained their impoverished situations. It is this poverty that lent itself to the vulnerabilities of assimilation and for the youth, the coercion to succumb to peer pressures (Bastien, 2005).

Those bearing the label of Haitian American carry a hybrid identity, particularly those who are first-generation Haitian Americans. On one hand, these Haitian Americans hold fast to their Haitian values and ideals that they were raised with. However, in an effort to assimilate to their new culture, most Haitian Americans will adopt the culture, behaviors and attitudes attributed to American culture to acquiesce into their new environment. The need to assimilate fostered the prevalence of substance use disorder within this community (Marcelin et al., 2005). However, through the previous trend of the Haitian youth immigrating to America, it has become increasingly apparent that education on the vulnerabilities and dangers of assimilation must take some precedence. If more resources were available to the diaspora youth of that time period, the need to engage in such risky and perilous behaviors may have been reduced and the stress induced on familial unit (both immediate and extended), as attributed to this phenomenon, may have been avoided.

Haitian Americans' Substance Abuse in the United States

Issues surrounding how to cope with mental health are already complex enough within this population. However, the issue becomes further compounded when substance abuse is introduced into the population. Unfortunately, the literature in this arena is considerably limited. Although I was only able to produce articles that discussed Haitian American substance abuse in the United States, I have insight and knowledge on the widespread usage within the community. However, because of the limited research conducted in this arena, there was a scarcity of resources from which to draw from.

Marcelin et al. (2005) conducted a study that sought to report on the prevalence of drug and cigarette use among a segment of the Haitian youth in the United States. This quantitative study cited from 296 participants in Miami-Dade, Florida, USA. Utilizing bivariate chi-square analyses, Marcelin et al. found that immigration, acculturation, and identity processes are considerable factors in determining and interpreting risk factors for substance abuse within the Haitian American youth. While the problem of substance abuse in the Haitian American population has been identified Marcelin et al. argue that little research has been conducted on the Haitian American substance abuse and their caregivers. Thus, the caregiver's psychological needs and concerns often go unmet within this community. The consequent sections examined the role and plight of a caregiver.

Haitian American Means of Coping

In order to gain an appreciation for the manner to which Haitians and Haitian Americans cope with mental illness, an exploration of the means of coping within this population were made. Upon surveying the literature, I was able to find a pertinent article

that spoke to the manner to which Haitians and Haitian Americans coped with mental illness and adversity. In their qualitative study, Logie et al. (2017) sought to explore the lived experiences and understanding of violence among internally displaced youth in Leogone, Haiti. Data for this study was extracted from six focus groups: 3 of which were comprised of internally displaced young women (N=30) and three internally displaced young men. Utilizing focus groups interviews and thematic analysis used to code data using inductive approaches (hope, family expectations for girls engage in sex work) and deductive approaches (intersection of gender, age and displacement), Logie et al. found that the violence experienced by the population was compounded by multi-levels of violence that included structural (poverty), community (gender norms) and interpersonal (family expectations) dimensions. Coping strategies included intrapersonal (hope), community (social support) and structural (employment/education) dimensions. The central theme and coping strategy found was the sense of hope in this population, inspired by their religious and/or spiritual beliefs. However, the reliance on religion and spirituality is not a foreign concept.

Studies such as those previously mentioned cite the importance of religiosity and spirituality within the Haitian and Haitian American cultures. Further, these studies demonstrate how religiosity and spirituality have been an integral part of human existence throughout the span of history. The influence of religion and spirituality far extends past the human consciousness and its concepts and virtues are immortalized in the fine and living arts, cultural governing, and the very manner to which one governs his life. Within the past century, these phenomena have been surveyed through the

perspective of the social sciences (Ai et al., 2005). Preliminary interests within the realm of psychology were sparked within scholars such as William James, G. Stanley Hall and George Coe (Galea et al., 2002). However, the true upsurge of interest in religion and spirituality occurred at the commencement of the 21st century (Galea et al., 2002). Before the discussion of the role of spirituality in the Haitian American culture can be examined, the term spirituality must be defined and distinguished from the concept of religion. As both the terms S/R are rather ambiguous, the manner to which they are defined will be done so in a manner pertaining to this research. The generally accepted understanding of religion typically revolves around a set of customs, traditions, practices, and rituals that pertain to and speak of a certain culture's belief of the sacred (Ai et al., 2005). It is in religion that individuals generally gather their morals and principles from, and it is religion that upholds the mystical laws to which one may govern himself accordingly. Such laws are instated to guide people's beliefs about life and the afterlife while providing guidelines for how people are to conduct themselves amongst others. The rigid structure of religion speaks of its roots deeply established in tradition and birthed from groups of people with communal practices and beliefs concerning the Unknown and sacred.

The following definitions have been collected by a series of scholars who have pondered the concepts of religion and spirituality and have offered concrete conceptualizations of otherwise abstract terms. Beit-Hallahmi and Argyle (1975) defined religion as a system or set of beliefs in which one places their faith in a divine, supernatural power, and dedicates themselves towards worshipping this deity.

Conversely, Batson et al. (1993) stated that religion is a concept that individuals create to arrive at resolutions that answer great mythical quandaries while helping us better grasp and appreciate our mortality (Milam, 2006).While Clark (1958) stated that religiosity is the expression of religion to which an individual's inner understanding allows him/her to perceive a Greater Experience, especially when evidenced of their ability to commune and actively harmonize with that which is beyond their existence.

The concluding definitions provided move from the egocentric perspective of religion to an inclusionary sense of religion to which the knowledge of the sacred is achieved through the fellowship and participation of a community. Dollahite (1998) describes religion as a covenant amongst the faithful were narratives and doctrines are used to enhance the quest for the sacred. Similarly, O'Collins and Farrugia (1991) and Peteet (1994) define religion as a system of beliefs in and to the response of the sacred and divine and the commitment to the system of beliefs within a particular tradition. All of these definitions have been presented to offer the manner to which religion is conceived, conceptualized and perceived among scholars. These definitions do not stand in opposition of each other; instead, they offer pieces to the whole, a whole of a conceptualization that is still expanding. However, the above presented definitions provide a foundation for the basis of this dissertation.

On the contrary, spirituality has a more ambiguous meaning. Spirituality is defined as a more personal connection with the divine, free of the rigidity and structure associated with religion (Smith et al., 2008). Within the realm of health care, spirituality has come to extend pass the understanding of a profound connection the ethereal. The

evolution of the term stems from an attempt to be more inclusive and pluralistic in mental health care settings to address the needs and concerns of both religious and nonreligious individuals (Park, 2006). When examined in research, spirituality is typically assessed in terms of religion or by positive psychological characteristics (Harris et al., 2008). For instance, current standard assessments of spirituality seeking the highest meaning of life and how beliefs surrounding such may influence the manner to which one leads their life. For this study, the terms 'religiosity' and 'spirituality' will be used interchangeably. For the majority of its colonized existence, Haiti has been a prevailing Christian country (Paul, 2016). At an estimate 80 percent, the majority of the Haitian population practices Catholicism; however, Catholicism is not the only dominating religion in Haiti. In a 2015 census, Protestantism ranked a 16 percent, overall, with Baptists at 10 percent, Pentecostal at 4 percent, Adventist at 1 percent and other Christian at 1 percent (Brown & James, 2015). Three percent identified as other religions, such as Islam, Bahá'í Faith, Judaism, Buddhism and less than 1 percent as either atheistic or agnostic.

However, there has been noted syncretism, or the blending of religions within the culture, as such is the case of 1 percent Christians who overtly identify as having the dualistic religious beliefs of Roman Catholicism and Voodoo (Brown & James, 2015). The most common syncretic religious affiliation is that of Catholicism and Voodoo, which is an amalgamation of the ancestral West African religions and traditions from the African slaves with Catholicism and some Native-American customs.

The Role of Spiritual and Religious Practices in the Haitian Culture

The prominent adapted religion in the Haitian culture is Catholicism as the island was first colonized by the French who had strong religious roots in the Roman-Catholic faith (Bastien, 2005). The understanding that the vast majority of the Haitian population ascribes to the religion of Voodoo is highly misleading. In fact, only 3% of Haitians identify as sole believers of Voodoo. Prior to the Haitian Revolution, religion played a minor role in colonial life as plantation owners were fearful that any religious education and indulgence could potentially threaten their control. Thus, the religious influences that were given to the enslaved population were the beliefs of the slave owners and masters. It is in this fashion that Christianity was able to flourish in the post-independent era of the Haitian constitutions.

Since its formal establishment in post-independent Haiti, Catholicism has flourished, and many Haitians describe Catholicism as the cornerstone of their lives, even upholding such allegiances to their religious and spiritual belief systems that dissuade them from seeking medical advice and interventive measures. This belief system has caused many to not seek medical assistance as they believe that engaging in medical interventions are in direct conflict with the pursuance and proactive involvement of their religious and/or spiritual lives. Moreover, many believe that medical is a futile endeavor as the advice offered is either untrustworthy or is not useful, due to the beliefs surrounding the infliction of illness (Bastien, 2005). As noted by Benoist (1993), the culturally-based beliefs regarding disease contribute to the psychosocial issues present within this population. While some Haitians maintain the belief that diseases are their

fates manifested by divine entities, others assert that diseases and misfortunes are caused by sorcery and witchcraft (Benoist, 1993). As such, the native inhabitants of Haiti will often either rely on their religious or spiritual deities to heal them of their ailments. Oftentimes, this population will resort to entrusting their health to the local "medicine practitioners" (commonly known as voodoo priests and priestesses within the community) or deny the existence of the disease (Benoist, 1993). As Benoist noted, "these cultural factors are deeply imbedded in the Haitian psyche and over time influence decisions about health, contributing to morbidity within the community." This belief system has been passed down from generation to generation and has even infiltrated the Haitian American culture. Even though the descendants of the Haitian heritage have no direct connection to their ancestral home, the practices, traditions, and beliefs of their native land still influence the manner to which they govern and live their lives.

The Voodoo Culture as a Religious, Spiritual, and Medicinal Practice

The Voodoo culture is one that not only institutes religious and spiritual beliefs, practices, and traditions, but constitutes a health-care system as well (Augustin, 1999 as cited by WHO, 2010). This health care system includes healing and restorative practices, health promotion, illness preventative measure, and holistic care (Augustin, 1999 as cited by WHO, 2010). Thus, Voodoo serves as a source of information on how to promote wellness, protocol on preventative and curative interventions, theories of illness origins and prescriptions for accompanying behaviors that are "congruent with widely held explanatory models" (Vornarx, 2008, p. 182 as cited in WHO, 2010).

There are several interpretations of illness in Voodoo; however, the first level of interpretation of illness is based on the need to establish a harmonious relationship with the Spiritual Realms and the ancestors (WHO, 2010). The second level focuses on the possibility of magic and/or sorcery being the source of an affliction or illness (WHO, 2010). According to the Voodoo tradition, the health or illness of a person is a direct physical manifestation of that individual's connection and relationship with the spiritual realms and beings, such as the ancestors and gods (WHO, 2010). In the Voodoo tradition, the practitioners possess a level of knowledge that allows them to affect those who are afflicted (WHO, 2010). These practitioners are endowed with the power to heal from their respective deities and are well respected within the community, which contributes to the power of their persuasion.

Haitians, despite religious persuasions, maintain beliefs that illness can either be sent or derive from deities that allow such misfortunes to befall an individual (Farmer, 1990 as cited in WHO, 2010). It is for this reason that the Voodoo culture has flourished in Haiti. Two notable syncretic religious faiths in the Haitian culture, the Protestant and Catholic faiths, assist people with coping with mental and emotional issues and provide parallel systems of healing often through the implementation of Voodoo practices (WHO, 2010). Thus, religion has a multifaceted role in the Haitian culture. It is in religion that the Haitian people find purpose, consolation, belonging, structure, discipline and tradition (WHO, 2010). Religion not only heals maladies but bolsters self-esteem, can alleviate despair, and instill hope during adversity. The effectiveness of religion and spirituality has led health professionals working in Haiti to align with spiritual leaders, who often

serve as consultants or co-medical professionals, in which they can seek their assistance because these leaders are able to encourage patients to seek help and adhere to the recommended treatment protocol (WHO, 2010).

The Role of a Caregiver

As previously mentioned, providing care for a loved one is often a daunting task that has devastating ramifications on the caregiver. Oftentimes, the caregiver's mental, physical, emotional, and socio-economic well-being is compromised (Mannelli, 2013). Thus, while attending to an ailing loved one, caregivers must contend with maintaining their quality of life, time, resources, and energy (Dodge & Kiecolt-Glaser, 2018; Griva et al., 2016; Shapiro et al., 2007). Several articles in the literature speak on the difficulties associated with providing care for a family member. Similarly, Dodge and Kiecolt-Glaser examined the adversities associated with providing care to a relative with Alzheimer's disease or progressive dementias. Through the thorough surveying of extracted electronic databases and manual searches of scientific journals, Dodge and Kiecolt-Glaser discovered that caregivers of family members with Alzheimer's disease and other forms of dementia suffer from various forms of depression, anxiety, sleep disturbances and fatigue. Furthermore, they noted the importance of clinicians' implementing holistic interventions that focus on the mind and body connection to mitigate the effects of psychological stress. The study conducted by Dodge & Kiecolt-Glasser cited the importance of implementing means of coping that focused on self-realization and self-care.

Several studies have been conducted surveying the issues associated with being a caregiver to an ailing loved one and the coping strategies employed by caregivers. Studies such as Griva et al. (2016) and Allen et al. (2013) explored the adversities surrounding providing care to a loved one with a degenerative disease. Griva et al. examined the adversities associated with providing care to a relative with peritoneal dialysis towards the end-stage of renal disease. This quantitative study sought to compare assisted PD versus self-care PD on quality of life. Data was collected from a sample of 231 patients who had peritoneal disease (N= 231), of which 142 patients chose self-care and 57 automated PD/85 continuous ambulatory PD and 89 assisted care PD (45 APD/44 CAPD)], 72 caregivers of assisted PD patients and 39 family members of self-care PD patients completed the Kidney Disease Quality of Life Short Form (KDQOLSF). Utilizing ANOVAs or ANCOVAs analyses, Griva et al. found that the levels of anxiety and depression present within caregivers remained stable between the population of infirmed patients surveyed. However, the perceived burden was reported by the caregivers of patients who did not implement self-care.

Similarly, Allen et al. (2013) examined the adversities associated with providing care to a relative with Alzheimer's disease or progressive dementias. Through their conduct of a quantitative systematic review which included the original studies related to providing care for an older relative with Alzheimer's, Allen et al. found that the leading causes to a community's reticence to seek professional counsel stemmed from concerns regarding medical care and cynicism towards free or subsidized care, difficulties

navigating through the health care systems, and language barriers (Allen et al., 2013), all of which plague the Haitian and Haitian American communities (Kohrt & Kaiser, 2014).

Caregivers' Coping Strategies

Researchers have analyzed the different methods to which individuals cope with psychological stress. The articles to be presented are studies conducted by psychologists who sought to explore how caregivers cope with the stress caused by providing care for an ailing loved one. Rodríguez-Pérez et al. (2017) aimed to analyze the relationship between coping strategies and quality of life dimensions in primary caregivers of dependent elderly relatives. Rodríguez-Pérez et al. conducted a study in which 86 caregivers in Southern Spain finding that dysfunctional coping was related to worse quality of life in the psychological dimension, while emotion-focused and socially-supported coping styles were related to superior psychological and environmental dimensions of quality of life. The physical and relational dimensions of quality of life were not related to coping strategies.

Another study conducted by del-Pino-Casado et al. (2011) cited the effect of coping strategies on subjective burden in informal caregivers of older adults. A quantitative systematic review was conducted including original studies, studies related to the caregiver's subjective burden as it relates to the caregivers' ability to implement coping strategies compatible to the classifications of Lazarus and Folkman or Moos et al. in informal caregivers of older relatives. del-Pino-Casa et al. found evidence for positive associations between avoidance coping and subjective burden in home-caregivers of older relatives with cognitive impairment. In the study, four coping categories were

shown to be related to subjective burden: problem-focused, emotion-focused, approach and avoidance. The only notable results were found for avoidance coping in which del Pino-Casa et al. found that positive associations existed between caregivers' ability to cope and avoidance.

Furthering this exploration of caregivers' coping strategies, Kumar et al. (2015) investigated the burden of providing care for stroke survivors and the coping strategies implemented by the caregivers. In addition, the study sough to identify the relationships between coping strategies and burden among 100 (N=100) caregivers in Punjab, India. Utilizing descriptive correlations, coping checklists and the Zarit burden interview schedule, Kumar et al. found that the level of burden as reported by the caregivers of stroke victims were high. Further, acceptance, social support, problem solving, and seeking help of the religious nature were among the most implemented coping strategies while denial and distraction were the least identified coping strategies, while burden was positively and significantly correlated with blame and denial in coping strategies.

For the final study presented in this section, I considered a study conducted by Hohmann et al. (2017) in which the investigators sought to expand upon the literature surrounding the usage of music therapy and music-based interventions used for the treatment of substance abuse and the use of music to assist in coping. Research was extracted from a systematic search of 6 qualitative and 34 quantitative published articles examining the effects of music, music therapy and music-based interventions. Through their survey of literature, the authors offered research on how clinicians utilized

spirituality and religiosity as primary coping mechanisms within the population battling substance use disorder.

To synthesize, the articles that were presented in this section cited explorations of varying strategies caregivers implement to cope with the stress of providing care or assistance to a loved one. In the findings, the reader can observe the commonality that receiving social support during the process of providing care and assistance created a buffer against the stress of the caregiver. Further, having tangible means of coping, such as psychotherapy and music, assisted in bolstering the morale and consequent ability of the caregiver.

Effects of Substance Abuse on Loved Ones

The effects of substance abuse on the caregivers and loved ones of individuals battling substance abuse are irrefutable and have been documented by several studies; however, the data surrounding the effects of substance abuse is deserving of further exploration with regards to strained inter- and intra-personal relationships with loved ones (Tanner et al., 2013). The effects of substance abuse on families and loved ones surpass disagreements and strained relationships; thus, experts have suggested that the road to recovery should not only focus on people battling substance abuse but should incorporate the familial unit and supportive members as a whole, in order to bring about the healing needed to affect restoration (Tanner et al., 2013). Oftentimes, the modality of therapeutic treatment employed for the victims of substance use disorder is family therapy. Researchers have found that family therapy is effective in that it not only repairs

strained and possibly damaged familial relationships, but also facilitates healing and acceptance through coping skills garnered in session.

Thus far, the typical interventions involved in family therapy tend to be the conventional means of conflict resolution, cognitive behavioral therapy (CBT) and motivational interviewing. Such interventions generally focus on the mitigation of interpersonal issues for the families surrounding jealousy, familial conflict, emotional traumas, violence, infidelity, and biological and environmental patterns. Western schools of modality have been reticent to incorporate complementary alternative therapeutic techniques to assist in the coping process of managing the stressors of a loved one who is battling substance abuse; however, Tanner et al., (2013) note that this may be the key to bringing about holistic and restorative healing.

Impact of Substance Abuse on Families

Oftentimes, people who suffer from substance abuse will isolate themselves from those that love them in an effort to protect their loved ones from their maladaptive behaviors. Extant literature suggests that substance use disorder bears distinct consequences on different familial structures **(**Tanner et al., 2013). The effects of substance abuse will often extend beyond the immediate family to the intermediate family members and may evoke feelings of anger, rage, fear, abandonment, concern, anxiety, embarrassment, guilt, or ignorance. Several issues, such as problems in communication and anger, may arise within different familial structures that may include the individual who is abusing the substances (Velasquez et al., 2015). For instance, if a couple is engaged in substance abuse, both individuals may need to seek assistance for

their substance use disorder prior to seeking couples counseling to diminish codependent and destructive behaviors. The treatments provided to either partner will invariably affect the relationship as both parties would have had the opportunity to explore the origins of their substance abuse (Velasquez et al., 2015). Likewise, if an individual within a committed relationship is battling substance abuse, the individual must first seek assistance to combat their substance abuse and consequent therapy to combat issues of potential codependency.

Another instance is when an individual battling substance abuse cohabitates with a spouse or partner and children reside in the household. Not only is the spouse of the substance abuser affected, but the children in the household will invariably be detrimentally affected by the individual battling substance use or abuse **(**Bertrand et al., 2013). In this scenario, the spouse of the individual abusing the substance is more inclined to protect the children and the family. The children in the household will either be overly sheltered or will be overly exposed to their environmental conditions. Oftentimes, for the children who are overly exposed, they will assume the majority of the parenting duties that are not fulfilled by the parent who is engaging in substance abusive behaviors (Velasquez et al., 2015). If both parents are engaging in substance abuse, the effect on the children worsens. In the case of a blended family, unique challenges are presented under normal circumstances; thus, substance abuse can intensify issues that are already present within a blended family dynamic and become an impediment to a stepfamily's integration and stability.

Similarly, when an adolescent with siblings in the family is engaging in substance abuse, the siblings in the family may find that their needs, desires, and concerns are not being met or are being minimized by the parents. This is because the parents are consumed with reacting and managing to the crises involving the adolescent always engaging in substance abuse **(**Bertrand et al., 2013). Often, adolescents who engage in substance abuse will have a parent who also engaged in the use and abuse of substances **(**Bertrand et al., 2013**).** This model can unfortunately begin to set in motion a combination of emotional and physical issues that, when coupled with underlying mental issues, can not only affect the adolescent, but the familial unit as a whole (Velasquez et al., 2015).

The Use of Spirituality and/or Religion as a Coping Strategy for Substance Abuse

Several researchers have evaluated the effectiveness of implementing spirituality and/or religion as coping strategy in treating substance abuse. The following articles cite instances in which spirituality and/or religiosity have been utilized to assist individuals with coping with substance abuse. Churakova et al. (2017) investigated the relationship between the frequency of alcohol consumption, spirituality, and coping with everyday life events in a cross-sectional, community-based sample of 320 Ukrainians (N=320). Churakova et al. performed a study that examined the relationship between the frequency of alcohol consumption, spirituality and coping. Thiele (2017) sought to explore the manner to which the indigenous populations in New Orleans conceptualized, processed and coped with natural disasters by collecting data that was extracted from research previously conducted by Thiele in New Orleans between 2008 and 2012. Thiele argued

that there is a need for more research to explore the manner to which different cultures cope by implementing their S/R beliefs into their coping styles. Krentzman (2017) examined the differences between men's and women's spirituality and religiousness, both in level and trajectory, during early and later recovery, while controlling relevant covariates, in a sample of individuals with alcohol use disorders. Data for this study was extracted from a subset of a parent study and presents as a secondary analysis in which 125 women and 239 men with diagnoses of alcohol dependence were followed prospectively over 30 months between 2004 and 2009 in the U.S. Midwest. By implementing binary logistic regression, Krentzman found that as purpose in life increased, through the use of spirituality, individuals were able to attain and maintain sobriety.

Another study conducted by Debnam et al. (2018) explored the correlation between engaging in substance abuse and the use of S/R to mitigate the dependency or proclivity towards engaging in substance abuse. The data was extracted from 27,874 high school students (Male=50.7%, Female=49.3%) across 58 high schools in Maryland that included an ethnically diverse sample (49% Caucasian, 30% African American) with an average age of 16 years old (Debnam et al., 2018). Utilizing bivariate and multilevel analyses, Debnam et al. found a correlation between substance use disorder as it related to S/R as a moderator. Similarly, to Krentzman (2017), Debnam et al. found correlations between spiritual/religious means of coping with overcoming substance use disorder. Finally, Jules and Maynard (2016) sought to examine the meaning of spirituality, discuss the role of interfaith youths within the Caribbean, posit a psychological explanation of the

period of emerging adulthood and the associated psychosocial characteristics which facilitate spiritual development among this demographic; and quantitatively explore the relationships among spirituality, drug use, peer associations and family relations in Black Caribbean emerging adults. The data extracted for this study was part of a larger multi-centric study involving eight countries in Latin America and the Caribbean. The sample for this research consisted of undergraduate students between the ages of 18 and 24 years, attending a university in Barbados. The sample included 250 students (N=250) recruited via convenience sampling. Jules and Maynard provided insight on how S/R have been used within the Haitian American community to bring about healing. Jules and Maynard also made mention of the reticence to seek medical assistance within the community and the community's inclination to explore alternative methods for healing.

Summary and Transition

In chapter 2, I reviewed pertinent literature concerning coping and caregivers perceived psychological stress forgiveness as it relates to substance use disorder. Chosen material for this literature review included peer-reviewed articles from journals and book chapters, largely gathered from the Walden University Library Databases. Relationships between psychological stress, spirituality, religiosity, forgiveness, coping, optimism, and psychological well-being were analyzed against substance use disorder and familial relationships using the following theoretical frameworks: Pargament's (1997) theory of religious and spiritual coping and Carver et al.'s (1989) theory of the concepts of coping.

The following themes were reviewed: (a) an introduction to the topic of this study; (b) theoretical frameworks surrounding religious and spiritual coping as it relates

to the adversities of being a caregiver; (c) the perception of mental health within the Haitian and Haitian American communities, (d) the effects of substance abuse on family members and loved ones, (e) treatment modalities offered to the family members of substance abusers and (f) a review of the literature surveying the aforementioned topics. Research has found that there exists a reticence within the Haitian and Haitian American communities with regards to seeking professional assistance. The literature demonstrates that, because of said reticence, these populations will rely on their religious, spiritual, and cultural backgrounds to alleviate and cope with physiological and psychological stressors. However, this research endeavor will extend the knowledge and conversation in this discipline as it will provide a foundation for the methods already implemented within the community so that they may be integrated into more conventional therapeutic means.

The study's methodology is presented in Chapter 3. This chapter reviewed the study's purpose while discussing the research design, research methodology, sampling procedures, participant recruitment, data collections, instrumentation used to interpret data (manual coding), data analysis, pertinent threats to validity, and pertinent addendums necessary to conducting said research.

Chapter 3: Research Method

Introduction

The purpose of this qualitative study was to explore how Haitian American caregivers experience the phenomenon of caring for a family member battling substance abuse and to understand how the caregivers cope with this demanding task. Because Haitian Americans tend to favor spirituality and/or religion as a primary way of dealing with stressful situations (Khoury et al., 2012), I attempted to understand how Haitian American caregivers use religion and spirituality as a coping strategy. In this chapter, I present the rationale for the chosen research design and the methodology used and explain my role as the researcher in this study, how the credibility of the study was established, and the ethical considerations that I made to ensure that the study remained ethically sound.

Research Design and Rationale

The research questions that guided this study were the following:

RQ1: How do Haitian American caregivers describe the experience of caring for a family member battling substance abuse?

RQ2: How do Haitian American caregivers cope with caring for a family member battling substance abuse?

SQ1: How do Haitian American caregivers use S/R to deal and cope with a family member battling substance abuse?

Central Phenomenon of the Study

The central phenomenon of interest in this study was the caretakers' experience of caring for a family member battling substance abuse within the Haitian and Haitian American communities and the caretakers' experience of coping with providing care. The research questions were used to explore the themes and contexts regarding the experiences of providing care for a loved one battling substance use and abuse and the experiences of coping with the demands of providing care. I used semistructured interview questions within the context of one-on-one interviews to capture the unique perspectives and sentiments of caregivers who provide care and assistance to loved ones battling substance abuse. As theoretical frameworks, Carver et al.'s (1989) concepts of coping and Pargament's (1997) theory of religious coping offered insight regarding the effects of psychological stress on the caregivers of individuals battling substance use and abuse within Haitian and Haitian American populations, which may be unique with regard to how members combat and cope with this psychological stress.

Interpretative Phenomenological Analysis

The qualitative method was selected as the most conducive research design for this research endeavor. Qualitative designs invoke an inductive approach to research to unveil deeper and personal meanings while focusing on a particular and targeted population (Maxwell, 2012). Thus, this design was the best suited approach for this study. However, I then needed to decide whether there was a particular approach within the qualitative methodology and tradition. After conducting introspective reflection and exploring the central aim of the study, I decided that IPA would be the most suitable

qualitative approach for this study. IPA was first proposed by Birbeck University professor Jonathan Smith as a means of exploring the depth of the human experience within psychological and health science disciplines. As time progressed, IPA found its origins in the psychological field and is increasingly utilized to explore the transitional life experiences that an individual may undergo when experiencing a psychological episode that may cause distress (Smith et al., 2009), making it a suitable methodology for the phenomenon of interest in this current study.

The central aim of IPA is to ascertain how the participants of a study find meaning and purpose in their subjective experiences as they relate to a specified phenomenon. The phenomenological approach's purpose is to explore how individuals perceive and conceptualize their subjective experiences in a manner that produces an understanding of their experience, as opposed to objectively describing the presenting phenomenon. When implementing the IPA methodology, a researcher must first have a concrete understanding of the participants' perception of the phenomenon. Then the researcher must discern and decode the interpretation provided by the participants' unique perspective through a thorough and interpretative process. The researcher then studies the participants' statements and utilizes the narratives provided to conduct comparisons between the participants to discover any similarities and/or variances. Therefore, even with the individualized focus paid to the collected data in an IPA study, the analytical structure of IPA assists in the generation of theoretical transferability to speak to a larger and more comprehensive human experience (Smith et al., 2009). These procedural foundations of IPA are in alignment with and support acquiring

comprehension and a deeper meaning of the caregiver experience as it relates to providing care for a loved one battling substance abuse.

Choosing Interpretative Phenomenological Analysis as the Research Design

IPA was selected to respond to the research questions in this study. Before deciding on IPA, I considered other qualitative methods but deemed them inappropriate to fulfill the purpose of this study. For example, the narrative approach is appropriate in reaching a deep understanding of a participant's life and experiences by taking the form of a biographical lens; however, this approach typically focuses on capturing the life story of a single participant or the exploration of natural turning points in people's lives (Creswell, 2009). Because this was not the purpose of my study, I chose not to use the narrative approach. The second approach considered for this study was the grounded theory approach. Grounded theory is a qualitative approach that uses participants' voices to discover a theory or conceptual framework. That is, grounded theory moves past describing something and aims to generate a theory (Creswell, 2009); however, this was not the goal of this study and therefore, it was not considered appropriate. The third approach considered for this study was the ethnographic design approach. Ethnographic design is often most appropriate for examining shared cultures, including language and behaviors in specific and natural settings (Creswell, 2009). The interpretation and analysis of cultures, subcultures, or specific social groups are the target of ethnographic studies. Because the goal of my study was to focus on understanding not shared cultural beliefs but the phenomenon of caring among caregivers, this approach was also deemed incompatible with the central aim and purpose of this study. While these qualitative

traditions provide the researcher with the ability to perform deep and investigative explorations into the meaning and purpose of a phenomenon, IPA was ultimately deemed to be the most appropriate for the design of this research and the purpose of this study, as the study's aim was to explore the manner in which Haitian Americans coped with the phenomena of providing care to a loved one battling substance abuse.

Role of the Researcher

The qualitative methodology requires that the researcher and the participant have a relatively close interaction during the data gathering process, as the researcher is the main conduit for collecting the data. This differs from quantitative studies in that the main means of gathering data in a quantitative study do not involve working in an interactive and close manner. Instead, researchers using quantitative methods will commonly employ questionnaires and surveys to extract the data needed to support the breadth of the study. Thus, my role as the researcher was to conduct interviews with Haitian and Haitian Americans who had experience with providing care for loved ones who had battled substance abuse, to transcribe the data presented via the conducted interviews, to analyze the data for deeper meanings that produced the themes of the study, and to present on my findings. Therefore, my role as the researcher entailed the need to present as an authentic and neutral listener to the narratives of the participants and in turn, work, in a collaborative effort, to explore and present their experiences to the scholarly community (Ravitch & Riggan, 2016; Shenton, 2004). To ensure that I maintained fidelity to the task at hand, I needed to ensure that any potential biases that might have influenced the manner in which I presented the results produced from the data

gathered and acquired were thoroughly analyzed and processed so as to not contaminate the interpretation of the data. To do this, I needed to evaluate and explore how my subjective experience might influence the manner in which I related to the content and context of this study. Because I am of Haitian descent and have had family members who have provided care for a loved one battling substance abuse, I needed to ensure that my personal and vicarious experiences did not skew the manner in which I presented and discussed the results of this research endeavor. Although I have not had the direct experience of providing care for a loved one battling substance use or abuse, there were similarities in the narratives that resonated profoundly with and for me that could have led to potential biases and contaminated the manner in which I interpreted the data, thereby prohibiting me from presenting the results in an objective manner.

The researcher, who is not infallible, is the primary means of collecting data in a qualitative study, and so it is imperative that the results are presented in a transparent and rigorous manner to allow the essence of the participants' narratives and perceptions to be relayed to the audience without a biased lens (Creswell, 2009; Shenton, 2004). Because of my personal affiliation with the topic at hand, it was imperative that I remained mindful of my biases and preconceived notions prior to and during the data collection process. To guarantee this, I made sure that I implemented methods within the qualitative methodology that would assist in confirming trustworthiness (Shenton, 2004). For instance, during the data collection and interpretative processes of the study, reflexive processes and methods were implemented as a means of providing a checks-and-balances system in which I explored and separated my personal beliefs and experiences from those

of the participant. I also included the reflections and observations made during the data gathering process. These notations served as a means of ascertaining the manner in which the research evolved during the totality of the data gathering process. Further, this process allowed me to ascertain how I was potentially influencing the manner in which the data were interpreted. In addition, I requested that the participants review their responses to ensure that their responses reflect the narrative that they wished to convey (Ravitch & Riggan, 2016; Shenton, 2004).

Methodology

Sample

Participants for this study were Haitian American caregivers of family members battling substance abuse and were considered to (a) be naturalized or Haitian-born U.S. citizens; (b) have lived in the United States for a minimum of 15 years to ensure acculturation into American customs to demonstrate a level of experience in the endeavor to integrate the culture of origin with the new culture (Schwartz et al., 2010); (c) be adults 35 years or older; (d) have attained at least an eighth grade education to have a grasp of the study; (e) have a command of the English language; and (f) have cared for at least one loved one with a history of substance abuse within the last 10 years.

For the purposes of this study, a homogenous sample was recruited. Homogenous sampling is most often applied in studies using IPA, as this sampling method allows for selecting a specifically defined group in which the research problem is aligned to the group being researched (Pietkiewicz & Smith, 2014; Smith et al., 2009). Participants who fell into the population of interest as previously described were sought out in a purposive

sampling strategy. My aim for this study was to utilize a target sample size that would allow me to extract quality data. According to Guest et al. (2006), a sample size of 12 participants is appropriate when using a semistructured interview guide. They indicated that most variation in the codes occurs between the first and 12th interviews. IPA generally utilizes a smaller sample size (usually between six and 10 participants) to allow the researcher to gain a comprehensive breadth of data from each participant and to allow the researcher to draw on the comparing and contrasting data presented in an efficient manner (Smith et al., 2009). Additionally, Creswell (2009) pointed out that samples in phenomenological studies tended to range from three to 10 individuals.

Considering these recommendations for sample size in phenomenological studies, I attempted to recruit 10–12 participants in my study. I began the data analysis process while still conducting the interviews for this study as I wished to consistently explore and ensure that saturation was reached with the number of participants for the study. The term *saturation* refers to the point at which no new themes are emerging from a data set derived from a homogenous sample of participant interviews. Saturation provides guidelines into the number of participants needed to make relevant conclusions related to the study's posed research question (Creswell, 2009). This target sample size was selected given the likelihood of reaching saturation with this number of homogeneous participants from this specific group of interest.

Sampling Procedures

The data collection process began after IRB approval was obtained for the study. This process commenced with recruiting participants from two prospective sites (a local

parish and a nonprofit 501[c][3] organization dedicated to assisting Haitian Americans). After establishing initial contact with the sites, I was able to schedule an appointment to present the nature of my study and to obtain consent from the sites to recruit potential participants. After contact was established and permission was granted to begin distribution of the invitation, I made announcements after church services and meetings/gatherings at both sites and distributed flyers that included my contact information to all interested persons. After potential participants contacted me expressing their interest in participating in the study, I invited them to participate in the screening process. Additionally, I utilized snowball sampling in order to ensure that I had the number of participants needed for the study and encouraged potential participants to forward and/or share the invitation to my study with other potential participants.

Potential participants were screened to determine their suitability for the study based on the inclusion/exclusion criteria via an initial phone call. During the initial phone call, I posed a series of preliminary questions to determine the potential participant's eligibility. After the potential participants were deemed eligible for the study, I sent them an email informing them of their eligibility and provided them with the consent form to proceed with participation as well as an invitation to coordinate a date and time suitable to conduct the interview.

Instrumentation and Materials

Participant Screening Guide

The participant screening guide served as a guide to assist me in ascertaining whether the potential participant was suitable for this study. The criteria for

inclusion/exclusion in the study was based upon the purpose of the study, the proposed research questions, and the standard research ethical considerations and requirements. The data for the screening form were documented once the initial announcement and phone call conversation with the potential participant had taken place. The initial phone call took approximately 20 minutes to complete. During the phone call, I ensured that the potential participant met the criteria for the study and requested that they affirm the following: that they were Haitian immigrants who were naturalized United States North American citizens, had lived in the United States for a minimum of 15 years, and had parented or provided care for at least one family member with a history of battling substance abuse.

Informed Consent Form

The informed consent form provided the participant and me with the opportunity to discuss the purpose of the study, the amount of time required of the participant, the potential risks and benefits of participation, the voluntary nature of participation, compensation, critical contact information, and referrals to mental health agencies (should the retelling of the narrative be a triggering event for the participant). By holding space for this in-depth conversation, I ensured that the participant was able to obtain a comprehensive overview of the purpose of the study and that the participant was able to make an informed decision prior to proceeding with this study. This form was mailed and emailed to the potential participants. After the initial screening process was completed, the potential participant was asked to affirm or deny participation in the study by responding “I consent” or “I decline.” In addition, the potential participant received

resources containing numbers for crisis hotlines as well as mental health facilities within the vicinity that the participant could contact if they felt that they needed support or assistance during the data gathering process.

Interview Guide

The interview guide was crafted based on the study's research purpose, research questions, and the theoretical concepts utilized in the study. The areas that were explored in the interview guide are as follows: how the participants described their experience as a caregiver for a loved one battling substance abuse, how the caregivers first discovered that their loved one's battled substance abuse, the stressors felt by the caregiver while providing care for a loved one battling substance abuse, and the chief means of coping with the stressors of being a caregiver to a loved one battling substance abuse.

Debriefing Form

The debriefing form was conducted with the participant once the interview was concluded. To perform the debriefing, I read the form to the participant and then provided the participant with the opportunity to pose any questions they may have regarding their participation in the interview or general questions about the study. In addition, the debriefing form contained pertinent information regarding how the participant will receive a copy of the final study. The participant was also given a hard and electronic copy of the debriefing form for their personal records.

Invitation Flyer

The invitation flyers were distributed at the end of weekly church services at the parish and at the end of a quarterly informative event at the site of the nonprofit to assist

me with the recruitment process of this study. The flyer contained the details of the purpose of this study and the inclusion/exclusion criterion necessary to be eligible to participate in this study. In addition, the flyer also included a bulleted list of what would be asked of the participant and an approximation of the length of the interview process. Finally, the incentive for the study was listed as each participant who agreed and was deemed eligible to participate in the study received a $20 gift card to Publix Grocery Store.

Audio Recording

I utilized audio recordings of the interview and as such, these mediums of recording were included in the consent form and discussed prior to holding the interview. The recording was done on the Google Application *Smart Recorder* which was downloaded on my cellular device for ease of access. The recording was continuous and ended once the interview concluded. These recordings were then be utilized during the data analysis process when transcriptions were performed to ensure accuracy of the data captured during the interview. The recording was then juxtaposed with the transcriptions of the interviews to assist me in analyzing the data collected.

Recruitment and Participation

The recruitment process for this research endeavor is outlined in the following manner:

- I first obtained consent from Walden University's IRB to proceed with the study.

- I then contacted the respective sites (the local parish and 501 [(c)(3)] organization) via email and followed-up the initial contact attempt with a phone call to schedule an appointment to present the nature of my study and to obtain consent from the sites to recruit potential participants at their sites.
- After contact was established and permission was granted to begin distribution of the invitation, I did the following:
    - At the parish, I made an announcement after Sunday service providing a brief overview of the study and stood outside to distribute flyers to all interested persons.
    - At the 501 [(c)(3)] organization, I made an announcement after the quarterly gathering providing a brief overview of the study and stood outside to distribute flyers to all interested persons.
- After the potential participant contacted me expressing their interest to participate in the study, I invited them to participate in the screening process.
    - I also obtained the participant's electronic mailing address so that they would receive an informed consent form as well as a confirmation of the date and time as to when the screening process would take place.
- I then hosted a phone call with each prospective participant to ensure that she met the minimum requirements for the study.
- After the initial screening process was conducted and the individual was deemed eligible, I scheduled a date and time as to when the interview would take place.

- The interview was scheduled to be conducted.
- I then mailed the participants their gift cards as a compensatory measure for their participation in the study, regardless of their decision and/or ability to complete the study.

The participants were informed that the interviews would be conducted via Skype or a telephone call, would last from 60 to 90 minutes and would be audibly recorded. During the interview, I utilized the interview guide that served as a guide to the series of open-ended questions I posed. The responses were manually and audibly recorded for future analysis.

Data Collection

Participants who were deemed eligible for the study were scheduled for a semi-structured interview that did not exceed 90 minutes. I used the interview guide to direct the open-ended questions that were posed. At the conclusion of the interview, I provided the participants with the opportunity to participate in the debriefing and clarification processes. This began with me reading the debriefing form to the participants and allowing them to pose any question they had pertaining to the conducted interview. If the participant made mention of any concerns, the concerns were aptly addressed. After the debriefing process, the participant was informed that she would receive this form via direct dissemination, email, and postal mail to ensure that the participant had this form for their records. I also confirmed the participant's postal address as this was the location the participant receives the $20 Publix Grocery Store gift card.

The manner to which the interview questions were formulated was purposeful in order to capture the full scope of the participants' description of their experiences with their loved ones' substance abuse and their experiences coping with the stressors of this task through the various coping methods they chose to employ. During the interview, I made certain to note verbal and nonverbal forms of communication, such as sarcasm, laughter, sorrow, shifting facial and body languages, and other indicators that signified and distinguished comfort from discomfort and truth from deception. My initial notes were abbreviated and used to record the accounts of the participants as they shared their narratives. These notes were written by hand and then later transcribed into a Microsoft Word Document. Any field notes regarding nonverbal communication (expressive body languages, gestures, grimaces, pauses, intonations, inflections, and silences) were recorded during the interviewer's first encounter with the data. Nonverbal communications were later recorded once I reviewed my subjective notes. After I reviewed my notes, both sets of the recorded field notes were integrated into the overall data. Immediately following the interview, I wrote comprehensive notes post-interview to clarify any ambiguous notes taken and promptly journaled reflexive thoughts about the process.

Data Analysis

Data analysis in the Interpretative Phenomenological Approach (IPA) tradition is malleable, creative, reflective, and interpretative (Larkin & Thomas, 2012; Smith et al., 2009). In the IPA methodology, every participant is individually considered, and as the researcher, I took care to scrupulously review the transcripts to ensure that the voice of

the participant was heard, and the lived experience was conveyed and relayed. Although IPA analysis can be flexible, the central aim is that it "directs our analytic attention toward our participants' attempts to make sense of their experiences" (Smith et al., 2009, p. 79).

To commence the process of data analysis, each interviewed conducted was transcribed and read over several times while listening to the audio recordings of the interview session. It was during these first stages of data analysis that I journaled to monitor any initial impressions and ideas. As I immersed myself further in the data, I paid close attention to the participants' usage of language to relay their narratives and the contexts which the participants' accounts were conveyed, thereby supporting the aim of comprehending the deeper meanings the participants are conveying as they share their lived experiences (Smith et al., 2009). The notes that I made to ascertain key phrases, words, and themes were noted in the left margin of the transcripts as comments to the documents.

I then began to look for emergent themes in the data (which is discussed further in Chapter 4). The manner to which the data was analyzed within the document followed a system in which I created a table on Microsoft Word and divide that table into three equal parts to reflect: the transcription, my analysis, and the emergent themes. It is after the emergent themes appeared from the data that the consequent phases of the data analysis process took place. During this segment of the data analysis process, I dedicated more time towards noting and distinguishing any similarities and variances within each interview. I looked for alignments within the story, reoccurring feelings or perceptions

and noted any contradictions that may appear within the participants' narratives (Smith et al., 2009).

Reflections, revisions, and receptivity to my chair's feedback were crucial as themes began to emerge. Once the emergent themes presented themselves, they needed to undergo their own subjective metamorphoses during the data analysis process (Larkin & Thomas, 2012). During this process, it was important to reflect back on my own interpretations and impressions of the narratives so as to ensure that my initial impressions were emerging organically and being extracted from the participants' experiences (Quinn & Clare, 2008). Through these efforts, I was able to ensure that each step in the interpretation of the data emerged from the narratives provided by the participant and had not developed from any degree of my subjective bias on the subject matter (Smith et al., 2009).

The emerging themes were compared to the data extracted from the participants' narratives. The leading indicator in determining the themes in the data was the consistency presented across interviews, which signified that I was nearing saturation in the data (Denzin, 2009; Fusch & Ness, 2015). Conversely, if I found conflicting or variated themes in the interview transcripts, I knew that I needed to consider recruiting more participants until consistent themes with no new findings emerge (Denzin, 2009; Fusch & Ness, 2015). However, there were no conflicting or variated emergent themes, with the exception of the negative case analysis (one of the ten participants) that is discussed and explored in Chapter 4.

Throughout the process of data analysis in the IPA methodology, the data is meant to expand and evolve to incorporate the notes and perceptions of the researcher (Smith et al., 2009). These expansions and evolutions usher the emergence of thematic development. Thus, when a researcher implements the hermeneutic cycle employed in IPA, he/she is regarding and analyzing the data in a holistic, whole, and completed state in which he/she dissects the data, examines the fragmented pieces and then re-constructs it in a manner that conveys and reflects the truth of the participants narratives juxtaposed into the purpose of the researcher's investigation (Smith et al., 2009). Utilizing this methodology, once the emergent themes were recognized as significant to the scope of the study, I began the process of mapping these themes to analyze how they are uniquely interconnected and interrelated. The themes that were most dominant were highlighted as other themes bearing less significant at this stage of data analysis were presented as subcategories to the overarching themes.

Issues of Trustworthiness

Trustworthiness is quintessential when ensuring the quality of a qualitative research study. Credibility, transferability, dependability, and confirmability are considered the qualitative researcher's equivalents for internal validity, external validity, reliability, and objectivity (Creswell, 2009). To elucidate how the aforementioned was adhered to, I implemented Creswell's (2009) and Lincoln and Guba's (1985) guidelines and recommendations to ensure the quality of my study. The issues of trustworthiness and their application to this study will be described in the subsequent sections.

Credibility

Credibility refers to the congruency of the findings found when describing reality (Creswell, 2009; Shenton, 2004). To ensure credibility within my study, I made sure to conduct thoroughly extensive interviews. I also employed prolonged engagement, delved into negative case analysis, and extensive debriefing. The following strategies were utilized during the data analysis process to ensure credibility:

1. I conducted in-depth interview sessions that lasted no more than 90 minutes (the shortest interview lasted 32 minutes and the longest lasted 72 minutes in duration) to ensure all responses to posed queries were detailed and rich in data. While I did not coerce participants to remain in the interview for the full duration of the allotted time frame, I ensured that there was ample time to allow the participants the full opportunity to express themselves.
2. I revised any instances of negative case analysis. To provide elucidation, negative case analysis refers to when special considerations and/or treatment is given to disconfirm or negate data (Hanson, 2017; Shenton, 2004). For this study, one participant fit the aforementioned criteria. In this instance, I made sure to revise the existing and emergent analyses of the data and separated the data that did not conform to the trending patterns to conduct a separate analysis to gain understanding as to why the data did not fit. The disconfirming of evidence was noted and documented within the analysis.
3. I implemented peer debriefing. I maintained a close and frequented correspondence with my committee for the entire duration of the data analysis

process and I discussed any reactions and/or issues that arose as it related to the data analysis process. This assisted me in gaining another perspective on the review of my own procedures.

Transferability

Transferability refers to the extent to which a study's results can be transferred to or applied under similar contexts. To ensure the possibility of transferability, the researcher should be able to demonstrate enough depth, breadth, and detail in the data description (Lincoln & Guba, 1985). One of the strategies I employed to enhance this study's transferability was the use of detailed description. Providing rich description assisted in establishing the relevance and context of the data in order to be able to utilize the results of this study to draw comparisons in similar contexts.

This study implemented substantial description in depicting the setting, participants, analytic memos, and documents related to the study were elucidated upon and included. Additionally, I endeavored to establish transferability by thoroughly identifying, coding, analyzing and documenting themes that emerged in this study. I provided rich, thick descriptions using vignettes and/or direct quotes from the participants with the expectation that the reader would be able to decipher the results so that the presented data maintains its applicability and transferability (Creswell, 2009).

Dependability

Dependability refers to the consistency and stability to which the research procedures are procured. The consistency, stability, and transparency were needed to ensure that the study could be replicated within the same context, participants, and

methods to yield similar results (Shenton, 2004). To ensure the dependability of the study, I described the plan of the study, reported the details obtained during the data gathering process and provided my reflections on the overall research process. The utilization of an audit trail contributed to the establishment of the rigor within this qualitative study. An audit trail was utilized to allow the reader to follow the path of the research in a concise manner (Shenton, 2004). For ease and reflexibility, I implemented the use of an audit trail included my field notes, interviews, reflexive journaled notes, and detailed data analysis procedure. The audit trail also permitted me to keep track of my research processes and procedures.

Confirmability

Confirmability refers to the manner in which a researcher can produce confirmable data while being aware of and stating the potential biases that may arise (Shenton, 2004). In order to ensure confirmability, I maintained a reflexive journal to document the biases I encountered as well as any decision or rationales that would influence or impact the study (Lincoln & Guba, 1985). The reflexive journal permitted me with the ability to capture my thoughts, reactions, and biases. In turn, I was able to review any issues that arose with my Dissertation Chair. It was my intention that the utilization of the journal would assist me in improving insight and awareness as to detect any potential biases during the data collection and analysis processes.

Ethical Protection of Human Subjects

I ensured that the individuals who met the inclusion criteria and consented to participate in the study were ethically protected for the duration of the study. The

protection and maintenance of dignity and integrity of the participants of this study was of the utmost importance. To ensure that the participants of the study were protected during the course of the data collection process, I implemented procedures that would ensure I was remaining ethically compliant. The employment of human subjects for this study was planned with regards to obtaining informed consent and ensuring the confidentiality of obtained data, and the protection of their inherent rights were upheld. I recruited the participants from a local church and local 501 [(c)(3)] organization, of which, I am not affiliated. By recruiting the participants of the study in this manner, I was able to ensure a reduction in possible breaches of confidentiality. Further, I made certain to adhere to the guidelines as outlined by Walden University's Institutional Review Board to ensure the confidentiality of the participants' data by securing obtained data and related records. My concern for the participants' safety and integrity were paramount and I ensured that all records, regardless of the format, were stored securely.

In addition to securing the data obtained from the participant, the protection of the participants against any physical or psychological harm was within my ethical considerations. The only exclusion that was enforced was that the participants of the study could not exclusively practice the religion of Voodoo. Confidentiality of the participants was maintained as identifying data was not collected. For instance, the participants were ascribed pseudonyms that made them identifiable to me (i.e. "Participant 1" or "Participant 2"). As pseudonyms were ascribed to the participants, I maintained a log with the participants names and corresponding pseudonyms within a separate research file, which was locked in a safe, for future reference, if necessary.

However, there was no identifying data that would be published, as to not compromise the confidentiality of the participant and compromise the integrity of the study. After the completion of the study, all data collected pertaining to the personal information of the clients, will be stored in a secured facility and will remain there for 5 years, at which point they will be shredded.

Management of Data

Data collected for the purposes of this study was kept confidential and unauthorized personnel did not have access to the data without my obtainment of a signed release from the participants. In an effort to maintain confidentiality of the participants in the study, the participants' identifying information was excluded from the final presentation of the results of the study. Instead, the dissemination of data was pseudonymized to ensure that no names were utilized and that any references to person or place were replaced with generic terms (or given false names to protect identity).

Furthermore, any data collected was not released and disseminated without my first gaining authorization from Walden University's Institutional Review Board (IRB) (IRB Approval Number: 10-15-20-0482104). The actual transcripts of the interviews were kept confidential in a locked cabinet in my home office and the electronic files were kept on my encrypted personal laptop, as previously mentioned. As I completed the transcriptions of the interviews, there was no need to obtain further permission or employ any further confidentiality agreements.

Protection of the Data

All of the data gathered from the participants (i.e. informed consent forms, screening guide, debriefing forms, transcripts, and recordings) was kept in a locked cabinet in my home office. I also retained all electronic Microsoft Word and Excel documents, such as transcripts and reports, and these electronic files were password encrypted to reduce the likelihood of any breaches to the participants' confidentialities. These files were created after the preliminary handwritten notes have been transferred to an electronic platform. As soon as handwritten notes were transferred, the handwritten notes destroyed via shredding immediately.

The participants' files were labeled with their respective pseudonyms and the code sheet that linked each participant to the pseudonyms was held in a locked file cabinet separate from the participant's data. Furthermore, to continue the insurance of confidentiality, I and the internal auditors and the Walden University Dissertation Committee were the only parties with privy access to these documents and files. After the completion of the study, all data collected pertaining to the personal information of the clients, is stored in a secured facility and will remain there for 5 years, as required by Walden University's IRB. Once the five years had elapsed, the documents stored in the facility will be promptly shredded. The participants of the study were also provided with the results of the study and were informed of this option within the informed consent form prior to agreeing to participate in the study.

Summary and Transition

In sum, I have provided a brief overview of the IPA (interpretative phenomenological approach) methodology and the rationale of choosing this methodology for this research endeavor. Based on the primary research questions, I determined that the phenomenological approach was the best methodology to reach solutions that satisfied the queries posed concerning the manner to which Haitian Americans utilize religiosity and spirituality to cope with a loved one battling substance abuse. I also identified the manner to which I recruited my participants. In this section, I made mention of how I addressed concerns of ethical treatment for the participants of the study. Finally, I provided a rationale for the means of analyzing the gathered data to ensure that the data presented was interpreted in a manner that established the trustworthiness of the study. The interviews, observations and reflections were the main components of data collection and were vital to the data analyses conducted to explore the depths of the participants' experiences. The analyses present emerging themes that have provided me with clarity about the depth of the phenomenon.

The penultimate chapter will discuss the findings of the study. In addition, Chapter 4 provides a description of the participants' demographics and any precipitating conditions that may influence the manner to which the data was analyzed and presented. Further, as Chapter 4 was composed after the data collection process has concluded, I reviewed and stated any and all amendments and variations that were made to study to accommodate any variations from the proposal and the crafted data collection plan presented in Chapter 3 to the conducted final study. I presented the discovered themes,

assimilated, and synthesized these themes to present the findings and ensured that the data collected and presented met trustworthiness. Finally, a comprehensive presentation of the results as they relate to the research questions posed is provided.

Chapter 4: Results

The purpose of this qualitative study was to explore how Haitian American caregivers experienced the phenomenon of caring for a family member battling substance abuse and to understand how the caregivers cope with this demanding task. Because Haitian Americans tend to favor spirituality and/or religion as a primary means of dealing with stressful situations (Khoury et al., 2012), the implementation of religious and spiritual coping mechanisms was also explored in the body of this research endeavor. The lack of research in this arena prompted me to explore this phenomenon to provide an authentic account of the lived experiences of Haitian American caregivers who provided care to a loved one battling substance abuse.

I implemented IPA as the method of extracting data for this research endeavor. IPA allowed me to capture the essence of the lived experiences of Haitian American caregivers through semistructured interviews to explore how these individuals coped with the stressors of providing care to a loved one battling substance abuse. During the interviews, the participants used the terms *substance user* and *substance abuser* interchangeably; however, for the purpose of this research endeavor, I have referred to the participants' loved ones as substance abusers to illustrate the level of crisis at the time of substance engagement. The secondary aim of this study was to address how Haitian American caregivers use religion and spirituality as a coping strategy.

The interviews focused on two main research questions and one subquestion:

RQ1: How do Haitian American caregivers describe the experience of caring for a family member battling substance abuse?

RQ2: How do Haitian American caregivers cope with caring for a family member battling substance abuse?

SQ1: How do Haitian American caregivers use S/R to deal and cope with a family member battling substance abuse?

Chapter 4 provides an explanation of the components that guided the data collection, data analysis, and study results, including a comprehensive description of the participants, setting, codes, themes, and subthemes that emerged from the participants' accounts of their experiences.

Setting

After I obtained approval from the Walden University IRB to commence the data collection process, with the expiration date of October 14, 2021, the initial step was to begin the recruitment process by contacting the prospective sites, which were a local parish and a nonprofit 501 [(c)(3)] organization dedicated to assisting Haitian Americans. After establishing this initial contact, I was able to schedule an appointment in order to present the nature of my study and to obtain consent from the two sites to recruit potential participants. After permission was granted to begin distribution of the invitation, I made announcements after church services and meetings/gatherings at both sites and distributed flyers, which included my contact information, to all interested persons. When potential participants contacted me expressing their interest, I invited them to participate in the screening process. During this screening, I hosted a phone call with each prospective participant to ensure that they met the minimum requirements for the study. I also provided each participant with an overview of the scope of the research effort, informed

the participants about the interview process and protocol, and provided information about the participation incentive. At this time, all pertinent information regarding the purpose of the research, criteria for participation, and the consent form were provided to the participant.

A total of 15 individuals expressed an interest in participating in the study; however, there were only 10 individuals (seven from the local parish and three from the nonprofit organization) who met the criteria to move forward in participation in this research endeavor. Thus, a total of 10 individuals qualified for participation. All 10 individuals provided consent and completed the interviews. All queries pertaining to the length of the interview, the requirements of the interview, and the language in which the interview would be conducted were addressed during the screening process. All of the participants resided in South Florida, and the interviews were digitally recorded in audio format to adhere to the ethical guidelines as stipulated by Walden University's IRB. In order to observe safety guidelines and protocols due to the COVID-19 pandemic, all interviews were conducted via telephone or Skype and done within a private setting. To maintain confidentiality and to ensure the participants' confidentiality, I referred to the participants using pseudonyms (i.e., Participant 1, Participant 2, etc.) during the audio recording and the transcription of the interviews. The length of the interviews varied and was contingent on the amount of detail that each participant was willing to disclose. The shortest interview lasted 32 minutes, and the longest lasted 72 minutes.

Demographics

A total of 10 Haitian American women caregivers of loved ones who had battled substance abuse participated in the interviews for this research endeavor. The ages of the participants ranged from 45 to 72 years old. The average age was 59.6 years old (*SD* = 8.5). Confidentiality for all participants was ensured by removing any potential identifying information.

All 10 participants self-identified as Haitian American and as caregivers to a loved one who had battled substance abuse. Because the central aim of this research was to explore the coping mechanisms of Haitian American caregivers as they related to their religious affiliations and spiritual beliefs, it was important to note each participant's religious association: Three participants identified as Roman Catholics, two identified as New-Age Christians, two identified as Protestants, two identified as nondenominational, and one participant identified as Syncretic. Although each participant had their own religious beliefs, each participant affirmed engaging in a spiritual practice that did not necessarily correlate with their religious affiliation. All other relevant sociodemographic information for all participants is described in Table 1.

Table 1

Study Demographics

Participant	Age in years	Civil status	Religious affiliation	Years in USA	SC or NSC	Duration of care provision	Gender of substance abuser	Relationship to substance abuser
Participant 1	61	Divorced	Roman Catholic	40	NSC	10–15 years	Male	Sister
Participant 2	67	Single	Roman Catholic	40	NSC	2 years	Male	Sister
Participant 3	68	Widowed	Protestant	68	NSC	17 years	Female	Mother
Participant 4	65	Widowed	Protestant	30	NSC	10 years	Male	Mother
Participant 5	53	Widowed	Non-denominational	40	SC	10 years	Female	Cousin
Participant 6	53	Divorced	Non-denominational	30	SC	19 years	Male	Ex-wife
Participant 7	45	Single	New-Age Christian	17	NSC	4–5 years	Male	Daughter
Participant 8	59	Widowed	Roman Catholic	35	SC	Undisclosed	Female	Goddaughter
Participant 9	72	Single	Syncretic	40	NSC	4 years	Male	Daughter
Participant 10	53	Widowed	New-Age Christian	20	SC	10 years	Female	Cousin

Note. SC = sole caregiver; NSC = non-sole caregiver.

Data Collection

I recruited the participants through the distribution of flyers at a local parish inviting all interested participants to contact me via the information provided on the flyer. The sites from which I sought permission to recruit participants were a local parish and a local 501 [(c)(3)] organization, both of which are geared toward assisting Haitian American communities in South Florida. Once I obtained permission from these sites, I distributed flyers at the respective locations.

Snowball sampling was also used to promote recruitment via various networks of family, friends, and acquaintances who expressed their willingness to refer potential participants for the study. All potential participants were meticulously screened to ensure

that they met all of the inclusion criteria. Prior to conducting the interview, I provided all participants with an explanation of the study, detailing the purpose of the research endeavor. The participants were then given the opportunity to pose any questions or voice any concerns that they had regarding their participation in the study. All protocols and documents for the study were developed in English, and no translations of materials were provided to adhere to the inclusion criteria of the study.

Before coordinating the time and date of the interviews with the participants, I provided the participants with a comprehensive and thorough explanation of the consent forms, the means of incentivized compensation for participation, and the purpose of the study. Once informed consent was obtained and signed, each participant then proceeded to schedule a time to hold the interview. Once the interview was completed, the audio recording was stopped, and I shared a debriefing statement with the participant. Once the debriefing statement was shared with the participant, the interview officially ended, and I disseminated the compensatory incentive gift card with a message of gratitude for their participation.

All of the interviews were conducted via telephone or Skype, to adhere to the social distancing regulations and guidelines of the COVID-19 pandemic. The interviews took place between November 2020 and April 2021. When originally considering the duration of data collection, I proposed that the data collection process would take 3 months; however, due to unforeseeable personal circumstances, the data collection process took 6 months to complete. The interviews were semistructured in nature and the questions posed were open ended to allow the participants to share the depth of their

experiences. The data generated from the conducted interviews were then typed and transposed to Microsoft Word in verbatim transcription. The data were stored on a password-protected computer and a password-protected document. The collected data from each participant did not contain any identifying information, and the transcripts of 10 interviews were used in the analyses.

Data Analysis

The data analysis process was rigorous and required active review and scrutinization of the information gathered during the data collection stage. I transcribed the semistructured interviews. I then engaged in rigorous review of the transcribed material, ensuring that I was reading and rereading the material and taking rigorous and detailed notes on my interpretations and sentiments regarding the emergent data. I then transitioned into reviewing the transcripts and coding the presented data line by line. This process was done to assist me in clearly delineating the rich and pertinent data from the data that were simply informative in nature. Once the initial codes had been produced, I began to look for any similarities, coherences, and parallels amongst the codes and began to group or cluster them into the initial themes to observe, with keener detail, what the data were seeking to relay about the phenomenon. Once the clustering of related themes and ideas had been formed, I then looked at the overarching themes that emerged, which I will present as I discuss the results of the research endeavor.

As previously noted, the data process was rather rigorous and underwent several transformations before arriving at the presented themes of the study, which will now be presented in greater detail. To begin, the initial coding of the data generated 108 codes.

The produced codes were extracted from the answers that each participant provided in response to the questions posed. The process of coding is a subjective endeavor to interpret the data presented by the participants of a study (Saldana, 2009). After the first set of codes was generated, I reviewed the work and analyzed the data to search for emerging themes. When reviewing the codes, I noticed that many of the codes could be collapsed and consolidated, as they were related in nature. This consolidation produced the second round of codes. Thus, the original 108 codes were consolidated to 31 after the second round of coding. For instance, many of the participants provided their narratives of how they became knowledgeable of their loved one's substance abuse, indicating the following: "started acting differently; was coming home late; started lying, missing work and stealing." Such descriptions prompted me to use the overarching code of "caregiver noticed unusual behaviors." A similar process was applied to the religious and/or spiritual means of coping implemented by the participants. The participants described the means of coping as the following: "I prayed; I sang; I meditated; I went to church." For this instance, I used the code "religiosity/spirituality as a means of coping," as this code best encapsulated the scope of the implementation of religious and/or spiritual means of coping.

Table 2 provides a visualization of the condensation process from the first cycle of codes to the second cycle as well as the definitions of the second cycle of codes. Further analysis of the 25 codes resulted in the production of 11 themes, which were then further consolidated to the following six themes:

- substance abusers' pathways from drug abuse to outcomes;

- relationship between the caregiver and substance abuser;
- how caregiver became knowledgeable of substance abuse;
- dangers of the caregiving journey;
- assistance given to caregiver; and
- caregivers' reactions and coping.

The developed and emerging themes were reflective of the lived experiences of Haitian American caregivers. For instance, I used the code "internal factors contributing to substance use" to describe the participants' beliefs that the substance abuser engaged in substance abuse due to an inability to cope with issues and/or situations and that, because of the substance abuser's inability to cope, they experienced mood fluctuations, which led me to the understanding that the participants believed that internal factors led their loved one to engage in substance abuse. Within the code "internal factors contributing to substance abuse," some participants mentioned stress, relational issues, depression, anxiety, and loss as the central contributors to their loved ones' substance abuse. Other participants noted that guilt and other mental health issues contributed to their loved ones' substance abuse. It was for this reason that the code "internal factors contributing to substance abuse" was used to encapsulate the breadth of data produced in this domain. Table 2 provides a comprehensive description of how the second-cycle codes were utilized to produce the themes that emerged from the data analysis.

Table 2

First and Second Cycle Codes and Definitions

First cycle codes (108)	Second cycle codes (31)	Definitions	Quotation illustrating meaning of code
Unemployment; Overwhelmed; Difficulty assimilating to new culture; Inability to cope	Inability to cope	Belief that the substance abuser engaged in substance abuse due to an inability to cope with issues and/or situations.	"I think she was having a hard time fitting in when she moved. She moved and left everything in Haiti."
Stress; Relational issues; Depression; Anxiety; Loss; Substance user's guilt Participant Believes Abuser's Mental Health Caused Substance use or abuse.	Internal factors contributing to substance abuse (mood fluctuations)	Belief that the substance abuser engaged in substance abuse due to an inability to cope with issues and/or situations and, therefore, experienced fluctuations in mood.	"It started when she was 18 with alcohol, or at least, that's when I found out, and that is around the time we sent for her to come and live in America. Then when she was 23, when her dad died, she started with the marijuana. Then when she was 30, she miscarried her child and started using cocaine. It was all bad from then."
Validation; Acceptance; Peer pressure; Curiosity	External factors contributing to substance abuse (mood fluctuations)	Belief that the substance abuser engaged in substance abuse due to external factors and pressures.	"Peer pressure! You know, 'hey come try this, come try this, you know, it makes you feel good."
Tough love; Nonacceptance from family; Feeling understood	Active support system	Belief that the substance abuser engaged in recovery due to having an active support system.	But the only thing I can say at the end of the day, you know, he got himself straight. You know, but I think my father's contribution helped him to get himself straight because he did not accept him to come near the house. Tough love, real tough."

First cycle codes (108)	Second cycle codes (31)	Definitions	Quotation illustrating meaning of code
Personal desire	Personal desire	Belief that the personal desire had an active role in the substance abuser recovery.	
The substance abuser is in recovery; Able to discuss experience	Positive outcome for substance abuser	Belief that the substance abuser has maintained a positive outcome since his/her battle with substance use or abuse.	"We communicate really well and sometime we discuss the past [substance abuser's battle with substances] we laugh about it, we cry about it.
Death of substance abuser; Relapse	Negative outcome for substance abuser	Belief that the substance abuser has maintained a negative outcome since his/her battle with substance abuse.	"She relapsed again and she um, then she died."
Participant stated relationship with substance abuser was significantly close prior to substance use; Participant tried to protect abuser; Communication with substance abuser improved; Relationship with substance abuser has improved	Close relationship	Experience of the relationship to the substance abuser was close.	Participant reminisces on her childhood with substance abuser: "He was my watching TV partner on Saturdays, we were watching cartoons. We were very close."
Participant stated relationship with substance abuser was strained prior to substance use; Participant stated relationship with substance abuser was minimal prior to substance use; Participant stated relationship with substance abuser was strained during substance use; Lack of communication with the substance abuser; Damage to relationship	Strained relationship	Experience of the relationship to the substance abuser was strained.	"She was always mad, she was always angry, she didn't want to talk to me. We never really had a good relationship."

First cycle codes (108)	Second cycle codes (31)	Definitions	Quotation illustrating meaning of code
Caregiver noticed unusual behaviors/ activity; Warning signs of substance use or abuse	Unusual behavior	Gained knowledge of her loved one's substance abuse by noticing his/her unusual behavior(s).	"We noticed that every so often, you know, he will, go out and come home late. And at times, you know on weekends he just go for the weekend and come back, you know, like maybe Monday or Tuesday, you know, all the signs were there but not knowing what was going on. You know, that was the problem."
Caregiver gained knowledge due to loved one's finding loved one impaired; Caregiver gained knowledge of loved one's substance abuse by finding loved engaging in substance abuse	Impaired loved one	Gained knowledge of her loved one's substance abuse by finding him/her impaired.	"I found out when I found her passed out on the bathroom floor—she overdosed."
Caregiver took on an active and physical role in caregiving; Caregiver took on an emotional supportive role in caregiving; Caregiver took on a financially supportive role in caregiving	Active role in caregiving	Took on an active role in the caregiving process.	"I handled it by myself. I didn't really do anything but take care of her and take care of myself. At first, it was just me taking care of her and it got so bad that I had to reduce my work hours to take care of her until my other cousin was able to come and um, help me."
Caregiver placed herself in danger; Safety of caregiver compromised; Participant lost weight during caregiver experience; Participant lost sleep during caregiver experience; Participant's personal relationships were affected by caregiver experience	Participant compromised well-being	Compromised own well-being while being a caregiver to a loved one battling substance use or abuse.	"I could remember at one point … I used to go out into the field and I used to go look for him in his drug holes. And at one point, believe me not, I was pregnant. And I used to go look for him and what gave me a wake-up call is that I said to myself: "What if the police decide to do a, uh, uh sting operation?" And by the time that I would clear myself they'll take you downtown before you

First cycle codes (108)	Second cycle codes (31)	Definitions	Quotation illustrating meaning of code
			can prove that this is the situation that you're in you were just looking for your brother and I say, "You know what? Untuh, I have to love me and and and the ones that I'm carrying in my stomach first."
Jeopardizing employment; Unable to maintain same level of employment; Financial struggle after becoming a caregiver	Participant compromised financial security	Compromised her financial security while being a caregiver to a loved one battling substance use or abuse.	"I had to work part-time instead of full time so that I could watch her."
Additional caregiver was present in beginning of caregiver journey; Additional caregiver was present in middle of caregiver journey; Additional caregiver was present in the end of caregiver journey	Additional caregiver(s) present	Received assistance from additional caregivers during the time in which the participant cared for a loved one battling substance use or abuse.	"The church community helped me take care of her, especially towards the end. They became my support and gave me strength."
Additional caregiver was member of nuclear family; Additional caregiver was member of immediate family; Additional caregiver was member of extended family; Additional caregiver was a friend of the participant; Additional caregiver was a medical professional	Additional caregiver(s) relationship to participant	Additional caregiver to the participant during the time in which the participant cared for a loved one battling substance use or abuse.	"My cousin and the lady. If it wasn't for them, I don't know where I would have gotten the strength."
Participant felt an obligation to provide care; Accepting assistance; Participant reached out to local health professionals for assistance for substance	Willingness to accept assistance	Willingness to engage in the caregiving experience and to accept assistance while providing care for a loved	Participant reflects on the adversity experienced during caregiving journey: "I lost a lot of weight. I lost a lot of sleep and um, I was horrible during that time. It wasn't until I started to

First cycle codes (108)	Second cycle codes (31)	Definitions	Quotation illustrating meaning of code
abuser; Participant reached out to religious/spiritual professionals for assistance for substance abuser; Participant reached out to religious/spiritual professionals for assistance for self		one battling substance use or abuse.	get some help from my um, other family members that I was able to um, kind of breathe."
Resistant towards assistance; Participant did not reach out to local health professionals for assistance for self; Faced barriers in obtaining assistance from health professionals for self; Reticence to engage in mental health treatment	Barriers to receiving assistance	Experienced barriers to receiving assistance while providing care for a loved one battling substance use or abuse.	"No, I didn't. We don't really do that in the Haitian culture and besides, I was worried about my father, not me."
Additional caregiver provided/linked individual to resources; Additional caregiver provided emotional support; Additional caregiver provided physical assistance social support linked caregiver to resources	Type of assistance received	Type of assistance the caregiver received during the time in which the participant cared for a loved one battling substance use or abuse.	"I was not asking for help. It wasn't until my cousin came and helped me and when I had the Church community that I started to ask and look for some help."
Received social support; Received moral and emotional support from family	Participant received support	Received support during the time she provided care for a loved one battling substance use or abuse.	"My mother was amazing but her support was really helping me with the kids, but the church family gave me a lot of the support I needed to keep going and do what I needed to do for my family."
Lack of family support; Social isolation	Participant did not receive support	Did not feel as though she received support during the time she provided care for a loved one battling substance use or abuse.	

First cycle codes (108)	Second cycle codes (31)	Definitions	Quotation illustrating meaning of code
Feels the need to give back to others; Shares experience with others	Altruism	A means of coping was to engage in altruistic acts.	
Music as a means of coping	Music as a means of coping	Music served as a means of coping while providing care to a loved one battling substance use or abuse.	"Music has always been very powerful and healing for me and singing and dancing were always passions of mine. But when life happened, I kind of let all of that go, you know? It was therapy for me, especially the music we sang at church."
Exercise as a means of coping	Exercise as a means of coping	Exercise served as a means of coping while providing care to a loved one battling substance use or abuse.	"I actually started to take up yoga to help me kind of calm my mind and take some of the um, stress away. And I found talking to my dad, when he was willing, really helped me kind of, you know, better understand what was going on."
Church involvement and participation as a means of coping; Religion as a means of coping; Prayer as a means of coping; Meditation as a means of coping; Spirituality as a means of coping; Faith; Reliance on prayer; Distinction between religion and spirituality; Religious beliefs; Spiritual beliefs; Religiosity; Spirituality; Instillation of hope; Forgiveness; Sense of relief; Sense of peace	Religiosity/spirituality as a means of coping	Religiosity and/or spirituality served as a means of coping while providing care to a loved one battling substance use or abuse.	"Well, to me, religion is um, the rules and the traditional stuff, you know? But spirituality is how I connect with it all and how I make God relevant for me."
Community involvement as a means of coping	Community involvement as a means of coping	Community involvement served as a means of coping while providing care to a loved one battling	"The church community helped me by supporting me spiritually and helping me find rehab places that I could send my son."

First cycle codes (108)	Second cycle codes (31)	Definitions	Quotation illustrating meaning of code
		substance use or abuse.	
Social support system	Social support system	Having a social support system assisted her in coping with the stressors of being a caregiver to a loved one battling with substance abuse disorder.	"They were so welcoming and so warm and it was just what I needed, so I started to go regularly to there, maybe two or three times per month. That really helped me."
Caregiver felt depressed; Caregiver felt guilt; Caregiver felt hopeless; Caregiver felt alone; Caregiver felt anger; Caregiver felt helpless; Caregiver felt stress; Caregiver bottled emotions; Participant reported temptation to engage in substance use; Participant reported engaging in substance use; Sadness	Inner means of coping and processing	Experiencing of negative emotions while providing care for a loved one battling substance use or abuse.	"It depressed me. I felt hopeless and helpless in it all because I couldn't help her. No matter what I did or tried, nothing helped."
Caregiver's awareness and acceptance	Caregiver's awareness and acceptance	Report of acceptance of the loved one's substance use or abuse.	

The emergent and finalized themes were as follows:

- relationship between the caregiver and substance abuse
- how caregiver became knowledgeable of substance abuse
- substance abusers' pathways from drug abuse to outcomes
    - reasons for engaging in substance abuse
    - reasons for recovery
    - outcomes of the substance abuser
- dangers of the caregiving journey
- assistance given to caregiver
- caregivers' reactions and coping
    - caregivers' emotions and reactions
    - caregivers' means of coping

It should be noted that the data produced one discrepant case, which is to be later discussed in the section addressing the negative case analysis. This participant reported discrepant findings with regards to how she coped with and managed the struggles of being a caregiver to a loved one battling substance abuse. Whereas the majority of the participants mentioned and noted productive coping skills, such as utilizing various religious and spiritual means to manage the psychological stress of the caregiving journey, this participant stated that she "began drinking. I was so stressed out with taking care of him that it made me start drinking." The participant explained that she did so as a means of mitigating psychological stress.

Evidence of Trustworthiness

To ensure trustworthiness, I utilized the concepts presented by Creswell (2009) and Lincoln and Guba (1985). By implementing these guidelines and recommendations, I was able to assess for credibility, transferability, dependability, and confirmability in my study. In collaboration with the guidance provided via a comprehensive literature review and the selection of the implemented theoretical framework, I developed a set of research questions that assisted and drove the data collection and data analysis processes.

Credibility

The accuracy of the data presented was based on my ability to capture the essence of the participant's narrative via verbatim transcriptions of the recorded interviews. One digital recording device was utilized for each interview and all the data gathered was transcribed from the recording device to a Microsoft Word document by me to ensure and safeguard the integrity of the content of each provided response.

Once the initial transcript was prepared, I then re-played each interview to ensure that the produced transcription was accurate and captured each word the participant expressed. This additional step assisted me in detecting any and all potential omissions that may have potentially skewed the essence of the narrative provided. By taking this extra step, I was able to ensure that the integrity of the data and the responses of the participants captured in the transcription were not compromised. Thus, the credibility of the study was attained because I captured an accurate description of the phenomenon and the lived experiences of Haitian American caregivers who provided care to a loved one battling substance abuse.

Transferability

Transferability refers to the ability to generalize the findings of a study to a collective population. To ensure the possibility of transferability, the researcher should be able to demonstrate enough depth, breadth, and detail in the data description (Lincoln & Guba, 1985). As noted in Chapter 3, one of the strategies I employed to ensure this research's transferability was the use of detailed description. By providing rich descriptions, I was able to establish the relevance and the context of the data, thereby, allowing future researchers to build upon this study to infer comparisons in similar contexts.

The overarching aim of this research endeavor was to describe the phenomenon and the lived experiences of Haitian American caregivers who provided care to a loved one battling substance use or abuse. To accomplish this, I presented thorough details founded on the narrated accounts of Haitian Americans which made it feasible to infer that, in some instance, the provided rich data allowed me to note disparities considering the population, setting, demographics and context that guided the research.

The central aim of this phenomenological research endeavor was to describe the subjective experiences, thoughts, behaviors, and coping mechanisms juxtaposed with the lived experiences of Haitian American caregivers. Because the population was so specified, the results may not necessarily be extrapolated to apply to the generalized population; however, this study may be used as a foundation for other studies as the themes developed may assist researchers seeking to explore similar phenomenon and experiences amongst different ethnic groups.

Dependability

The term dependability refers to the consistency and stability to which the research procedures are procured. Thus, consistency, stability and transparency are needed to ensure that the study can be replicated within the same context and methods to yield similar results (Shenton, 2004). To ensure the dependability of the study, I focused on the narratives of the Haitian American caregivers of loved ones who battles substance abuse that was provided to me via the use of semi-structured interviews in which open-ended questions were utilized and posed.

The unadulterated data of the narratives were transcribed verbatim to uphold the essences of each participant's story, to reinforce the study's dependability. Moreover, details such as the data collection process, the demographical information of the participants, procedures in place to manage the data, coding cycles and the data analysis all contributed to and informed the manner to which themes emerged and developed. Painstaking detail to the aforementioned considerations were implemented to strengthen the study's dependability and ensure that the research efforts could be replicated.

The dissertation committee chair, assisted in conducting the audit trail in which transcriptions, field notes, interviews and reflexive journal entries were all carefully reviewed prior to proceeding with data analysis. Through her assistance, all potential biases and other considerations that might have potentially compromised the integrity of the data were addressed and resolved prior to the commencement of data analysis and coding. This will be further addressed in the section entitled confirmability.

Confirmability

As discussed in Chapter 3, confirmability refers to the way a researcher produces confirmable data while being aware of and stating the potential biases that may arise (Shenton, 2004). One of the ways I ensured confirmability was by maintaining a reflexive journal in which I documented any biases, decisions, or rationales that I held that may have potentially influenced or impacted the integrity of my study. The reflexive journal provided me with the opportunity to capture my thoughts, reactions, and biases. Once my reflexive journaling was complete, I then looked to the dissertation chair to serve as my external auditor. By holding a space for neutrality, the dissertation chair was able to assist me in presenting the data in a neutral way to not allow my biases to overshadow the integrity of the study.

The dissertation chair would continue to serve as a neutral space in the data analysis process. During every stage of the coding process, I presented my findings to the dissertation chair as a means of establishing the necessary reliability of the data. In the process of her review, the dissertation chair and I would discuss any potential discrepancies that would arise in my analysis. The conversations held during this time contributed to the selection, refinement and finalization of the codes and emerging themes and subthemes that developed that closely reflected the lived experiences of the study's participants.

Results

Two central research questions and one sub-question drove the development of this research endeavored that explored the lived experiences of Haitian and Haitian American caregivers who have provided care to a loved one battling substance abuse.

RQ1: How do Haitian American caregivers describe the experience of caring for a family member battling substance abuse?

RQ2: How do Haitian American caregivers cope with caring for a family member battling substance abuse?

SQ1: How do Haitian American caregivers use S/R to deal and cope with a family member battling substance abuse?

Four interview questions addressed the first research question; eight interview questions addressed the second research question and its subsequent sub-question. The applicability of each theme and sub-theme to the posed research questions are presented in Table 3.

Table 3

Emerging Themes and Subthemes Based on Research Questions

Research question and subquestion	Themes	Subthemes
RQ1: How do Haitian American caregivers describe the experience of caring for a family member battling substance abuse?	Relationship between the caregiver and substance abuser	
	How caregiver became knowledgeable of substance abuse	
	Dangers of the caregiving journey	
	Substance abusers' pathways from drug abuse to outcomes	Reasons for engaging in substance abuse
		Reasons for recovery
		Outcomes of substance abuser
RQ2: How do Haitian American caregivers cope with caring for a family member battling substance abuse?	Assistance given to caregiver	
SQ1: How do Haitian American caregivers use S/R to deal and cope with a family member battling substance abuse?	Caregivers' reactions and coping	Caregivers' emotions and reactions
		Caregivers' means of coping

Emerging Themes Based on Research Question 1

The narratives of the experiences provided describe how Haitian American caregivers utilized and implemented their preferred methods of coping to manage the stressors of the caregiving process while giving a voice to the magnitude of their experiences, in which they faced danger, experienced the deterioration of relationships, lived in a self-sacrificial and selfless manner, and experienced a lack of assistance to assist the substance abuser in meeting recovery and attaining sobriety.

Theme 1: Relationship Between the Caregiver and Substance Abuser

The first theme that emerged was an exploration of the nature of the relationship between the caregiver and the substance abuser. Two contexts emerged: the natural relationship the caregiver had to the substance abuser and the emotional/behavioral relationship the caregiver had to the substance abuser. As demonstrated in Table 2, 6 out of the 10 participants reported that they were not the sole caregivers of their loved ones and the relationships between the participants and the caregivers tended to be a relationship that existed in the nuclear, immediate, or extended family. Although this was not a requirement of the study, respondents to the initial inquiry for participation fell within the category of a family member, therefore, no friends, acquaintances, or peers served as primary caregivers for this study.

The majority of participants shared that, in the beginning of their caregiving journey, they were the sole caregivers; however, as they continued to provide care for their loved one, they began to receive assistance, often times in the form of emotional, moral or social support. There were no participants who reported receiving physical or

financial assistance. For most participants, receiving emotional, moral and/or social support made all the difference in the caregiving journey.

> *Participant 4*. At first, it was just me. Then one day, I called a friend of mine and I was just crying on the phone—she couldn't understand me when I tried to speak to her. So she came over and found me on my couch just crying with broken glass on the floor. She asked me what happened and I told her that I had an argument with my son and he smashed the vases on the floor. When she asked why we fought, I told her it was because I was trying to get him to stop drinking and that is how she found out my son was an alcoholic. From then, she tried to help me anyway she could. She would come over and stay with him while I went to work, she would listen to me cry and she even took me to her church where I was able to get some more comfort. I had stopped going to church when my husband died—I think I was angry at God. And then when my son started drinking, I got more angry with God. But I got so tired of being sick and tired and angry and decided to give church a chance again, and I'm glad I did. I needed to be in the church environment again to help me through that time.

Several participants noted that the social, emotional, and spiritual support received through their respective support systems provided them with the strength needed to continue their subjective caregiving journeys.

> *Participant 6.* The church community was my support system, and they became family. I really turned to them for love and support when I was going through that darkness of taking care of my husband.

This theme also included how the relationship changed prior to, during and after the caregiving process. Participants 3, 6, and 9 noted that the relationship held with the substance abuser was strained prior to the caregiving process. Participants 4, 5, 7, 8, and 9 reported that the relationship was strained during the caregiving process. As Participant 4 noted: "Our relationship was bad. He hated me for trying to help him. He would curse me and sometimes, he tried to fight me because he was so mad…Our relationship was really bad when he was drinking the alcohol." During the abuse of substances, many participants noted that the relationship between them and their respective loved ones were particularly strained or damaged once they took on the role of *caregiver*.

To conduct a contrast, when I asked the participants if the relationship between themselves and the substance abusers improved once sobriety was attained, many noted a vast improvement in the nature of the relationship between themselves and their loved ones. Thus, although there was a considerable amount of damage done to the relationships held between the participant and the substance abuser, half of the study's participants reported an improvement in the communication and the overall relationship with the caregiver either when sobriety had been met or when the caregiver developed a sense of empathy and compassion towards the substance abuser. Moreover, many of the participants who reported developing empathy and compassion attributed it to their active means of coping in either religious or spiritual interventions and methodologies. Those who reported developing empathy and compassion stated that they forgave their loved one and released the pain experienced from their caregiving journeys. Participant 6 noted:

"So I felt like after we had our conversations, and I could really understand his pain, I was able to forgive him."

Further exploration into the evolution of the relationships between the caregivers and the substance abusers demonstrated the manner to which resolutions in the relational dynamics were made. Participant 2, noted: "Well the relationship now is, like right now, he looks at me like a mother for him based on the effort that I put out to help him get out of the situation." Such reconciliations and evolutions were noted in the instances to where the substance abuser pursued and maintained sobriety. However, the participants who reported the death of the substance abuser seldomly reported a resolution and reconciliation in the relationship prior to the death. Participant 5, attributed the lack of closure and reconciliation to the death of the loved one, citing that closure was never attained as illustrated in this vignette: "We never really resolved or healed anything because she died, and we never really talked about it before she died."

Theme 2: How Caregiver Became Knowledgeable of Substance Abuse

The common premise within this theme was that the caregivers noticed behaviors unlike the substance abuser's characteristic behaviors and mannerisms, which led them to the awareness that their loved one was engaging in substance abuse. There were four central premises: the participant noticed unusual behaviors/activities, the participant found the loved one impaired due to his/her substance abuse, the participant witnessed the loved one engaging in substance abuse, or the participant began to note warning signs of substance abuse.

Participant 1 gained knowledge of her loved one's substance abuse because she was knowledgeable about the warning signs of substance abuse; Participants 5, 9 and 10 found their loved ones impaired (either delusional or unresponsive); and Participant 6 and 7 reported that they found their loved ones engaging in substance abuse. Participant 3 noted: "She was acting weird, staying out all night, coming in at weird hours, stealing from me, hardly sleeping, hardly eating, stayed in her room unless she was going out—she was acting weird." Of the participants who disclosed the manner to which they gained knowledge of their loved one's substance abuse, none of the participants shared that the substance abuser readily disclosed this information, but stated that they came into the knowledge, by happenstance or by observations.

After discovering their loved ones' substance abuse, many participants noted experiencing depression and anger towards both, the substance abuser and themselves. This is because of the secrecy the substance abusers partook in while engaging in substance consumption. Many noticed their loved ones engaging in lying, stealing, and leaving the home for extended periods of times. While the substance abuser was engaging in such activities, many of the participants reported experiencing confusion, depression, and anger because they did not know what was occurring at the time and they did not know, with certainty, why their loved ones were engaging in such suspicious and unusual behaviors. In an effort to understand what was occurring for their loved ones to cause them to fall into substance consumption, many of the participants engaged in investigative activities that would later be perceived as their beginning stages to being a caregiver. Such activities are explored within the discussion of theme 4, dangers of the

caregiving journey. However, one poignant example of the investigative activities the participants engaged in is seen in the following vignette:

> *Participant 1*. I could remember at one point… I used to go out into the field, and I used to go look for him in his drug holes. And at one point, believe me not, I was pregnant. And I used to go look for him and what gave me a wake-up call is that I said to myself: "What if the police decide to do a, uh, uh sting operation?" And by the time that I would clear myself they'll take you downtown before you can prove that this is the situation that you're in you were just looking for your brother and I say, "You know what? Untuh, I have to love me and and and the ones that I'm carrying in my stomach first."

Here, the participant is providing full detail of the lengths she went to in order to discover the substance abuser's activities and whereabouts. This example is an excellent instance of how the participant compromised her overall safety.

Theme 3: Substance Abusers' Pathways From Drug Abuse to Outcomes

The third theme revealed how participants perceived the substance users' pathways from drug abuse; and it showed the contributing factors that led to the loved one's substance abuse. Within this theme, three concepts emerged: reasons for engaging in substance abuse, reasons for recovery and the outcomes of the substance abuser. Special credence was given to the breadth of the substance abuser's experience from the eyes of the participants as a means of providing a comprehensive narrative of the substance abuser's probable causes of engaging with substance abuse, the manner to which recovery was or was not met and the ultimate outcomes of drug abuse for the

substance abuser. Thus, the third theme sought to explore the narratives of the substance abusers told through the perspective of the participants, who served as the caregivers. In this theme, the following domains were explored: considerations as to why the substance abuser began to engage in substance abuse, the manner to which the substance abuser attained or did not attain sobriety and the fate of the substance abuser.

Reasons for Engaging in Substance Abuse. Within this subcategory, an exploration as to the reasons why the participants' loved ones began to engage in substance abuse was explored. These included an inability to overall cope with life's circumstance, internal factors that revolved around mood fluctuations or external factors that focused on the substance abuser's attempt to acclimate to the new culture.

Inability to Cope With Life Circumstances. Participants believed their loved ones presented an inability to cope with various life circumstances, such as unemployment or a difficulty to attain employment (in which the participant believed the substance abuser engaged in substance abuse due to his/her inability to cope with unemployment), financial issues and an inability to cope with their various emotional states as they responded to their unique life circumstances.

Internal Factors Contributing to Drug Abuse. The second major factor revealed mood fluctuations that contributed to engaging in substance abuse. Several of the participants reported that they believed their loved ones engaged in substance abuse as a means of managing and coping with their subjective stress, including psychological stress, relational issues, depression, anxiety, loss, guilt, and mental health issues. Participant 2 attributed her loved one's substance abuse to the relational issues that were

occurring within his home between himself and his girlfriend. The majority of the participants reported believing that their loved ones engaged in substance abuse as a means of self-medicating against depression, anxiety, guilt, grief and loss, and an overall sense of hopelessness.

External Factors Contributing to Drug Abuse. External factors that contributed to drug abuse referred to peer validation, acceptance, peer pressure, curiosity, and assimilation to the new culture.

Participant 1. Experiment, wanting to fit in, I guess, acceptance. (*the participant takes a moment to recall the term she wishes to use and exclaims)* Peer pressure! You know, 'hey come try this, come try this, you know, it makes you feel good. Thus, this vignette demonstrates a need for belonging, which came in the form of assimilation within the American culture.

The Process of Recovering or Attempting to Recover. After describing the contributing factors that led their loved ones to substance abuse, participants described the process of seeking recovery. In the context of this research, reason for recovery refers to the substance abuser's motivation to take action-oriented steps that would lead to sobriety. As this research was conducted from the perspective of the caregiver, the reasons for recovery are speculative in nature. From the participants' perspective they identified the following events that contributed to recovering or attempting to recover: the loved one received *tough love*, the lifestyle was not accepted by their family members and loved ones, the substance abuser sought out sobriety because of his/her own personal desire, and the substance abuser felt supported, validated, and understood. Participant 1

provided an example of how family members influenced the recovery of the substance abuser.

> But the only thing I can say at the end of the day, he got himself straight. You know, but I think my father's contribution helped him to get himself straight because he did not accept him to come near the house. Tough love, real tough.

Outcomes of the Process of Recovering. The third concept this theme explored was the substance abuser's reason for recovery. As previously noted, not all participants were able to report the recovery and sobriety of their loved ones. Out of the 10 participants of the study, only three participants reported that their loved ones attained sobriety and did not relapse. Several of the participants reported that their loved ones either suffered a relapse in recovery and/or met their demise as consequent to diseases attained due to their substance abuse. Those who reported relapse expressed that the substance abuser made earnest attempts to maintain sobriety (multiple attempts to enter rehabilitation programs and remain under the care of family) but was unable to do so for reasons unknown to the participant.

> *Participant 5*. She relapsed and I had her to go back to rehab. Then she started to get herself together again and she came back to live with me for another year or so, and she relapsed again and then she died.

This is an unfortunate example of the recursive process of substance abuse. Many who seek assistance in their rehabilitative and recovery process will unfortunately experience recidivism or meet an untimely demise due to an inability to maintain and adjust to their new and sober lifestyle.

Theme 4: Dangers of the Caregiving Journey

The fourth theme to emerge related to the dangers of the caregiving journey. This theme referred to the challenges the participants were presented in their caregiving role. The challenges involved health ramifications. Half of the participants noted that they compromised their well-being either by actively placing themselves in danger, compromising their safety during the caregiving journey, facing health complications or weight-loss due to the stressors of being a caregiver, or creating stress in their personal relationships. The final domain that emerged within this theme was the financial constraints placed on the participants during the caregiver journey. Participants reported their employment security was jeopardized or they were unable to maintain the same level of employment (such as transitioning from full-time to part-time employment) due to the demands of being a caregiver.

> *Participant 2.* I started working overtime on my job so I can pay the rehab. I took him to a rehabilitation facility, and I took him to another rehab, but you have to pay as you go what he used to do is keep the money and do not go to the session.
>
> *Participant 8.* I, well my whole family, needed to work around her schedule to make sure she was okay and safe. I had to also take out loans so that I could pay for her rehab and am still paying some of those loans back to the bank or from friends I borrowed the money from.

Many of the risks assessed and explored compromised the caregivers' physical, emotional, and financial well-beings as well as compromised and interrupted the subjective familial dynamics within their personal households. While all the

aforementioned factors were considered, the area which appeared to be most prevalent and common across most of the participants was the fact that the sense of financial security was compromised. Most participants remarked that they were no longer able to maintain the same level of employment due to their caregiving duties.

> *Participant 5.* I had to lessen my hours at work which meant I wasn't making the same money I was making before. And that was stressful on me because I still had the same bills, you know? It was just a lot to go through and I didn't have help for a long time. I just had only me; and I had to take care of her and watch her.

The majority of the participants noted that they took on an active role in the caregiving process, either by physically caring for the substance abuser (such as looking after the substance abuser and bathing the substance abuser), taking on an emotional and supportive role in the caregiving process (such as attending meetings with the substance abuser and talking to the substance abuser), and/or stating that they took a financial role of support during the caregiving process (such as covering the costs of substance abuse treatments, meetings and therapies, and providing the substance users/abusers with their basic needs, such as food, clothing and shelter). Participant 7 stated: "I was bathing him and changing him—because there came the time that he was so sick, he couldn't do it by himself." Participant 1 referred to providing emotional support, "I was there for him, thick or thin, whenever that I can and encouraged him to go for some kind of treatment, you know, go to treatment programs."

Results of this theme solidify the notion that caregiving is an all-encompassing vocation that, should it not be maintained in its proper balance, may have detrimental

effects for the caregiver. The participants of the study executed the caregiver role with a level of self-sacrifice to assist their loved one overcome the battles of substance abuse.

Emerging Theme Based on Research Question 2

Theme 5: Assistance Given to Caregiver

The fifth theme that emerged from the data collected concerned the assistance caregivers offered, gave, and received. Participants reported receiving support not only from personal relationships such as friends and loved ones, but also from medical, religious, and spiritual professionals. Participants also discussed their receptivity to these varying levels and means of support. Most of the participants of the study attested to receiving some level of support during their caregiving journey; however, because of the common conception within the Haitian American households of relying on self and family, support was not readily received. Some of the participants demonstrated the reticence to receive assistance, expressing that they did not seek assistance from outside sources until they felt absolutely overwhelmed with the burden of caregiving. Few of them even reported periods of social isolation due to their inability to actively accept assistance. When assistance was sought out, it often time appeared in the form of social, emotional, and moral support and/or linking the participant to valuable resources.

> *Participant 5*. Well at first, I handled it by myself. I didn't really do anything but take care of her and take care of myself. At first, it was just me taking care of her and it got so bad that I had to reduce my work hours to take care of her until my other cousin was able to come and help me.

When asked about their efforts to actively seek out assistance from a medical professional or licensed mental health clinician, several participants noted that they experienced self-imposed barriers due to their reticence to engage with such services. When seeking further clarity on this issue, an overwhelming number of participants noted that they had not sought out assistance either because it went against what they were taught culturally, or they were focused on their duties as a caregiver. Participant 9 expressed: "No, I didn't. We don't really do that in the Haitian culture and besides, I was worried about my father, not me." Participants expressed the cultural and upbringing influences in their help seeking behaviors. Participant 5 reported: "I was always taught to keep private and family life at home…So, I dealt with it by myself." And participant 10 stated:

> Well, hmm, in the beginning, like I said, it was me and I think it was because I didn't necessarily want the help. I am a private person, and I was always taught that what happened at home stayed at home. So, I was not asking for help.

Besides the self-imposed cultural barriers that prevented them from seeking assistance, participants seemed to feel invalidated by medical and/or mental health professionals and felt a severe distrust in the healthcare systems. They did not seek mental health support for themselves. Out of the ten participants, only two affirmed that they did contact local health professionals to assist the substance abuser with entering a rehabilitative program.

When seeking assistance, participants relied more on family members, or religious professional support. Participant 1 expressed: “One of the older siblings, my sister, you know, she was very hands on.” And participant 2 mentioned:

> I had a priest friend that I used to call with this and talk to him and sometimes he comes to the house, pray with us, and talk to him. And I had a doctor friend that used to talk to him, and he'll call him and tell him what damage that drugs can do to his brain.

In sum, the idea of devoting oneself, almost entirely, to the caregiver vocation was seen in most of the participants and interfered in their ability to readily accept assistance from sources outside of self. Only when the task of caregiving became difficult the participants made attempts to seek out assistance either in friends, family, or church communities. Participants explicitly reported seeking religious and/or spiritual counsel to assist them in managing the stressors of providing care to a loved one battling substance abuse. This only demonstrates the comfort that this population experiences with this type of support.

Emerging Theme Based on Subquestion 1

Theme 6: Caregivers’ Reactions and Coping

The final theme to emerge from the study was chiefly concerned with the caregivers’ reactions to the substance abuse of their loved ones and the means they implemented to cope with stressors. Within this theme, two sub-themes, caregivers’ emotions and reactions and caregivers’ means of coping, emerged.

Caregivers' Emotions and Reactions. The sub-theme of caregivers' emotions and reactions refers to the way the participants internally coped with discovering their loved one's substance abuse and the stressors of being a caregiver. Participants reported feeling and experiencing negative emotions while providing care for a loved one battling substance abuse. Specifically, they expressed various types of reactions including a range of emotions (via feelings of sadness, depression, guilt, hopelessness, anger, loneliness, helplessness, and/or stress), and implosions in which the participants stated they *bottled* their emotions.

Depression was the emotion most frequently mentioned. All participants actively affirmed experiencing a sense of depression during their caregiving journey. Participants expressed the inextricable link to feelings of hopelessness, loneliness, isolation, and/or helplessness, consequent to feeling ineffective at alleviating the substance abuser's plight.

> *Participant 8*. It depressed me. I felt hopeless and helpless in it all because I couldn't help her. No matter what I did or tried, nothing helped. I tried to help her on my own and it didn't help I tried to put her in rehab, and it didn't help, she would just go back to the alcohol when the rehab was done. I tried to have her go to the meetings and it didn't help because she wouldn't talk to the people. Nothing helped her and it seemed like the more I tried, the worse she got. So, I felt helpless and hopeless.
>
> *Participant 10*. It caused me to feel really sad and in despair. I felt like I was helpless in really helping her because it seemed like no matter what I did, she was still using drugs, or she would relapse, and I couldn't get her to stop.

Experiencing guilt was another pervasive emotion that participants described. Participants reported experiencing guilt because of feeling as though they contributed to their loved ones' substance abuse. As Participant 3 noted: "It made me feel guilty… I felt like a bad mother because I brought this into my daughter's life. If I didn't have her move, she wouldn't have started drinking and if she didn't start drinking, she wouldn't have started with those other drugs." Participant 4 noted that the guilt she experienced prevented her from engaging and implementing self-care measures that would have assisted her in the coping process and assisted her in managing her stressors. "I couldn't think about myself, I didn't feel like I had the right because I really blamed myself for what happened to him." Finally, Participant 6 provided a glimpse of how detrimental the sense of guilt was during her caregiving experience.

> *Participant 6:* I felt hopeless, I felt alone. I felt weak and I felt like I was not a good wife because if I was, then I would have been able to help my husband with working so he wouldn't have been so stressed. I felt like it was my fault… Because if I didn't have the miscarriage and was able to work, he probably would not have felt as stressed and then he probably would not have started drinking like he was.

Participants reported experiencing anger because of feeling as though they needed to suppress their emotional anguish in order to tend to their loved one's substance abuse. Participant 3 stated: "When she started smoking the marijuana, I felt angry because I was hurting too—I mean my husband just died and I couldn't even really feel sad about it because I had to watch her." Participant 7 shared: "I felt angry that I didn't have the

chance to kind of get myself together and heal from my divorce because I had to take care of him, you know?" In both accounts, the participants explicitly stated that they were in the midst of experiencing their personal adversities. The anger felt is a reaction to the frustration experienced by being overwhelmed with their set of circumstances and not feeling as though they had a means to truly seek refuge.

Stress and emotional suppression were another set of emotions participants described. Several participants reported experiencing heightened levels of stress while providing care to a loved one battling substance abuse. The stress experienced was associated to feeling overwhelmed with the task of caring for their loved one, while still managing the other affairs in their respective lives that required their full attention.

Participants also reported suppressing their emotions while providing care to a loved one battling substance abuse. Participant 10 stated: "I guess, I didn't want to burden people. I mean I had friends, but I was always taught to keep private and family life at home. So, I dealt with it by myself." When exploring the detrimental effects of emotional suppression, Participant 7 reported that, in not having an outlet to which she felt she could freely express and release her stressors, she became tempted to engage in substance use while providing care for loved one battling substance abuse.

Caregivers' Means of Coping. All the participants of the study noted an intersectionality that occurred between their emotional processing and the activities they engaged in to cope with the stressors of caregiving. The preferred and most popular strategy revolved around religion or spirituality. All participants stated that their main means of coping was through their faith (religious) and prayer or meditation (spiritual).

They described prayer, performed individually or in a collective setting such as church or family setting, as the key resource they resorted in stressful moments.

> *Participant 2*: We have prayer groups in the house. And the whole family and close friends that know the situation and friends that have people that were involve in that same kind of behavior. We used to do a lot of group prayer here in the house. Since we believe in prayer, and that was one of the hopes we had—that prayer breaks anything—that was the hope we had and that's what helped us cope with it.

Statements such as these signify that prayer was a means of unifying all caregivers involved through a shared instillation of hope, strength, and community. Participants also addressed the concept of faith. Many of the respondents juxtaposed faith with religion, often utilizing *faith* and *religion* interchangeably. When asked how the use of faith assisted in the healing process, many of the participants stated that their faith provided them with the strength and peace to continue the caregiving journey.

> *Participant 5*. Oh, it was very important. It was how I found peace and that peace was how I found the strength to continue. There were many times I wanted to give up, you know? But I couldn't because I had her depending on me. So, when I didn't have the strength, I relied on my faith.

All participants of the study noted the influence of faith, religion, or spirituality as a chief means of coping. Although the manner to which religiosity and spirituality were implemented varied among participants, participants identified a distinction between religion and spirituality.

Participant 10. Well, to me, religion is the rules and the traditional stuff. But spirituality is how I connect with it all and how I make God relevant for me…how I relate to God and make Him more real and closer to me. Religion kind of makes you think that God is separated from us and that we can't reach Him, but spirituality makes Him reachable to me.

Another layer to participants' faith and spirituality related to the use of music. While most of the participants expressed engaging in and maintaining an active prayer life, many participants expressed amalgamating their prayer life with music.

Participant 1: Okay, every so often they have like Feast of something [at Church] so they call it like a Revival. The Revival may last up to a week or to a week and a half where people will go and worship, and through a lot of prayers and a lot of music they feel the spirit. Through that music, through the words of the music, they will feel, you know, the spirit and pain and a way of dealing with problems, dealing with situations. Because when they're there—I experienced it myself— I am full of joy. And like whatever problem you're going through ceased for that time. You don't feel the problem, it stops. You pray and then you become calm, and you don't really think about the problem.

Participant 6: I started to dance again and started to sing at church. Music has always been very powerful and healing for me and singing and dancing were always passions of mine. But when life happened, I kind of let all of that go, you know? It was therapy for me, especially the music we sang at church.

Although the previous excerpts demonstrated the use of music within a communal setting, participant 7 expressed the use of music in her private moments as a means of providing comfort and inducing solace in the midst of adversity.

> *Participant 7*: Hmm, well I know when I was bathing him and changing him—because there came the time that he was so sick, he couldn't do it by himself, I would sing songs from church, and I found it helped both me and him.

Within these excerpts, it is noted that the participants found a sense of consolation in engaging music as a means of coping. Religion and spirituality provided participants with specific tools to deal with their stressors and burden of caregiving. Particularly they described developing altruism and feeling the need to give back to others, instillation of hope in expecting the best for their loved ones, forgiveness towards the substance abuser, and experiencing a sense of relief and peace.

Finally, other means of coping participants described were exercising, engaging in community activities, or relying on their social support system. These seemed more action-oriented activities that implied doing something. Examples participants provided were attending support groups or community gatherings, or even receiving psychoeducation (such as literature to read and conversations to debrief what was contained in the literature) from trusted friends within the medical field regarding their loved ones' battles with substance abuse and how to best support their loved ones through this period.

Negative Case Analysis: Participant 9

Although there were some inconsequential discrepancies and variances between the details of the participants' narratives, participant 9 reported quite a different experience when she discussed her means of coping with the stressors of being a caregiver. Unlike the other participants of the study who disclosed implementing religious and/or spiritual methods as a means of coping, this participant disclosed that she, began to resort to substance use (alcohol) to cope with the stressors of being a caregiver, despite having seen how detrimental it was to her father. She stated that she knew alcohol and substances were harmful, but in an effort to cope, prior to employing R/S techniques, such as going to church, she admitted to indulging in alcohol use to cope and found herself falling victim to potentially becoming an alcoholic herself.

> Honestly, I began drinking. I was so stressed out with taking care of him that it made me start drinking. But after dealing with all of the depression and frustration, I started to begin praying again. I used to pray all the time but found when I got into all of the stress, I was just trying to deal with it the best way I could. I wasn't thinking about coping, I was thinking about surviving the next minute and pushing through. What eventually helped me do that was praying and then going to church but for at least a year, I was so frustrated, all I did was cry and take care of him.

Summary

The purpose of this study was to explore the manner to which Haitian American caregivers cope with providing care for a loved one battling substance abuse. There were

two foundational research questions and one sub-question to address this phenomenon: (a) How do Haitian American caregivers describe the experience of caring for a family member battling substance abuse? (b) How do Haitian American caregivers cope with caring for a family member battling substance abuse? and (c) How do Haitian American caregivers use S/R to deal and cope with a family member battling substance abuse?

A total of 10 participants met the criteria for participation and during the interviews, they provided rich and detailed descriptions of their experiences. The first theme that emerged from the results was the substance abusers' pathways from drug abuse to outcomes. The second theme that emerged from the results was an exploration of the relationship between the caregiver and the substance abuser. The third theme that emerged from the results was an investigation of how the participant (who served as the caregiver) became knowledgeable of the substance abuse. The fourth theme that emerged from the results was a consideration on the dangers of the caregiving journey. Within this theme, an exploration of the reasons for engaging in substance abuse, the reasons for recovery and the outcomes of the substance abuser were considered to explore the extent of the substance abuser's narrative. The fifth theme that emerged from the results was the assistance given to caregivers and the exploration of the role of the participant and the caregivers attempt to receive assistance for self and assistance given to caregiver. The sixth and final theme that emerged from the results was an exploration of the caregivers' reactions and coping and this theme considered both the caregiver's coping mechanisms and the reactions and emotions of the caregiver at the time of providing care to their loved ones battling substance abuse.

The first, second, third and fourth themes and corresponding sub-themes responded specifically to the first research question. Many of the participants described the totality of their experiences as caregivers. During this exploration, participants provided their narratives on how they began the caregiving journey, how the caregiving journey impacted them and the substance abusers' pathways from drug abuse and to their outcomes. For many of the participants, the caregiving journey was a long, arduous and tumultuous one filled with adversity and heartache. Many of the participants expressed sentiments of being distraught and overwhelmed by the duties imposed upon them as caregivers. Thus, many found that they needed to make adjustments physically, mentally, financially and spiritually to endure the hardships they experienced.

The fifth theme and its corresponding sub-themes responded specifically to the second research question. The second research question sought to explore how the Haitian American caregivers coped with the struggles of being a caregiver to a substance abuser. The theme and sub-theme that was pertinent to this question explored the assistance provided to the caregivers. Some of the participants acknowledged having assistance at various times of the caregiving journey; however, many reported that they were either sole caregivers or received assistance for a fraction of their caregiving journeys. Further, as this theme explored the caregivers attempts to receive assistance for themselves and the assistance they were willing to accept, many of the participants reported a reluctancy towards receiving assistance and shared that they were opened to assistance once they were overwhelmed with the responsibility of being a caregiver.

The sixth theme and its corresponding sub-themes responded specifically to the second research question's sub-question. The sub-question explored the manner to which the participants coped with the stressors of being a caregiver for a loved one battling substance abuse. The participants shared that they engaged in behaviors, emotions and actions which contributed to their means of coping. However, all of the participants emphasized the significance of their faith, religiosity and spirituality and credited these factors towards their ability to cope with the stressors they faced and endured during their caregiving journeys.

The concluding chapter of this presentation will provide a comprehensive description and synthesis of this research's findings, a discussion on the implications for social change, various recommendations for future research endeavors to expand on the findings of this endeavor and the limitations of this study.

Chapter 5: Discussion, Conclusion, and Recommendations

The central aim of this research endeavor was to explore how Haitian American caregivers coped with the stressors that they faced as they provided care to their loved ones who battled substance abuse. To depict and convey the essence of the narratives provided by the Haitian American caregivers, I employed the IPA methodology.

The results of this study indicated that the main means of coping with the stress was engaging in religious and spiritual practices as a means of managing the psychological and emotional stressors associated with being a caregiver. Chapter 5 presents a discussion of results in terms of previous studies and the theoretical frameworks and addresses the limitations and recommendations for future research and meaningful contributions to social change.

Interpretation of the Findings

Relationship Between the Caregiver and Substance Abuser

One of the first themes to develop was that of the relationship between the caregiver and the substance abuser. Special credence was given to this relationship as a means of establishing the foundation to explore the extents the participants went to in order to try and ensure the well-being of the substance abuser. This research endeavor was consistent with findings in the literature regarding relationships within the caregiving context. The study demonstrated that the caregivers within the study were familial, paralleling the findings of Reyes and Duchene (2015). The 10 Haitian American caregivers presented experiences that were consistent with the findings of previous research endeavors conducted utilizing Haitian and Haitian Americans. The study's

results with respect to this theme parallel the findings of several research endeavors that found that the caregivers of substance abusers tend to have immediate and nuclear familial ties and tend to be female (Rafiq & Sadiq, 2019; Soraya et al., 2021; St-Amant & Schwind, 2021). The notion that this is because of a woman's perceived inclination to display more nurturing qualities is speculative; however, the data presented in both this study and other scholarly endeavors are consistent in both the gender and relation to the substance abuser.

How Caregiver Became Knowledgeable of Substance Abuse

The second theme represents how participants noticed unusual behaviors/activities, found the loved one impaired due to their substance abuse, witnessed the loved one engaging in substance abuse, or began to note warning signs of substance abuse.

These results are consistent with the findings found in Ventura and Bagley's (2017) study. Participants in this study reported gaining knowledge of their loved one's substance abuse by the individual engaging in behaviors that were secretive or suspicious in nature; neglecting responsibilities in the home, work, or school; having a sudden change in friends and hobbies; having an unexplained need for money and surmounting financial issues; and exhibiting a withdrawn nature toward family, friends, and social activities. The results found here are consistent with previous studies in which caregivers and loved ones became knowledgeable about their loved ones' substance abuse by observation (Kressler, 2020), noticing risky behaviors (Carney et al., 2020), and noting extreme behavioral and emotional changes, such as mood swings, irritability, euphoria,

and depression (Settley, 2020). As previously noted, the findings in this study remain consistent with the findings of other research endeavors, demonstrating a parallel phenomenon that transcends culture, time, and space. Although I did not investigate further as to the reasons why participants' loved ones did not readily share their struggles, one can only deduce that the shame surrounding the use of substances prevented them from providing such disclosures.

Substance Abusers' Pathways From Drug Abuse to Outcomes

The third theme revealed the reasons as to why the substance abusers began to first engage in drug abuse. The results from this study were consistent with the findings in the literature that substance abusers generally engage in drug abuse as a means of self-medicating against the difficulties that they are experiencing within their subjective lives (Weiss et al., 2018). The main contributing factors found within the study parallel those found in other scholarly endeavors and were inclusive of emotional struggles (Weiss et al., 2019) such as psychological stress (Weiss et al., 2019), depression and trauma, financial issues, and insecurity or instability (Contractor et al., 2020). Marcelin et al. (2005) examined the prevalence of substance use and abuse within the Haitian population in the United States. The results of this study parallel those found in Marcelin et al., in that the leading causes for substance abuse within this population were immigration, acculturation, and identity processes, such as wishing to acclimate and assimilate with peers.

The second aspect of this theme was the substance abusers' movement toward sobriety or substance abuse. The results from this study demonstrated that the participants

believed that active support and disapproval of the substance abuser's destructive lifestyle contributed to the substance abuser's recovery. This is consistent with Pettersen et al.'s (2019) findings in that the sustained abstinence of the substance abusers was largely attributed to the perceived support that they received from caregivers, family, friends, and community. Both studies demonstrate that sustained and substantiative abstinence was attained when the substance abuser was able to acknowledge the damage that substance abuse was creating in their life and the lives of those who cared for them, garner a sense of responsibility for their behaviors and actions, and rely on a strong sense of community to assist them in their recovery processes.

Dangers of the Caregiving Journey

The fourth theme to emerge was represented in all the interviews conducted and encompassed the participants' physical safety and proximity to harm, the participants' overall health and well-being, and the participants' financial well-being and stability. Results of this theme were consistent with the results found in the extant literature. Previous research found that often, caregivers' mental, physical, emotional, and socioeconomic well-being is compromised due to their duties of being a caregiver (Manelli, 2013; Settley, 2020).

To further corroborate these findings, a study conducted by Schulz and Sherwood (2008) noted that, aside from the burdens of a chronic stress experience, the caregiving process is one that creates psychological, physical, emotional, and financial strains over extended periods of time and has the capacity to create "secondary stress in multiple life domains such as work and family relationships, and frequently requires high levels of

vigilance" (p. 25). The difficulty seen amongst caregivers maintaining a sense of balance and equilibrium within their subjective lives is a noted phenomenon found within the literature with regard to caregiver stress and burnout and is attributed to an inability to maintain their quality of life (Labrum, 2020; Kressler, 2020), time (Labrum, 2018), resources (Bosk et al., 2021; Labrum, 2018), and energy (Labrum, 2018) due to the demands of being a caregiver (Dodge & Kiecolt-Glaser, 2018; Griva et al., 2016; Shapiro et al., 2007).

Assistance Given to Caregiver

The fifth theme was addressed by all of the participants in the study and involved the caregiver receiving assistance from individuals, particularly individuals within the medical profession. Many of the participants in the study expressed feeling invalidated by the medical health professionals and felt a severe distrust in the healthcare system. Such responses are found consistently throughout the literature when exploring the reticence to seek medical assistance within the African and Afro-Caribbean cultures. Previous studies in this arena indicated that participants reported that seeking outside assistance, especially for issues surrounding mental health, is a practice seldom done in the Haitian and Haitian American communities, and therefore, assistance was not proactively sought with regard to how the caregivers managed their stress (Marcelin et al., 2005). Results like this are not uncommon, as there is prevalent shame and stigma surrounding mental health issues (Labrum, 2018; Tyo & McCurry, 2020) that leads to a desire to either self-medicate through substance usage (Labrum, 2018) or internally cope with the psychological stress and burden of being a caregiver (Su & Gelford, 2020; Tambling et al., 2021).

Alsan and Wanamaker (2017) noted that there is a severe lack of trust and confidence in the medical field amongst individuals who identify as African American due to the egregious acts of medical professionals against this group of people during the Tuskegee syphilis trials that lasted from 1932 to 1972, in which African American men were utilized in experiments to observe the effects of the disease when left untreated. Although not completely related, this instance provides a basis as to why there is such a prevalent reticence within the African-American and Afro-Caribbean population to seek medical intervention when needed. When compounded with the unique issues that immigrants encounter when in the process of becoming acclimated to the customs of the host country, Allen et al. (2013) suggested that immigrants, such as those belonging to the Haitian American community, maintain a hesitation to seek medical counsel and intervention due to their concerns regarding medical care and cynicism toward free or subsidized care, difficulties navigating through health care systems, and language barriers (Allen et al., 2013).

Caregivers' Reactions and Coping

The sixth theme involved two areas: the participants' emotional states and reactions during the caregiving process and the participants' means of coping with the stressors. These results were consistent with what has been reported in the literature. In previous literature concerning caregivers' reactions, it was found that the effects of substance abuse for caregivers invoked feelings of anger (Tanner et al., 2013), depression (Susanti et al., 2019), rage (Mafa & Makhubele, 2020), fear (Sremac, 2018), abandonment (Ludwig et al., 2021; Sremac, 2018), concern (Tanner et al., 2013), anxiety

(Tanner et al., 2013), embarrassment (Sremac, 2018), and/or guilt (Sremac, 2018), all of which were exhibited with the chosen sampled population in this study. Further, the participants in this study reported experiencing strained relationships between themselves and the substance abusers, consistent with Velasquez et al.'s (2015) report of issues with communication and anger that are present within familial structures when an individual is abusing substances.

The results about coping were also consistent with the findings of other scholarly studies and reviews that explored the coping methods of indigenous groups and cultures whose members prefer holistic means of restoration over Western means of healing. Consistent with the results found in the study, Mesidor and Sly (2019) found that positive religious and spiritual coping, active coping, and perceived social support contributed to a significant amount of resilience garnered in their participants' posttraumatic growth quotient, finding that religious coping was the strongest predictor of posttraumatic growth. Further to this stance on posttraumatic growth and one's ability to cope with adversity, a study conducted by Rodriguez-Perez et al. (2017) found that dysfunctional coping was related to worse quality of life in the psychological dimension, while emotion-focused and socially supported coping were related to superior psychological and environmental dimensions of quality of life.

Theoretical Framework

Carver et al.'s (1989) concepts of coping and Pargament's (1997) theory of religious and spiritual coping constituted the theoretical framework for this study, as both theories explore the various means of coping that individuals implement to manage

psychological stress. As a brief review, psychological stress is defined as the relationship that people hold with their environments in which they perceive and deem their environments to be particularly demanding and challenging that, when compounded with a limited amount of resources, can potentially present risks that endanger the well-being of the individual (Lazarus & Folkman, 1984). Special consideration needed to be applied to the psychological stress that the participants in the study experienced while providing care to their loved ones battling substance abuse. Acknowledging and understanding the psychological stress that individuals often face when providing care for a loved one battling substance abuse inspired an exploration as to the manner in which these individuals cope. Lazarus and Folkman (1984) defined *coping* as "constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (p. 141). Within this study, an exploration as to the manner in which these individuals emotionally reacted to their loved ones' substance abuse and the manner in which they coped were at the foundational basis as a means to understand the Haitian and Haitian American means of coping with psychological stress.

Concepts of Coping Applicability to the Study

Carver et al.'s (1989) concepts of coping were utilized in this study as a means of exploring the emotional responses that the participants had during their caregiving journeys. As the results stipulated, the emotional responses ranged from depression to anger to guilt and shame. The participants of the study all described periods in which they found themselves needing to adjust to the overwhelming task of caring for a loved one

battling substance abuse, which was necessary for their mental, emotional, and spiritual stability. Thus, the theory was applicable to the study as it provided a basis for the understanding of the way that Haitian Americans processed the emotional and psychological stresses of providing care for a loved one battling substance abuse while mitigating stress to eventually arrive at coping mechanisms. The study found that, within the domain of problem-focused coping styles, the participants implemented the following coping styles as a means of managing their psychological stress due to their duties as a caregiver: *active coping*, in which some of the participants actively ignored warning signs and problematic behaviors, either as a means of avoiding conflict or due to an inability to properly address the issue with the substance abuser; *suppression of competing activities*, in which some of the participants compartmentalized and prioritized and became engulfed by their duties as caregivers; and *seeking social support for instrumental reasons*, in which some participants actively sought out advice and counsel from family members, friends, and religious or spiritual professionals within their communities.

Religious and Spiritual Coping

Pargament (1997) recognized that people will often rely on religion and spirituality to cope with adversity because of accessibility and appeal. Thus, Pargament's theory of religious coping and that of spiritual coping was founded on the basis that individuals will select a coping style that is religiously or spiritually aligned with their belief systems. As demonstrated in the study, the Haitian and Haitian American cultures rely heavily on their religious and spiritual belief systems as a means of moving forward from life's adversities. It is for this reason that Pargament's theory of religious coping

and theory of spiritual coping were applicable to this study. Using Pargament's theory, the reader may understand the manner in which religion and spirituality influenced individuals' ability to cope with the psychological and emotional stressors of providing care to a loved one battling substance abuse. As seen in the results of this research effort, religious and spiritual coping activities and mechanisms, such as prayer and community, assisted the participants in garnering a level of resiliency that made the caregiving task one that was surmountable as opposed to impossible. As noted in the previous discussion of the results, many of the participants expressed a level of formidability that was attributed to their implementation of their religious and spiritual means of coping.

Limitations to the Study

The first notable limitation was that the recruitment efforts were mainly from spaces that served the Haitian American community and had an emphasis on the implementation of religious and spiritual conduits as integrations of everyday life. Given that the individuals who were recruited already had a predilection toward implementing religious and spiritual tools in their lives, it was not unlikely that they would disclose the use of such tools as coping mechanisms during the caregiving process.

The second identified limitation of the study was that I needed to rely on the participants' reports of being a caregiver to a loved one with substance abuse. With this limitation, I need to acknowledge two phenomena that might have occurred. The first involved the accuracy of the information being disclosed. Because many of the posed interview questions queried about the caregivers' experiences retrospectively, it was possible that certain details pertaining the totality of the experience were lost due to

memory decay. The second phenomenon that I need to acknowledge is that the participants might not have been as forthcoming about their experiences because they may have felt uncomfortable in sharing and disclosing certain intimate pieces of information that might paint them or their loved ones in a negative light.

Although the sample was relatively small, it provided me with the opportunity to extract rich and meaningful data as I explored the narratives and the lived experiences of the Haitian American women who provided care for a loved one battling substance abuse. The third limitation that must be noted is that there were no male caregivers in the sample. This may be attributed to the bias that women generally are the nurturers and caregivers in the family; however, although this may be a prevailing belief in society, it does not necessarily equate to objective truths of the caregiving experience.

Despite many of the provided limitations, the research findings captured the thoughts, opinions, and subjective experience of many Haitian American caregivers who provided care for a loved one experiencing substance abuse. As this is a population that has not been given much credence, attention or intention in the past, this breadth of work is now contributing to the scholarly discussion, and it is my hope that such investigations will continue to improve the lived experiences of those who identify as Haitian or Haitian American.

Recommendations for Future Research

This research endeavor has contributed to the extant body and discussion of scholarly literature by exploring how Haitian American caregivers cope with the stressors of providing care to a loved one battling substance abuse. Furthermore, in this

investigative study, this research has contributed to the manner in which religiosity and spirituality are utilized by varying populations as a means of coping with stressors and adversity. However, the scholarly discussion can certainly be expanded by future research endeavors that incorporate other under-represented cultures and populations, such as individuals with other racial/ethnic/religious associations and affiliations. Further, increasing and diversifying the sample size, and including the perspectives of male caregivers, will lead to the further generalizability of the explored concepts, thereby, assisting larger populations from varying demographics.

Additional studies seeking to examine the lived experiences of Haitian American substance abusers would provide the scholarly community with a perspective that provides more accurate insight as to the struggles and plight of those individuals from this community who engage in substance abuse. This would be beneficial as it will enhance the depth and breadth of the understanding the pathways to substance abuse and the challenges, adversities, and barriers that this population experiences when choosing to detach from that lifestyle. Explorations as to how this population specifically copes with the process of attaining recovery would be helpful as it would provide scholarly and clinical practitioners with the indications needed to know how to culturally inform their helping efforts in transition and transformation.

Implications for Social Change

The findings associated with this research endeavor have the potential of producing significant positive social change. First, the study contributes to the extant scholarly body of literature and discussion that, prior to this research, had not explored

the plight of Haitian American caregivers or the manner to which they cope with the stressors of providing care to a loved one battling substance abuse. By exploring this phenomenon and reporting on the lived experiences of this population, individuals are able to garner a better understanding of the caregiving vocation of individuals from this ethnic population and the means to which this population utilizes cultural, religious and spiritual methods to cope with the adversities they encountered.

This research study also impacts social change by providing clinical professionals with the insight needed to implement interventions that closely align with the existing methods of coping for this population. Throughout the study, the participants have demonstrated the significance of their senses of religiosity and/or spirituality with regard to their ability to cope. It is for this reason that mental health professionals obtain access to objective scientific data on this subject matter to better understand the members of this population and to begin to develop and implement culturally relevant therapeutic modalities that promote positive social change towards and for disenfranchised, marginalized, and under-represented minorities experiencing similar phenomenon.

Another potential for positive social change is that the results of this study may serve as a tool to educate members within the religious and spiritual communities who provide spiritual counseling and pastoral care. The findings yielded from this research demonstrate the significant role church officials carry in circumnavigating and maneuvering through the adversities of the caregiving vocation of providing care to an individual battling substance abuse. Oftentimes, religious leaders will be approached by individuals seeking support, assistance, and guidance with the spiritual and religious

adversities they are experiencing. Thus, providing proper education to key individuals will assist caregivers in receiving assistance that may speak to their natural means of coping while integrating evidenced-based therapeutic interventions to minimize the harmful effects of caregiving stress and burnout. Furthermore, joining forces with religious and spiritual leaders assists in bridging the gap between science and religion and continues to assist the shift of turning the conversation to one that explores the intersectionality of religious/spiritual beliefs with science as opposed to fueling further division between the two disciplines.

Finally, it is my hope and intention that positive social change is garnered for other caregivers of individuals struggling the stressors of providing care for individuals battling substance use and abuse. By gleaning from the narratives of the Haitian American women of this study, I am intentionally hopeful that other populations will become self-aware of their own challenges while caring for their loved ones and proactive in implementing adaptive coping mechanisms to circumvent caregiver stress and burnout.

Conclusion

The central aim of this research endeavor was to explore the lived experiences of Haitian American caregivers and investigate the manner to which they coped with the stressors of providing care to a loved one battling substance abuse. To explore this phenomenon, I utilized the IPA methodology of the qualitative persuasion. All of the 10 participants of the study (all female) identified as Haitian American and affirmed that they served in a caregiver's capacity to someone who battled substance abuse. Further, all

participants for the study met the inclusionary requirements of the study, spoke fluent English and were between the ages of 45 and 72 years of age.

In obtaining their narratives, I was able to explore the manner to which the caregivers became knowledgeable of their loved one's substance use, learn about the struggles they endured and glean from the techniques they incorporated as a means of managing the stressors of being a caregiver. Thus, the data extracted from the interviews demonstrated that although many of the participants experienced their subjective struggles, battled with their own mental health, struggled to cope with the challenging position they found themselves in, they all implemented various cultural methods of coping that incorporated their religious and spiritual beliefs.

In addition to learning about the caregivers' subjective journeys, I was able to explore the substance abusers' pathways from substance use and their outcomes, as told by the participant (who served as a caregiver). Although the presentation may vary from the objective truth of the substance abuser's experience, being able to hear the narratives of the substance abuser from the perspective of the caregiver provided me with an understanding as to the plight of the substance abuser, which contributed to the overall richness of the study. Receiving these two narratives in a concurrent fashion assisted me in perceiving a comprehensive picture of the totality of the caregiver's journey. The participants of the study were able to provide extremely rich responses that allowed me to piece together the depth of the experience.

The current literature has demonstrated that there is a level of strife and difficulty that caregivers encounter when caring for a loved one who is unable to care for

themselves properly (Rodríguez-Pérez et al., 2017); however, with the addition of this work, the literature can be expanded to include how Haitian American caregivers cope with the challenges they experience while providing care to a loved one. The role of religion and spirituality within the Haitian and Haitian American culture is undeniable and the impact of religion and spirituality certainly extends beyond the Western side of the Hispaniola Island. Such considerations can assist medical and mental health professionals in compiling treatment interventions for this population that closely align with their subjective belief systems and implemented techniques. The integration of the New and Old-World Ways will allow for a more holistic, welcoming, and balanced approach to treatment interventions in the future in which the cultural methods and considerations inform the interventions implemented with such populations and ethnic communities.

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Appendix: Interview Guide

Demographic questions:

1. What is your age?
2. How many years have you been in the United States?
3. What was your relationship with your loved one who battled substance abuse?
4. What was the age of the loved one who battled substance abuse?
5. What was the length of time you took care of the loved one while they who battled substance abuse?
6. What was the gender of the loved one who battled substance abuse?
7. What is your marital status?
8. How many children do you have and what are their ages?

RESEARCH QUESTION# 1

RQ 1: How do Haitian American caregivers describe the experiences of caring for a substance use disorder in the family?

INTERVIEW QUESTIONS FOR RQ1:

1. I want to begin this interview by knowing a little bit more about you and your family.
    a. Tell me a little about the person you took care of. What was the relationship of the loved one who battled substance use disorder?
        i. Probing: Were you the sole caregiver to your loved one who battled substance use disorder?
2. How and when did you gain knowledge of your loved one's substance use disorder?
    a. What do you believe contributed to your loved one's substance use disorder?
        i. What was a pivotal incident that may have contributed to your loved one's substance use disorder? If so, what was it?
        ii. What else might have contributed?
    b. Tell me about a time where you took a very direct action for coping with the challenges of caregiving? What did you do?
3. What was the most profound effect of your loved one's substance use disorder on your life?
    a. What else affected you?
    b. How has your loved one's substance use disorder shaped your consequent relationship with him/her?
    c. How is your communication with your loved one who had substance use disorder?

   d. How has witnessing your loved one's battle Battling substance use and abuse influence your perception of the use of controlled and uncontrolled substances?
   e. In what way did your perception of substance use disorder alter?
   f. Were there any extenuating circumstances that may have contributed to your loved one's substance use disorder?
      i. Such factors include professional and personal adversities.
4. What adjustments did you need to make to your life to accommodate your loved one during the recovery process?

Please note, the researcher will provide the necessary prompts should they be needed by the participant.

RESEARCH QUESTION# 2

RQ 2: How do Haitian American caregivers cope with caring for a substance use disorder in the family?

SQ1: How do Haitian American caregivers use S/R to deal and cope with a substance use disorder in the family?

INTERVIEW QUESTIONS FOR RQ2:

1. What did you do to cope with the stressors of being a caregiver to your loved one battling substance use disorder?
   a. Can you provide any examples?
   b. What else did you do to cope?
   c. What influences encouraged you to use *(What the participant mentioned)* as a means of coping?
2. What do you do when you feel stressed by taking care of a loved one?
3. How important was your religious or spiritual beliefs to you in coping with your loved one's substance use disorder?
   a. Can you give me an example of how you use your religious and/or spiritual beliefs to cope?
   b. How do you describe your religion or spiritual beliefs?
4. What you to use religion or spirituality as a means of coping?
5. What did you do?
6. Tell me about the support you received while providing care to your loved one who battled substance use disorder?
7. Tell me about your social support system?
   a. How was social support involved in managing the care giving experience?

   b. Do you believe having an active social life aid in the alleviation of stress caused by your loved one's substance use disorder by providing a support system of individuals experiencing the phenomenon with you?
8. In addition to personal coping strategies, what was your experience of seeking professional help? (of the religious and/or spiritual nature), did you seek professional counseling
9. So, we spoke earlier about the role of your R/S in supporting you during this time, what else can you tell me about how your beliefs helped you cope?
   a. Was there anything thing else that you found to be helpful in coping?