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Globalization as Re-traumatization: Rebuilding Haiti from the Spirit Up

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This article provides a case study of Haiti within the context of both its distant history of colonialism and its recent history of globalization. We then provide a discussion that highlights the relationship between globalization, poverty, and mental health in low and middle-income countries and describe the development of Pwogwam Santé Mantal, a community-based mental health program in Jeremie, Haiti. We present results of focus groups and interviews that provide a sense of how mental health issues are discussed in this region and present results from a pilot survey which corroborate focus group and interview data. We describe a mental health seminar that took place in July of 2010 and present outcome evaluation data for the seminar. We end with a discussion of how these data and this mental health program address the problematic relationship between globalization and mental health and highlight implications for future research and program/policy development.

> "As disasters often do in poor countries, Haiti's earthquake has exposed the extreme inadequacies of its mental health services just at the moment when they are most needed. 'I want you to bear witness,' Dr. Franklin Normil, acting director of the public hospital told a

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> reporter. 'Clearly mental health has never been a priority in this country. We have the desire and the ability, but they do not give us the means to be professional and humane." (Sontag, 2010).

In this article we seek to understand the implications of this quote by providing an analysis of the impact of colonialism and globalization on the people of Haiti. We then present data and a description of a mental health program that seeks to address mental health issues in Haiti within the context of this historical and global analysis. Although the relationship between globalization, poverty, and mental health is not unique to Haiti (see below), it is important to situate an analysis of globalization and mental health within a specific country context in order to develop psychological theory and interventions that are historically and culturally accurate and appropriate.

In Haiti and other low and middle income countries (LAMICs), globalization has three distinct but equally important, implications for mental health. The first is the way in which globalization exacerbates poverty; the second is the manner in which globalization policies hamper a government's ability to invest in the social and cultural infrastructure of its country; the third is the growing critique of the Westernization of mental health. Underlying these inferences is an ecological understanding of mental health which connects individual mental health outcomes to macro system dynamics, thereby allowing us to draw linkages between globalization, mental health and the structural requirements of mental health programs in low and middle income countries.

Globalization and Haiti

Haiti, once the Pearl of the Antilles and the most lucrative agricultural colony of its time, is today an environmental catastrophe and, as so often quoted, the poorest country in the Western Hemisphere. According to the most recent United Nations Human Development Index Haiti ranks 145 out of a total number of 169 countries (United Nations Development Project, 2010). The devastating transformation of Haiti from a verdant productive country to a landscape of desert chaparral and relentless human struggle is the end result of centuries of shortsighted policies both internal and external to the country (Farmer, 2003; Silie & Inod, 1998). A brutally destructive colonial history was followed by generations of internal corruption upon whose heals came the highly misguided economic policies of globalization.

France's colonization of Haiti can be broadly labeled as extractive colonialism (Price, 2003; Viljoen, 2007). With no intention to create an offshore colony where its residents could permanently settle, France's colonial practices in Haiti focused solely on the systematic extraction of resources with little to no attention paid to the development of local infrastructure. The lack of infrastructure in Haiti today can be traced to this colonial history.

When Haiti won its independence in 1804 the French government, in cooperation with other global powers such as England and the United States, refused to recognize Haitian independence until the Government of Haiti (GOH) paid France for the revenue shortfall incurred from the loss of its former slaves and agricultural plantations. Without international recognition as a sovereign state, no country would trade with Haiti thereby removing any possible source of economic revenue for the young country. In 1825 the GOH agreed to pay France 150 million francs in reparations, a debt it could only pay by borrowing from private French banks at exorbitant rates and by closing half of its schools. Although France eventually curtailed the debt to 60 million francs, the loan repayment consumed nearly 80% of Haiti's national budget and was not paid off in full until 1947 (Library of Congress, 2001). The completion of this initial debt did not end the detrimental impact of external debt payment on the people of Haiti. Throughout the past several decades economic development in Haiti has been severely hampered by a series of globalization policies, most notably structural adjustment programs (SAPs).

In the early to mid-1990s international donors followed a narrowly defined neo-liberal policy of "integrating" Haiti into a global economy as a way of decreasing the country's historical poverty. International Financial Institutions (IFIs) such as the World Bank, International Monetary Fund, International Development Bank, and United States Institute for Aid and Development tied loans and development packages to the GOHs agreement to implement SAPs. These SAPS cut government workers, increased taxes on the poor, provided subsidies to assembly industries, decreased import tariffs to near zero and privatized nine state enterprises. Because of wide-spread grassroots protests against privatization, the GOH moved slowly toward the sale of state enterprises such that by 2000 it had sold only two of the nine designated state enterprises; in response, large aid packages were held back and some even withdrawn (Arthur, 2007). Over time SAPs resulted in the loss of agricultural livelihood, loss of subsistence farming, and the externalization of profits through industry privatization.

In a country where the majority of people make a living from the agricultural sector, the loss of agricultural livelihood resulting from the reduction of import tariffs has been devastating in both environmental and human terms. Comparative social and economic indicators show that since the mid-1980s Haiti has fallen behind other low-income developing countries (U.S. Department of State, 2010). The 1990s brought the near total collapse of Haiti's local rice industry and it is well agreed that the primary reason for this collapse is the 1994 agreement between the GOH and the International Monetary Fund that resulted in the reduction of tariffs on rice imports from 35% to 3%, the lowest in all of the Caribbean (Aristide, 2000; Georges, 2004). Cheap subsidized rice from the United States flooded the open-air markets, economically undermining Haitian rice farmers who received neither government subsidies nor access to cheap capital to help develop and expand rice

production (also a result of SAPs). The following story recounts the human toll of these policies:

> "... several dozen impoverished rice-growers and their families decided they could bear life in Haiti no longer. They pooled their meager savings, bought a rickety boat and headed northward to the British-administered Turks and Caico islands. Halfway into the 150-mile trip, the vessel capsized, killing all 60 on-board. "We are mourning now, because we lost so many members of our families," said Emince Berhard, one of the villagers who remained behind, and who heard about the disaster on the radio. "But the same thing is going to happen over and over again, because the people here no longer have any hope." (Georges, 2004, p. 6).

Similar stories can be told regarding agricultural industries throughout Haiti. Today Haiti imports over 90% of its eggs from either the Dominican Republic or Miami, a direct outcome of the influx of cheap poultry from the United States and the Dominican Republic which undermines local poultry production (Nienaber, 2010; Regan, 2011). In the area of coffee, the flooding of the international coffee market with cheap subsidized coffees from Vietnam helped destroy small farm production in Haiti and throughout the world (Gressel & Tickell, 2002). Several years ago a leader of a peasant cooperative in the south related to the first author his concern that the loss of coffee production was not only devastating the environment, as farmers pulled out coffee trees, but was also decimating an entire culture that had developed around the picking and processing of coffee beans.

Colonial practices, internal corruption, political instability, economic globalization–against this backdrop, the infrastructure of Haiti including roads, sewer systems, agricultural inputs, electrification, public schools, public health, and most certainly mental health, have been either inadequately developed or not developed at all. As stated astutely by a Haitian Senator, just as Haiti was beginning to recover from a long brutal history of first colonialism then brutal dictatorship, globalization policies retraumatized the Haitian people, giving them little opportunity to build the infrastructure required to heal themselves and their land (Romer, personal communication, 2009).

The reality of this deep poverty came to the world's attention in January of 2010 when an earthquake of 7.6 magnitude rocked Port-au-Prince; 35 seconds which left in its wake at least 200,000 people dead, many more homeless and collapsed buildings and lives at every turn of the road. In the days, weeks, and months following the earthquake mental health practitioners from around the world became aware of the complete absence of mental health care in Haiti. As we can surmise from the above analysis, however, the need for mental health services in Haiti did not being on January 12, 2010, but has been present for decades.

Poverty, Globalization, and Mental Health

We cannot understand mental health dynamics in Haiti, and in many other LAMICs, without understanding the relationship between mental health and

economic underdevelopment. Despite some claims that global corporate development lifts all boats (i.e., Dollar, 2001), there is general consensus that for many countries globalization deepens poverty thereby negatively impacting mental health (Cornia, 2001; Gershman & Irwin, 2000; Harrison & McMillan, 2007; Mander & Goldsmith, 1996; Marsella, 2012; Prilleltensky, 2003). Over the past decades there has been a growing consensus that SAPs, in particular, increase poverty rather than decrease it (United Nation Economic Development Forum, 1992; Watkins, 1995). As discussed by Woodward and colleagues (Woodward, Drager, Beaglehole, & Lipson, 2001), the effects of globalization on health occur through a network that begins at the level of international policy and that lands, ultimately, at the doorstep of families in rural communities throughout the world. The story of the rice farmers narrated above is a clear example of this.

According to Patel (2007) poverty and mental health impact each other in a cyclical fashion—economic deprivation, malnutrition, low education, inequality, indebtedness, overcrowding, lack of social networks, and inadequate healthcare lead to depression, substance abuse, stress and anxiety which, in turn, result in reduced economic engagement and productivity thereby exacerbating economic underdevelopment and deepening the cycle of poverty and poor mental health. Patel and Kleinmann (2003) report that most studies demonstrate a positive relationship between poor mental health and various indicators of poverty such as inadequate housing, nutrition and education. These authors conclude that even with study limitations the association between common mental disorders (i.e., depressive and anxiety disorders) and poverty is universal.

As a whole, least developed countries and rural areas in low and middle income countries appear to be harmed most by policies of free trade which target agricultural products (Corrigal, Plagerson, Lund, & Myers, 2008; Deshpande, 2002; Gregoire, 2002; Shiva, 2004). As we see in the case of Haiti, the negative impact of free trade policies is manifest primarily through the loss of agricultural production in response to the introduction to the local economy of subsidized foreign food products in combination with blocks to government subsidies for local agricultural production. As reported by Corrigal et al. (2008) in addition to the cognitive impairments associated with poor nutrition, food insecurity is associated with major depression, suicidal behavior, and psychological distress (see also Weinreb et al., 2005). In the case of Haiti, but certainly not unique to Haiti, (see Watkins, 1995), loss of rural agricultural livelihood leads to internal migration to urban areas, a process which carries with it its own psychological consequences: identity confusion (Jensen & Arnett, 2012; Bhavsra & Bhurga, 2008), the loss of intergenerational knowledge (Norberg-Hodge, 1997); the destruction of traditional social support mechanisms (Bhavsra & Burga, 2008). In Haiti, internal migration set the foundation for the tragedy of the earthquake of January 2010 since over the years hundreds of thousands of people, no longer able to make a living in the rural provinces, migrated to Port-au-Prince in the hope of finding work. Sweat

shop labor in Port-au-Prince, however, cannot ameliorate the loss of agricultural livelihood throughout the country.

Globalization and Health Infrastructure

The ability for distant officials to shape the internal social policies of LAMICs is an ongoing hallmark of globalization. Most egregious are SAPS which disallow governments from using international loans for social services and which require governments to reduce expenditures on social services such as health and education (Watkins, 1995). These stipulations have made it historically difficult for governments in LAMICs to address public health issues, let alone mental health issues. It is the poorest countries in the world, where mental health needs are arguably the greatest, that governments spend the lowest percentage of overall health budgets on mental health (Saxena, Thornicroft, Knapp, & Whiteford, 2007). In Haiti, before the earthquake there were 23 psychiatrists and 10 nurses with expertise in mental health in a country of 9.5 million people. Today, international health agendas do not include mental health nor is it a millennium development goal (MDG). In Rwanda, the fact that mental health was not explicitly stated as a MDG meant that the Rwandan Ministry of Health was not allowed to finance mental health services out of the World Bank loan/credit fund (Baingana, as cited in Saraceno, 2007). Government neglect of mental health issues creates a culture which allows for the stigmatization and abuse of those with mental illness (Patel, 2007).

The Westernization of Mental Health

Within the domain of clinical psychology there is little known about mental health issues across LAMICs in spite of the fact that mental health accounts for an important percentage of the burden of disease in these countries (Razzouk et al., 2008). Despite this paucity of information, Western trained psychologists are often eager to export and implement diagnostic categories and treatment that have little to no proven cross-cultural validity (Timini, 2005; Watters, 2010; Ziegenbein, Calliess, Sieberer, & Wielant, 2008). The speed at which U.S.-trained psychologists have entered into postdisaster areas to provide psychological services to populations has led to cases where cultural norms of response to trauma are ignored in favor of Western psychological categories of mental health and intervention (Watters, 2010). Within the context of Haiti, Nicolas and her colleagues have demonstrated that Western criteria for depression are not valid when understanding or identifying the depression of Haitian women in the Diaspora (Nicolas et al., 2007; see also World Health Organization, 2010). Globalization is not only about a global economic infrastructure, it is also about exporting dominant

ideologies and cultures (Aneesh, 2012); psychology, as a whole is a clear contributor to this latter aspect of globalization (Arnett, 2008; Marsella, 2012).

Global Mental Health

Researchers and practitioners within the field of Global Mental Health have developed clear strategies for building mental health services which address each of the three aspects of globalization and mental health discussed thus far. These strategies include: (1) a focus on social inclusion, economic participation, freedom from discrimination and violence; (2) strategic attention to developing and eventually expanding services in contexts where services are either minimal or nonexistent; (3) eliminating competition over resources and maximizing collaboration between health sectors; (4) developing, evaluating and implementing culturally appropriate assessment and intervention techniques; and (5) implementing low-cost approaches to community mental health promotion (Jacob et al., 2007; Lancet Global Mental Health Group, 2007; Mollica et al., 2004; Patel et al., 2007; Prince et al., 2007; Saxena et al., 2007; World Health Organization, 2007a). Bhavsra and Bhurga (2008) also point out that within the context of globalization, psychological therapies must clearly address the disenfranchisement brought about by the development of policies at levels far removed from either local or national governments.

Developing a Mental Health and Development Program in Rural Haiti

We entered into the work presented below with solid knowledge and experience regarding Haitian history and culture. We also began the work clearly aware of the need to address each of the points discussed by practitioners and researchers in the field of Global Mental Health. We chose a participatory action research approach to allow for the full inclusion of community members in program design and development and to reflect the need to adapt to the realities of conducting field work in a highly under researched domain (Kidd & Kral, 2005).

Project and Study Site

Initial discussions regarding the development of a community mental health program for the Grand' Anse region of Haiti began in July of 2009. The Grand' Anse is 1 of 10 administrative departments in Haiti and one of the poorest with the greatest paucity of social services. The one state hospital in the region is located in Jeremie, the county seat; this hospital has no pediatrician and only one gynecologist. There are currently two psychologists serving the Grand' Anse, one focused specifically on HIV/AID and another as part of a faith-based initiative; both of these psychologists are based in Jeremie. The closest psychiatric services

are those in Port-au-Prince either a 45-minute plane ride away, which few can afford, or a seven to 8 hour drive each way on very challenging roads.

Initial Data Collection

We conducted individual interviews and four focus groups in July of 2009. We had two major objectives for these interviews and focus groups. The first was to assess the extent to which individuals in the community of Jeremie saw a need for a community mental health program. The second was to gain a better understanding of mental health as discussed and experienced by the people of this community. Interviews were conducted with religious leaders, public health workers, nurses and medical personnel, educators, the local psychologist and the senator of the area. Without fail, all individuals interviewed agreed wholeheartedly in the importance of a mental health program. The following narrative of our interview with a Baptist pastor reflects the urgency we heard across all interviews.

No sooner had we sat in the two chairs in his office and opened with our standard statement "We are here to discuss the possibility of creating a community mental health program" that he nodded his head vigorously and began to tell stories of the people in his parish. He narrated the story of a man who came to speak with him and who shared all the difficulties of his life and the challenges his family was facing—illness, hunger, lack of work, no money for the children's school. The man was clearly disturbed and overwhelmed by the enormity of the struggles in his life. When the man left, the pastor realized that not once had they spoken of how the problems the man discussed were affecting him emotionally, even though the pastor could personally feel the emotional toll the man was experiencing. The pastor stated that there are many, many more in his parish like this man, but that he does not have the time to sit and talk with them in a way that would help alleviate their emotional burdens. He spoke of men and women he knows who suffer from depression and who do not receive treatment and who get progressively worse, some even who have died.

Nurses and administrators at the local hospital spoke of the many patients who present with physical symptoms that have no physical cause but that the hospital staff does not have the capacity to address the psychological underpinnings of physical ailments. A public health worker spoke to us of men and women in the mountain regions who do not want to burden family or friends with their mental health problems and so move further up into the mountain and die of hunger or dehydration. Educators spoke about students who are stigmatized by their peers because someone in their family suffers from a mental health problem. The local psychologist spoke about the huge needs he sees and how he is unable to address all that must be done. He spoke about the stigma attached to an HIV/AIDs diagnosis or to a diabetes diagnosis. Since many people diagnosed with diabetes do not have the money for the medication or for special

dietary restrictions and food substitutions, a diagnosis or diabetes can be a death sentence.

From the psychologists we learned of how the dearth of psychiatric services in the Grand Anse impacts individuals. He told us of families and caregivers who manage to put together the funds required for a family member to visit a psychiatrist in Port-au-Prince but who, upon the family member's return and completion of prescribed medication, are unable to finance a second visit and the family member decompensates. It is in these instances, where family members no longer have the financial or emotional resources to cope with psychiatric illness, that individuals are mistreated or, of their own accord, move further up into the mountains so as not to further burden their families. It is not uncommon to hear accounts of people with mental illness who eventually die from neglect.

Focus Group Results

We conducted four focus groups with various community stakeholders. The first was with a small group of local community organizers and public health people; the second was with a group of young people in the town of Jeremie; the third was with a group of farmers and community members in the mountain regions, and the fourth was with a group of nursing students from the local nursing school. We did not tape-record group meetings since we believed that the presence of a tape-recorder would make participants uncomfortable. Since one of the facilitators (Schneider) is fluent in Creole and the other (Diaz) has a working knowledge of Creole we did not require translators. During the group meetings one facilitator took notes and after each meeting we discussed what transpired and extracted information most relevant to our research objectives. Results from these focus groups are presented in narrative form to best convey the quality of the conversations.

In both the meeting with the youth and the meeting in the mountain region, participants had never spoken about mental health issues and we found no clear language in Creole to speak about these things. We realized that when we spoke directly about "mental health," roughly translated into Creole as "problems in the head" or "mental problems," people spoke primarily about individuals in the community who were schizophrenic (the Creole word is "foo"). Since we were interested in learning about common mental disorders such as depression, anxiety or substance abuse, rather than more severe instances of psychosis, we modified our questions to ask people to talk about a time when "they were feeling good" and a time when "they were not feeling good". We also asked participants to provide examples of individuals whom they knew who suffered from mental health issues since most participants were not comfortable speaking directly about themselves.

Not unexpectedly, everyone spoke about the constant difficulties associated with poverty; typically the first 15–20 minutes of discussion were taken up by animated discussion of the shared experience of chronic economic hardship. Participants shared how stressful it is not to have enough money for food, for sending children to school, or for medicine. There was unanimous agreement regarding the constant struggle to find work. In the mountain region, participants spoke of the stress associated with poor harvests. A gentleman spoke about how bad he feels when he sees his neighbor doing better than him even though they both went to the same school. Another man spoke about how when he has a little bit of extra money to have a cup of coffee in the morning or play lotto, then he feels good, but on those days when he does not have that little bit extra then life does not feel good at all. In the mountain regions "having enough money to buy a cup of coffee" means the ability to buy the small amount of coffee grounds, sugar and charcoal needed to brew one cup.

Chronic stress was a common point of agreement. Several participants expressed concerns about becoming "too stressed" because of the belief that stress leads to diabetes. Others spoke of all the physical ailments people experience when they are stressed: head spinning, not seeing well, women missing their periods, having headaches or stomach aches, hair falling out.

Young people spoke of the great deal of stress students are under to do well in exams and of how stressful it is for someone who does not do well in exams. (In a country with 80% unemployment education is universally understood to be the key to success.) We heard stories about young women who are betrothed whose fiancé breaks off the relationship which then causes serious mental anguish since young women in the countryside have few vocational outlets other than that of wife and mother. Several young people spoke of the complete lack of diversion—movies, television, restaurants—and how this exacerbates psychological distress since they have no way to temporarily forget their problems. One young man stated that the only time he remembered feeling good was when the community had a festival and he was able to go and listen to music and talk to friends and forget about his problems.

Several people spoke about relational stressors. Participants described how husbands and wives oftentimes marry for practicality rather than love and so when the stressors of life develop the couple does not have the relational skills required to constructively work through conflicts, placing even greater stress on the family system. A young man spoke about a general lack of conflict resolution skills and gave an example of two young men who were best friends who got in an argument and, without knowledge of how to talk through difficulties, ended up in a physical altercation that destroyed the friendship thereby leaving each one more isolated than before. It was in the context of this conversation that a participant spoke of the use of alcohol as a form of self-medication and how this can lead to domestic violence.

A young man told the story of how his mother had just died leaving him in charge of his three younger siblings and he stated how he is unable to stop thinking about all his problems. We heard stories of people in various communities who were clearly suffering from psychosis and how family and friends have no knowledge of how to care for the person.

Common in the language people used were the terms "thinking too much" which is a literal translation of the Creole expression "*reflechi twop*"; the expression refers to those times when a person cannot stop thinking about his/her problems and the thoughts just go around and around in the person's head with no way out. Another common phrase is "the head is spinning" (*tet vire*) again referring to this sense of finding no way out of problems and the head literally spins with the problems, leaving a person unable to think about anything else.

Pilot Survey

Several months after these focus groups, and in close cooperation with a team of public health workers in Jeremie, we conducted a pilot study to begin to create a mental health data base for the region. The foundation for the development of the questionnaire itself was the information gathered in the focus groups, in depth discussion with two local public health agents, and the research of Nicolas and colleagues on depression in Haitian women in the Diaspora (Nicolas et al., 2007).

Three domains were covered in the survey: physical symptoms, emotional states, coping mechanisms. The physical symptoms included: pain in whole body, feeling weak, having gas, severe headaches, the head spinning, stomach pain, difficulty sleeping, numbness, inability to eat, crying a lot, inability to see, and losing weight. The emotional states included: constantly thinking about problems, inability to concentrate, persisting in activities even when the activities hold no interest, feeling like life does not work at all, experiencing increased conflict with friends, family or others, feeling discouraged about life and waiting to die, feeling like an evil spirit is consuming one, feeling like one is simply waiting for someone to come and take him/her out of his/her misery. The response format for both the physical and emotional symptoms was: never, sometimes, constantly. Coping mechanisms was: talking to friends, family, sitting alone and thinking, going to church, reading the bible, praying, drinking alcohol, smoking, getting angry, turning to indigenous spiritual traditions, going to the doctor. The response format for the coping mechanisms was "yes" or "no." The questionnaire was designed and developed in Creole.

Ten community public health workers collected survey data through face-to-face interviews and went through a day-long training on how to collect survey data. Training included a careful review of the survey so that each person was familiar with the items; a discussion of mental health within the context of survey questions; training on basic listening skills (i.e., how to engage the person if he/she

appears to be losing interest; how to probe when necessary; how to maintain eye contact; how to encourage people to open up so as to collect valid data). The 10 public health workers were randomly assigned through a toss of the coin to which village they would work with so as to prevent the situation where someone would collect data from his/her own village. These 10 individuals were instructed to randomly select people from the village so as to reflect general age ranges and equal numbers of both men and women.

Results

Physical Symptoms

Of the 99 people surveyed, 31 were men and 68 were women; the modal age was 22 and the mean age was 43 with the ages ranging from 17 to 80; eleven individuals were 60 or over. The mean scores for the physical symptom data were grouped into three groups: low physical symptom reported (mean < 1.5); moderate physical symptoms reported (mean 1.5–1.85) and high physical symptoms reported (mean > 1.85). Not unexpectedly, there was a relationship between age and the frequency/severity of physical symptoms ($X = 13.33$, $p = .038$) with respondents 41 and over tending to report moderate or high physical symptoms and the majority of respondents in the highly physical symptom category were over 50. When looking at the specific symptoms, age was a significant determiner in "pain in the whole body" (X^2 (6, $N = 97$) $= 17.708$, $p = .007$); "difficulty sleeping" (X^2 (6, $N = 97$) $= 13.522$, $p = .035$); "difficulty eating" (X^2 (6, $N = 98$) $= 19.422$, $p = .005$).

Emotional Symptoms

The mean scores for the emotional symptoms data were grouped similar to the physical symptoms data and categorized into low, medium and high reports of emotional symptoms. There was a statistical relationship between sex and emotional manifestation X^2 $(2, N = 99) - 8.722 - p = .013$, such that women were more likely to score in the high emotional symptoms category than men. We did not find a statistical relationship been severity of physical symptoms and severity of emotional symptoms indicating that, in this sample, the presence of extreme physical discomfort might simply be due to age rather than somatizing emotional content.

Categorizing emotional symptoms into levels of severity hides the information revealed through simple frequency counts. We were struck by the fact that 52% of the sample indicated that they always feel like "they cannot concentrate when engaged in activities"; 48% of the sample indicated that they always "worry all the time (*reflechi twop)*"; 44% of the sample indicated that they always feel like

they must "continue in activities even when they don't want to" and 48% of the sample indicated that they always feel like "nothing is working in my life". In a simple yes/no answer which asked people if they can remember a time when "life was working" 48% of the sample indicated that they could not remember such a time. The core finding of this pilot survey was the presence of extreme emotional distress in the majority of our sample.

Coping Mechanisms

In the category of coping mechanisms we found that overall participants in this sample did not engage in any great numbers in negative coping activities such as smoking, drinking or getting angry. Instead, we found that the majority of respondents engaged in activities such as talking with friends, or family members, going to church or reading the bible.

A focus group meeting scheduled with the 10 individuals who collected the survey data had to be cancelled since it was scheduled right about the time of the earthquake. In informal conversation with the interviewers, we did learn that in the process of collecting data the public health workers themselves gained a greater understanding of what mental health means within the context of their communities. One person told us: "I never realized until we began this work what mental health problems are. Let me tell you a story. A man from my work began to drink a lot and lost his job because of this. When I went to visit him in his home in the mountain I realized that his wife had left him and had left him with six children. Before our work together I would not have known that his drinking is a mental health issue."

Mental Health Seminar

On July 4, 2010, in coordination with members of PSM, we conducted a mental health training to respond to the needs on the ground in the aftermath of the earthquake and to further the groundwork for a Haitian mental health program. We used a collaborative training model which included extensive dialogue combined with presentation of information and multiple opportunities for practice across four full days.

Twenty-seven individuals participated, 15 women and 12 men. The group included public health workers, teachers, nurses as well as the director of the local nursing school, a doctor, a dentist, community organizers, members of faith based communities and local business people. These individuals were self-selected community members who had participated in previous focus groups and in an initial seminar conducted in January of 2010. Over the 4 days the following areas were covered: Understanding mental health; the impact of mental health

problems on individuals and communities; etiology and symptoms of common mental disorders; mental health first aid; community development and outreach.

A central component of each day was group brainstorm and team problem solving activities which provided the participants and facilitators with important information regarding how mental health and mental illness are understood and experienced in Haiti. Practice activities were selected for both their perceived cross-cultural generalizability (i.e., active listening, nonverbal communication, massage, emotional and physical relaxation) as well as empirically shown cross-cultural validity. An example of the latter is behavioral activation where counselors work with individuals to help them define pleasurable activities and then find ways of doing these activities more often (Powder, 2009). Key characteristics of each of the activities we chose were ease of administering and low cost, both crucial to success in community mental health promotion efforts (Powder, 2009). We used games throughout the 4 days as both ice breakers and intervention strategies. We also integrated local practices for group animation such as music. To ensure follow up activity, six groups were formed on the final day of the training with the task of designing mental health activities for their communities.

Evaluation Results

At the end of the 4 days all participants completed a written evaluation form; the following results are taken from two of the questions included: (1) what were the three most important lessons you took away from the seminar and (2) what was the most important experience for you in the seminar. These responses were translated from Creole into English and a content analysis performed which revealed the following categories: mental health literacy; active listening skills; stress; relaxation techniques; games; problem solving skills; collaboration/team work.

Mental health literacy. This was by far the largest category with 24 of 105 pieces of information falling into this category. Following are some sample responses from this category: "I learned how not to judge people with mental problems; I know that mental illness is like other illness like fever, diabetes, high blood pressure, and heart problems."

Active listening skills. This was the second largest category with 22 of 105 pieces of information falling into this category. Following are sample response: "I learned how to show sympathy for another person who has problems; I believe now that it is not when you give advice only that you help others, but when you listen to others you give them a big encouragement."

Stress. Eighteen comments were related specifically to learning about stress. Several people simply stated that they learned how to "deal with stress." One person stated "During the seminar we saw why we are stressed and what we can do to surpass those problems."

Relaxation techniques. A large handful of statements (10) focused on the specific techniques of massage, relaxation techniques and the use of the "butterfly hug." One person stated "I think that it's the first time I got a massage from someone else and it made me feel good."

Games. Eight statements spoke specifically to the use of games. One person stated "The moment that we had in the beginning before the seminar started to give everyone energy to chase away all the stress and worry/anxiety."

Problem solving skills. Several statements (7) spoke specifically about the various problem solving activities we engaged in. One person stated "What I learned during the seminar is when I saw I had the capacity to identify my own problems."

Collaboration/team work. Six statements spoke specifically about the use of group-based activities to create information and respond to questions. One person stated "I understand now that when we work in a group we can do a lot."

Anecdotal information. Each day people told us stories of how they were going back to their home or community and using the skills they learned that day either through initiating active listening conversations with members in their community or family or by actually demonstrating and using some of the skills of relaxation and problem solving that they learned. A group of medical professionals from a local public health clinic had, before the seminar, planned a youth outreach activity to discuss HIV/AIDS. At the end of the seminar they showed us their revised flier which included a separate day on mental health where they would present and demonstrate some of the skills and knowledge they acquired during the seminar.

Follow-up activities. Five of the six community groups formed during the seminar had follow up community meetings and, in total, reached 356 people throughout the region. Their activities included providing information on nutrition and mental health, providing general information about mental health issues, discussion of the vision of PSM, sharing techniques (i.e., butterfly hug, relaxation techniques) and opportunities for group sharing and active listening.

Discussion

The data and results presented above are limited by the small sample size and by the exclusive focus on one region of the 10 administrative departments in Haiti. Regional differences in Haiti are exacerbated by the lack of transportation infrastructure in the country and it is therefore not possible to generalize from the findings presented above to Haiti as a whole. At the same time, the research presented provides insight into how to address the three foci of globalization and mental health discussed above—globalization and poverty; globalization and health infrastructure; the westernization of psychology.

Poverty, Globalization, and Mental Health

Our data illuminate how the historical and ongoing economic underdevelopment of Haiti contours the experience of mental health. We were struck by the common threads of economic hardship which framed all of our interview and focus group discussions. We were distressed at the extent to which participants in the pilot study reported feeling dispirited and hopeless. As we move forward with program development it is imperative to address poverty within the context of mental health intervention. Toward that end, the vision of PSM includes a solid focus on sustainable livelihood (Raja et al., 2008). Sustainable livelihood includes: microfinance loans for individuals with mental health issues; scholarships for students who have parents with mental health problems; horticultural therapy; the development of Care Farming programs where individuals with mental health problems are involved in subsistence farming work as a form of mental health intervention (Hine, Peacock, & Pretty, 2008).

Globalization and Public Health Infrastructure

From the outset we sought to directly include public health workers and medical personnel in all training and program development activities so as to allow for the use of local public health clinics as sites for mental health clinics. In our ongoing work we seek, where possible, to companion with existing infrastructures, such as the schools and public health clinics, rather than create new ones. Such partnership not only allow for the sharing of resources but also for the development of integrative dialogue regarding mental health policy.

Our choice of skills and techniques to include in the mental health seminar was also based on our awareness of the need to develop a skill base of easy to teach, easy to learn and easy to implement mental health interventions with demonstrated cross-cultural validity. The work of PSM is designed to create a low cost system of informal community and individual self-care (World Health Organization, 2007b).

Westernization of Psychology

Two aspects of the work directly address the westernization of psychology. The first is its contribution to an empirical foundation for a Haitian psychology, a particularly important contribution given the paucity of research on mental health in Haiti (World Health Organization, 2010). In the analysis of pilot study data, we were struck by the lack of a statistical relationship between physical and emotional symptoms. It is likely that data collected in a hospital setting would yield different findings. We also noted that activities such as praying or going to church did not differentiate any particular group in the sample (i.e., those with high emotional states vs. those with low). Nicolas' work (Nicolas et al., 2007) describes a unique type of depression in Haitian immigrant women which the researchers call "faith in God." This depression is characterized by an overreliance on prayer, bible reading and church going as a way of managing depression. Again, it may be that a clinical sample, as opposed to a random sample would yield different results. It may also be that immigrant women without traditional support systems turn to religion more so than do women who remain in the home country. Both of these findings suggest the need to conduct additional research both in a medical or clinical sample and in the general population of Haiti.

The second aspect of our work which addressed concerns regarding the Westernization of psychology is the use of exploratory qualitative methods of data collection (see also Bolton, Surken, Gray, & Desmousseaux, 2012) as well as the interactive pedagogical model used for the mental health seminar. We entered the work with broad questions: what is the nature of mental concerns in Haiti; would members of this particular community be supportive of a community mental health program? We were impressed at the extent to which participants in all aspects of this work embraced the idea of community mental health; we expected people to downplay mental health intervention in favor of more concrete economic development programs. The fact that participants embraced the idea of community mental health underscores their intuitive understanding of the importance of mental health within the context of community development. This point brings us back to the starting point for this paper—the relationship between macro-economic systems of globalization and individual and community psychosocial wellbeing.

Conclusion

The literature suggests two approaches for ameliorating the negative mental health impacts of globalization, one top down and one bottom up. Corrigal et al. (2008) suggest the creation of global policies which enhance mental health (i.e., the expansion of trade preferences for developing countries; revising the Global Agreement on Tariffs and Trade to ensure food security). Moane (2003) and Maton (2008) suggest that individual healing and empowerment are precursors

to individual and community level approaches to systemic change. In Uganda, for example, mental health literacy campaigns resulted in public demand for government support of national mental health services (Baingana, 2010).

The extent to which community based mental health interventions ameliorate, in the long run, the negative impacts of globalization as discussed in the introduction to this article are yet to be determined. What we do know is that the ongoing use of participatory action research models in conjunction with the use of mental health intervention models which integrate sustainable livelihood and community empowerment can move us in this direction. We cannot address mental health issues in Haiti, nor in other low and middle income countries, without breaking the cycle of poverty and mental health; we cannot break this cycle without addressing the negative aspects of globalized economic policies (Marsella, 2012; Prilleltensky, 2012).

Former Haitian President Jean-Bertrand Aristide stated that what the Haitian people want is to move from misery to poverty with dignity (Aristide, 2000). If the objectives of this work are met then expanding individual and community wellness will result in just that—communities regaining their ability to heal themselves and their country.

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