



Research Article

Cultural and Structural Barriers to Mental Health Integration in Haiti: A Multi-Perspectival Qualitative Study

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Abstract

This study addresses the urgent but underexplored challenge of integrating psychological care into Haiti's national healthcare system. Framed within a constructivist interpretive paradigm, it treats mental health beliefs as socially produced phenomena shaped by culture, history, and collective experience. We conducted an exploratory qualitative study in Haiti's Northern Department with 30 purposively sampled participants, health professionals, patients, and community leaders, using semi-structured interviews and focus group discussions in Haitian Creole. Thematic analysis identified three principal themes: widespread, deeply rooted distrust of psychological services linked to Vodou and syncretic religious frameworks; a critical shortage of trained personnel and material resources; and an emerging, cautious shift toward acceptance of holistic, culturally grounded models of care. Findings indicate that community sensitization and cross-sector partnerships can meaningfully improve attitudes toward mental health services. By examining the specific cultural and structural dynamics of the Haitian context, this study contributes to global mental health literature and offers implications for public health policy, clinical training, and future research.

Keywords

Mental Health Integration, Haiti, Cultural Barriers, Vodou Practices, Constructivist Paradigm, Stigmatization, Community Sensitization

1. Introduction

Haiti presents a particular challenge for mental health service delivery—one shaped by a convergence of historical, structural, and cultural forces that no single variable can explain. The country's trajectory—marked by colonial violence, repeated environmental catastrophes, chronic poverty, and unrelenting political instability—has produced a psychosocial burden that the health system cannot absorb. James [10] has shown that the process of Haitian state formation itself, dis-

torted by successive foreign interventions and persistent democratic insecurity, created the structural conditions under which psychological distress is both more likely to occur and less likely to receive care.

The epidemiological picture is unambiguous. Major depressive disorder, PTSD, generalized anxiety disorder, and substance use disorders are widespread across Haitian territory, driven further by repeated humanitarian shocks—the 2010

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earthquake, successive Category 4 and 5 hurricanes, gang violence, and the COVID-19 pandemic [21]. Fewer than 0.28 psychiatrists serve every 100,000 Haitians, and formal psychological services are concentrated almost entirely in Port-au-Prince, leaving rural communities with no meaningful access to care [21]. The problem, however, is not reducible to infrastructure. Haiti's healing culture is woven from Vodou, Evangelical Protestantism, Catholicism, and a dense web of syncretic practices that defy easy categorization [12]. Any credible analysis of mental health access must engage with both dimensions at once.

What results from the collision of structural failure and cultural complexity is what we call a *double barrier* to mental health integration. On one side: insufficient facilities, too few trained professionals, near-total absence of dedicated public funding. On the other: stigmatization, spiritual explanatory models that leave no room for the psychologist, and deep institutional distrust. These two sets of obstacles do not simply coexist—they reinforce each other, and it is that reinforcement which any viable integration strategy must address.

This paper reports findings from a qualitative study conducted in Haiti's Northern Department, organized around three questions: What do patients, health professionals, and community leaders actually think about psychology and psychological services? What cultural and structural barriers prevent integration? And are there practices that have begun to shift the picture?

This study contributes to the global mental health literature by offering an empirically grounded, contextually specific analysis of the Haitian case—a context that remains substantially underrepresented in international research. It responds to the agenda set by Patel et al. [21] for research that is rooted in local realities and capable of informing policies that might actually work.

2. Literature Review

The treatment gap in low- and middle-income countries (LMICs) is one of the most cited statistics in global mental health: more than 75% of people with diagnosable mental disorders receive no treatment at all [21]. The Lancet Commission framed this not as a medical curiosity but as a development emergency—measurable in lost productivity, fractured families, and preventable suffering. Haiti sits at the extreme end of this gap. Its health infrastructure was already fragile before the 2010 earthquake; what followed compounded rather than created the crisis [21].

The most widely cited strategic response is task-sharing: integrating mental health into primary care rather than concentrating it in specialized facilities that most of the population cannot reach [3]. Collins et al. [3] foundational *Nature* article made a compelling operational case for this model, and Ravivola et al. [20] demonstrated over a decade at Zanmi Lasante—in Haiti's Artibonite Department—that it can be made to work at scale, given sustained investment in local human resources

and a genuine partnership with the Ministry of Health. What that experience also revealed, however, is the cost and difficulty of building such a system: ten years, stable teams, territorial continuity. These are conditions that are far from given.

Kleinman [13] framework of explanatory models, developed in *Patients and Healers in the Context of Culture*, is the theoretical anchor of this study. The core argument is straightforward even if its implications are not: therapeutic effectiveness depends heavily on whether the clinician and the patient share a working understanding of what the illness is and where it comes from. When those understandings diverge sharply—as they routinely do in Haiti between biomedical and Vodou cosmological frameworks—the treatment relationship is structurally impaired before it begins. Hagaman et al. [7] confirmed this empirically in rural Haitian communities: patients regularly attributed mental distress to the action of *lwa* (Vodou spirits), demonic forces, or disrupted ancestral relations. Within that framework, the psychologist has no obvious role.

Drawing on fieldwork in Nepal, Kohrt and Hruschka [14] argued that mental health programming which bypasses or pathologizes local explanatory models fails irrespective of its clinical quality. Kirmayer et al. [12] extended this argument to diverse primary care settings. More recent work by Kohrt et al. [16] sharpened the point further: what makes integration durable is not technical training in isolation, but the practitioner's ability to move between competing systems of meaning without subordinating one to the other.

Stigmatization—defined by Corrigan [4] through three levels of self-stigma, public stigma, and structural stigma—works as a critical brake on help-seeking. Jean-Jacques [11] documented that in Haitian communities, a mental illness diagnosis carries social consequences that extend beyond the individual: family networks are damaged, marriage prospects diminished, community standing eroded. Eustache et al. [6] found high rates of depression and PTSD among school-going Haitian youth alongside near-zero rates of formal care-seeking. The stigma burden explains much of that gap.

Metzl and Hansen [19] sharpened the analytical lens further with the concept of structural cultural competency, arguing that individual clinician sensitivity matters little when the institutions they work within neither fund, value, nor support culturally competent practice. Kohrt et al. [16] showed that durable integration in resource-constrained settings requires not just clinical training but a genuine transformation of institutional culture—including formal recognition of local therapeutic knowledge systems. These findings point toward the kind of dialogic, partnership-based approach examined in this study.

3. Theoretical Framework and Epistemological Positioning

This study is situated in a constructivist interpretive paradigm. That is not a formality. It reflects a substantive position:

the mental health representations we collected from participants are not distorted reflections of some objective reality waiting to be uncovered. They are themselves the reality—shaped by history, power, community, and lived experience—and they deserve to be analyzed on their own terms [2, 5]. The knowledge this study produces is co-constructed between researchers and participants, carrying the marks of both.

Three theoretical bodies converge in our analytical framework. Medical anthropology—and specifically Kleinman [13] attention to the cultural embeddedness of illness—provides tools for analyzing explanatory models without imposing a biomedical ranking on them. Global mental health scholarship [21] keeps the equity stakes in view: this is not merely a cultural question but a political and economic one, involving resource allocation and institutional priorities. Community-based participatory research methodology [9] shapes our fieldwork approach, insisting that knowledge generated with communities rather than about them carries different weight—and different responsibilities.

A word on positionality, because honesty here is not optional. The first author is Director of CRIPsy and co-founder of CHED—two institutions at the center of this study. The second is a researcher at UFCH, a partner institution. Institutional proximity gave us access and contextual understanding that outside researchers would not have had. It also created genuine risks: the temptation to see what we hoped to see, to hear confirmation rather than challenge. We took specific methodological steps to manage this, described below. We do not claim to have eliminated the risk entirely.

4. Methodology

4.1. Research Design

We adopted a qualitative exploratory design—not as a default but as an active choice. Mental health in Haiti is a phenomenon that is complex, under-theorized, and rooted in subjective experience that does not yield easily to predetermined hypotheses [5]. What we needed was not hypothesis testing but interpretation: understanding how people make sense of psychological suffering, what makes them seek or avoid care, and what conditions allow attitudes to shift. Qualitative methods are purpose-built for that kind of question.

4.2. Participants and Sampling Strategy

We recruited 30 participants through purposive sampling [20]—a non-probabilistic approach chosen not for statistical representativeness but for analytic diversity. The goal was to assemble a sample rich enough to illuminate the range of perspectives relevant to our research questions, not to approximate a population distribution. Recruitment continued until we reached thematic saturation: the point at which successive interviews stopped adding substantively new material to the

emerging themes. We reached that point around the 26th participant and conducted four additional interviews to confirm it.

Participants were organized into three groups:

- 1) Health professionals (n = 12): general practitioners, nurses, and psychologists working at CHED and affiliated community health posts in the Northern Department.
- 2) Patients (n = 10): individuals who had received care at CHED and had some prior contact, however limited, with formal psychological services.
- 3) Community leaders and traditional healers (n = 8): Evangelical pastors, Catholic leaders, Vodou practitioners (houngans), and respected elders from the commune of Plaine du Nord.

The three-group design was deliberate. Understanding why psychology is marginal in Haiti requires perspectives from outside the formal health system—from the people who fill the therapeutic space that psychology has not yet occupied. Restricting the sample to health professionals or patients would have produced a systematically partial picture.

Inclusion criteria

- 1) Age 18 or older
- 2) Direct personal or professional experience related to mental health in Haiti
- 3) Living or working in the Northern Department, specifically in the commune of Plaine du Nord or at CHED
- 4) Willingness to participate voluntarily, confirmed by signed informed consent

Exclusion criteria

- 1) Severe cognitive impairment affecting capacity to consent meaningfully
- 2) Refusal to permit audio recording
- 3) Age below 18

Participants were identified through CHED's institutional networks and the community contacts of CRIPsy field agents. Written informed consent was obtained from all participants prior to any data collection. The study protocol received clearance from the relevant institutional oversight bodies.

4.3. Data Collection

Data came from two sources used in parallel: 22 individual semi-structured interviews (between 40 and 60 minutes each) and two focus group discussions of four participants each. The interview guide was kept flexible—structured around core open questions rather than a rigid script—covering personal and professional experiences with mental illness, perceived obstacles to care, knowledge of available resources, and views on the relationship between traditional and biomedical healing.

All sessions were conducted in Haitian Creole by trained research assistants with native fluency and genuine familiarity with local norms and communication styles. Every session was recorded with participant consent, transcribed verbatim, and translated by bilingual team members. All personal identifiers were replaced with pseudonyms and removed from

transcripts.

4.4. Thematic Analysis

We followed Braun and Clarke's [1] six-phase thematic analysis framework. The phases are not a checklist to be cleared in sequence—in practice, analysis is recursive and involves repeated movement between phases, provisional conclusions revised against new readings. But they provided a disciplined structure for our interpretive work:

- 1) Data familiarization: repeated reading of all transcripts, with running notes on patterns, tensions, and questions.
- 2) Initial coding: systematic generation of codes across the full corpus, without premature organization into themes.
- 3) Searching for themes: grouping codes into candidate themes and sketching a preliminary thematic map.
- 4) Reviewing themes: testing each candidate theme for internal coherence and distinctiveness from adjacent themes, against the full data set.
- 5) Defining and naming themes: articulating precisely what each finalized theme captures, beyond its working label.
- 6) Writing up: selecting the most analytically forceful extracts and producing the thematic account.

Analysis was supported by NVivo 12 software. Both authors independently coded a randomly drawn 25% subset of the corpus. The resulting Cohen's kappa of 0.78 reflects satisfactory inter-rater agreement at established thresholds [15, 17]. We resolved all disagreements through sustained discussion until we reached genuine consensus—not merely procedural agreement.

4.5. Rigor and Trustworthiness

We built trustworthiness [18] into the study through several interlocking measures. Source triangulation across three participant groups with substantively different positional perspectives allowed us to compare accounts that had no structural reason to converge. Method triangulation—using both individual interviews and focus groups—generated different kinds of data on the same questions, catching dynamics that individual interviews alone would have missed. Independent dual-coding established inter-rater reliability (Cohen's $\kappa = 0.78$). A reflexive journal was maintained throughout: not as a procedural requirement but as a running record of analytical decisions, interpretive doubts, and the moments when the data pushed back against our prior expectations. We conducted member-checking with six volunteer participants, presenting our main themes and inviting critique. None contested the thematic structure; several added nuances that strengthened the final analysis.

Reflexivity, for us, meant more than noting institutional affiliations in a disclosure paragraph. It meant actively tracking how those affiliations shaped what we attended to, what we foregrounded, and what we may have failed to see. The aim was not to perform a detachment we did not possess, but to

make our positioning explicit and analytically answerable.

5. Results

Thematic analysis of the full corpus—22 interviews, 2 focus groups, 30 participants across three groups—produced three principal themes, each with internal sub-themes. One preliminary observation: the three participant groups did not simply offer different perspectives on the same object. They often spoke about different things, even when answering identical questions. Health professionals and community healers were sometimes not in the same conversation at all. That heterogeneity is part of the finding.

Theme 1: Deep-Seated Distrust and Therapeutic Pluralism

1a. Spiritual Frameworks as the Dominant Explanatory Logic

The most consistent finding across all three participant groups was pervasive distrust of formal psychological services. But “distrust” risks distorting what the data actually show. For many patients and community leaders, the issue was not that psychology was seen as harmful. It was that psychology was seen as beside the point. When mental distress is understood as the effect of a *lwa*'s action, a *kout djabb*, or a rupture in ancestral relations, the psychologist—whatever his training—is not the relevant interlocutor. The *houngan* or the pastor is. This matches exactly what Hagaman et al. [8] found in rural Haitian communities with high rates of suicidal ideation.

One participant put it plainly:

"When the lwa speaks through someone, a psychologist cannot understand what is happening—only the houngan knows how to respond." (Participant 4, community leader).

Another participant was careful to draw a distinction that the data confirmed repeatedly: the problem is not hostility, but a sincere epistemic mismatch:

"I am not saying the psychologist cannot help. But for what I have, his medicine is not going to work. It is a family matter, a matter of the lwa." (Participant 12, patient).

What this reveals is not a problem of ignorance. The spiritual explanatory frameworks documented here are coherent systems of meaning, built over centuries of collective experience with suffering, colonialism, and recurrent catastrophe. Treating them as mere obstacles—as barriers to be overcome through better communication—commits exactly the paternalistic error that James [10] traced as a recurring feature of foreign intervention in Haiti.

1b. Stigmatization and Its Cultural Mechanics

Stigmatization operated across all three of Corrigan [4] levels—self-stigma, public stigma, and structural stigma—and their interaction produced something specific to the Haitian context: psychological distress becomes a family secret, managed not through individual shame alone but through collective risk calculation. In communities where family reputation is a real and finite social resource, disclosing a mental illness can cost alliances, standing, and opportunities.

"Many of my patients still think that seeing a psychologist

means being crazy. And here, being 'crazy' is a shame for the whole family, not just for the person." (Participant 2, physician, CHED).

A family member gave the most precise account of how this calculation plays out:

"My mother suffered for three years before we agreed to bring someone to help her. We were afraid of what the neighbors would say." (Participant 17, family member of a patient).

Three years. That number is not in the treatment gap statistics—but it may say more about the mechanisms of care avoidance than most epidemiological data.

1c. How Stigmatization Operates Inside Health Institutions

Among health professionals, distrust took a different but equally consequential form. Several physicians and nurses described an institutional environment in which attending to patients' psychological needs made them feel professionally marginal:

"When I raise mental health with my colleagues, they look at me as if it were not a real medical problem. Physical emergencies always take precedence, even when I can clearly see that someone is in psychological crisis." (Participant 6, nurse).

This institutionalized hierarchy replicates at the system level the same dynamic that stigma generates at the level of individuals and families. Corrigan [4] terms this structural stigma: prejudice embedded in institutional rules, priorities, and funding decisions, where it proves substantially more resistant to change than individual attitudes.

Theme 2: Structural Deficit and Its Clinical Cascades

2a. A Shortage That Cannot Be Minimized

Alongside the cultural barriers, the data document a material reality no less obstructive: there are simply not enough psychologists. Not remotely enough to address the caseload clinicians face each week. At CHED, as in most public health facilities outside Port-au-Prince, there is no dedicated psychological consultation space, no psychiatric beds, no systematic mental health screening. Clinicians encounter psychological distress routinely. They have almost no resources with which to respond to it.

"Every week, I see patients who clearly need psychological follow-up. But we have no psychologist on staff. I do what I can with what I have, but what I have is insufficient." (Participant 1, general practitioner, CHED).

This is not a failure of individual practitioners. It is the accumulated outcome of decades of neglect of mental health content in Haitian medical and nursing training—documented in detail by Eustache et al. [6]. Clinicians cannot be expected to do what they were never taught to do.

2b. What Goes Wrong When the Psychological Goes Unaddressed

The deficit in psychological care generates clinical costs that reach well beyond the mental health domain. A case observed during fieldwork makes this concrete: a patient with type 2 diabetes mellitus, showing clear signs of moderate-to-severe depression, was placed on the CRIPsy waiting list be-

cause the clinic was at capacity. Three months later, her glycemic control had deteriorated markedly—a pattern consistent with the bidirectional comorbidity between depression and glycemic regulation extensively documented in the literature [3].

"I knew she needed psychological support in addition to diabetes management. I tried to refer her, but the waiting list was long. When I saw her again, her physical condition had worsened. I cannot separate the two." (Participant 3, internist).

2c. Traditional Healers in a Structural Void

One finding we had not fully anticipated: several traditional healers described their role not as an ideological stance against biomedicine, but as a practical response to structural absence. They are present because formal services are not.

"People come to me because there is nowhere else to go. It is not that the psychologist is worthless—it is that he is not there. I am here." (Participant 25, houngan, Plaine du Nord).

This reframes the integration question. If traditional healers function largely as last-resort providers in a structural void—which the data suggest they do—then the task is not to convince them to yield space to psychology. It is to think seriously about what each can do that the other cannot, and to build something from there.

Theme 3: Cautious Optimism and Emerging Change

3a. When Therapeutic Frameworks Start to Talk to Each Other

Despite the weight of the preceding themes, a third pattern surfaced in the data—less uniform than the first two, but analytically important precisely because of that. Among health professionals and younger community members in particular, there was a growing sense that biomedical and traditional therapeutic approaches are not necessarily enemies. They may be dealing with different things.

"I have started to see that what I do and what the houngan does are not necessarily contradictory. There are things I can treat, and things that exceed my medicine. What matters is that the patient is helped." (Participant 8, nurse).

Several health professionals expressed support for a holistic care model that integrates physical, psychological, social, and spiritual dimensions—the kind of convergence that Israel et al. [8] identified as a precondition, though not a guarantee, of durable community health integration.

3b. The CHED-CRIPsy Initiative: What the Evidence Shows

The community sensitization initiative launched in 2022 through the CHED-CRIPsy partnership was cited spontaneously by multiple participants as a tangible marker of change. The program organized monthly workshops across six communes, facilitated by interdisciplinary teams that included community leaders and religious Figures—not as symbolic endorsers lending legitimacy from the margins, but as genuine co-facilitators with a real hand in shaping the content.

"Before the workshops, I would never have advised someone to see a psychologist. But now I understand better what it

is. And I have even referred a few people who had problems I could not address." (Participant 27, Evangelical pastor).

Over eight months, the initiative reached roughly 400 community members. Pre- and post-program surveys showed statistically significant improvements in attitudes toward psychological services, reduced self-reported stigmatization, and measurable increases in declared willingness to seek help. Some traditional healers began referring patients to the CRIPsy clinic when their own tools did not suffice. These results are real. They are also limited to one setting, over a short timeframe, under conditions that are not infinitely replicable. The point is not that this is a solution—it is that it is evidence change is possible.

6. Discussion

Taking stock of these findings requires resisting two temptations: the temptation to extract clean lessons and the temptation to retreat into complexity as an excuse not to act. What the data show is that the situation is genuinely difficult—but not intractable.

6.1. What Cultural Resistance Actually Is

The most consequential analytical finding concerns the nature of community resistance to psychological services. A straightforward sensitization reading—if people only understood what psychology is, they would use it—does not survive contact with the data. The resistance documented here is not produced by ignorance. It reflects the internal logic of explanatory systems that have their own criteria of relevance, coherence, and therapeutic authority.

Kleinman [13] articulated this dynamic more than forty years ago, and the Haitian data confirm it: a patient who attributes distress to supernatural causation is reasoning coherently within their own framework. Proposing a psychologist in response is, in effect, answering a question that was never asked. James [10] showed how this pattern—replicated across decades of international intervention in Haiti—explains why so many programs designed for the country have left so little that endures.

This recognition cannot, however, be used to justify inaction. Psychological distress is real, it is treatable, and abandoning evidence-based intervention in the name of cultural respect would be its own form of harm. What the data suggest is that this tension does not resolve—but it can be worked with, by practitioners and institutions willing to take both frameworks seriously without declaring either one the final authority.

6.2. Why Task-Sharing Alone Does Not Solve the Problem

The task-sharing model proposed by Collins et al. [3] —

training community health workers in basic psychological interventions to address the specialist shortage—has real merit. Raviola et al. [20] showed it can work at scale in Haiti under the right conditions. Our findings add a complication: task-sharing that does not simultaneously address the cultural and symbolic status of mental health risks reproducing the same barriers at lower cost.

Who delivers psychological care matters less than how that care is received, and within what systems of meaning it is encountered. Training a community health agent in an evidence-based intervention does not automatically confer the ability to translate that intervention into the spiritual explanatory framework of the person sitting across from them. It is at precisely that interface that acceptance or rejection is determined. The CHED-CRIPsy initiative staked its approach on that interface—by positioning traditional healers and religious leaders as genuine co-facilitators rather than legitimizing props. Whether such an approach can be scaled and sustained under conditions of resource scarcity remains a genuinely open and consequential question.

6.3. International Partnerships and the Risk of Repeating Known Mistakes

Haiti's history with international health programming contains a recognizable failure pattern: programs well-designed elsewhere, deployed quickly, showing results within project timeframes, then collapsing when external teams and funding leave. James [10] analyzed this not as a series of individual failures but as a structural dynamic—each intervention that bypasses or substitutes for local institutions leaves those institutions slightly weaker.

Mental health is particularly vulnerable to this pattern because building local capacity is slow. Training psychologists, creating supervision structures, institutionalizing practice norms—none of this fits within a three-year project cycle. Kohrt et al. [16], synthesizing evidence across low-income mental health programs, showed that the most durable ones invest specifically in training local trainers and in supervision systems that can operate without expatriate support. That lesson applies directly here.

7. Study Limitations

Several limitations warrant explicit acknowledgment—not as a ritual disclaimer, but because they bear directly on how far the findings can reasonably be generalized.

The sample is geographically and institutionally bounded. Thirty participants recruited through CHED and CRIPsy networks in the Northern Department cannot stand in for the full range of Haitian experiences with mental health. Port-au-Prince, other rural departments, and communities with no contact with formal health institutions of any kind fall outside the scope of this study.

Recruitment through institutional networks likely

overrepresented participants already sympathetic to formal mental health services. The people most resistant to those services—arguably the most analytically important group for understanding the barriers—are probably underrepresented in our sample.

The data are based entirely on self-report. What participants say about their attitudes and behaviors in an interview context does not map directly onto how they act when confronted with actual situations of psychological distress. Social desirability bias is a particular concern among health professionals, who may have calibrated their responses to align with perceived professional norms.

Our institutional proximity to the organizations under study represents a genuine and acknowledged source of confirmation bias. The methodological safeguards we implemented reduced this risk without eliminating it. Some interpretations may reflect what we expected or hoped to find rather than what the data, strictly read, support.

Data collection occurred in 2022 and 2023, a period of acute security deterioration in Haiti. This constrained access to certain communities and may have influenced how participants responded to questions touching on institutional trust.

The cross-sectional design yields a snapshot rather than a trajectory. Whether the attitudinal shifts observed following the CHED-CRIPsy initiative prove durable, deepen over time, or gradually erode remains unknown. Answering that question will require longitudinal data.

8. Implications

8.1. For Public Health Policy

Mental health remains marginal in Haiti's official health priorities—not because the need is unknown, but because political will and resources have not followed the evidence. The minimum structural changes needed are clear: mandatory mental health content in medical and nursing training curricula; psychologist positions funded and placed in departmental hospitals; a dedicated, protected mental health budget line in national health financing. These measures will not resolve the cultural barriers documented here. They will create the conditions without which nothing else can be built.

8.2. For Clinical Practice

Clinicians in Haiti—national and international alike—need more than cultural sensitivity training. They need practical competency: the ability to hear a spiritual illness account without pathologizing it, to find productive points of contact between a patient's explanatory framework and what psychology can offer, and to work alongside traditional healers without treating them as competitors or as instruments of legitimacy. That kind of training does not exist yet in any structured form in Haiti. It needs to be built.

8.3. For Future Research

The most pressing gap in the evidence is longitudinal. Do attitudinal shifts after sensitization programs translate into actual care-seeking? Do they last? Through what specific mechanisms does stigmatization recede when it does? And what do traditional healers—whose perspectives are almost entirely absent from the published literature—think about working alongside formal services? These are not peripheral questions. They are the ones on which any sustained integration program would need to be built, and answering them requires designs capable of tracking communities over years, not months.

9. Conclusion

Mental health integration in Haiti is not primarily a technical problem—a gap to be filled by training more practitioners or buying more equipment, though both are needed. It is a problem of meaning, legitimacy, and power. The cultural and structural barriers documented here do not sit side by side; they are entangled, and strategies that address only one will be undermined by the other.

What the data also show is that movement is possible. Where genuine dialogue has taken place—where health professionals, religious leaders, and traditional healers have worked together not to persuade each other but to build something neither could build alone—things have shifted. That observation does not license optimism, but it does license persistence.

The path is narrow and requires commitments that most systems find difficult: structural investment over years rather than projects, epistemic humility in institutions that are not accustomed to it, and a willingness to treat the complexity of the Haitian experience not as an obstacle to navigate around, but as the actual starting point for anything worth building.

Abbreviations

APA	American Psychological Association
CHED	Centre Hospitalier Ervilus Donnet
CRIPsy	Centre De Recherche Et d'Intervention En Psychologie
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
ICD-11	International Classification of Diseases, Eleventh Revision
LMIC	Low- and Middle-Income Country
PTSD	Post-Traumatic Stress Disorder
UFCH	Université Franco-Haïtienne Du Cap-Haïtien
WHO	World Health Organization.

Author Contributions

Donnet Ervilus: Conceptualization, Resources, Investigation, Writing – original draft, Supervision

Wander Numa: Methodology, Validation, Writing – review & editing, Writing – original draft

Conflicts of Interest

The authors declare no conflicts of interest.

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