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Assessing Mental Health Needs In Northern Haiti: A Multidimensional Approach

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by

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ABSTRACT

This study assessed mental health needs in Northern Haiti, with the socioeconomic and sociocultural factors which predispose to mental disorders. Following the Key Informants approach to needs assessment, two groups were chosen to participate in this study: 27 out of 60 physicians and 30 out of 70 clergymen (N = 57), completed a questionnaire which asked specific questions on certain mental disorders they have either observed or dealt with among the population. The participants were also asked to give the frequency with which those disorders occurred among the population, and to rate the importance of factors contributing to those mental health needs.

Descriptive statistics were used to analyze the questionnaire data. The two respondent groups consistently reported the incidence and the prevalence of anxiety disorders and anxiety-based disorders, such as Hypertension and Shortness of Breath. In addition, the clergymen reported the prevalence of depressive symptoms among the population. Other prevalent disorders reported included: Migraine Headaches, Sleep Disorders, and Paranoid Disorders. The two groups also agreed on three basic mental health needs in Northern Haiti. They include: 1) Need for mental health services; 2) Need For mental health education; and 3) Need for Clinical Psychologists and other mental health practitioners.

The contributing factors to those disorders and needs among the population were listed as follows: Inadequate sanitation, beliefs in supernatural causes of illness, childhood malnutrition and chronic undernourishment, and illiteracy.

Some general recommendations were made with a view to reduce the incidence and to prevent the occurrence of some of those disorders. These recommendations included: inclusion of mental health in the overall

public health programs; development of manpower through existing resources; and mental health education both for the public and for the service providers. The respondents were encouraged to participate more actively in the development of mental health programs and to prepare themselves through continuing education, to meet some of the psychological needs of those who seek their help.

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CHAPTER I

INTRODUCTION

Statement of the Problem

In their article "Psychopathology and Society", Nathan and Harris (1975) allude to the work of Oscar Lewis, a famous anthropologist who provides a list of factors which have psychopathological effects on Mexicans and Puerto-Ricans. Some of the factors include low wages, constant struggle for survival and employment, crowded quarters, considerable alcoholism, violence in training children, authoritarianism, political apathy, belief in sorcery and spiritualism, hatred of police, mistrust of government and those in high position, strong feelings of helplessness and dependency, feelings of inferiority and unworthiness, resignation and fatalism, high tolerance of psychopathology, low level of education and literacy, lower life expectancy and relatively high death rate. Lewis (1961, 1966) argues that 'culture of poverty' is largely responsible for those psychological factors.

By culture of poverty, he refers to the totality of influences that characterize the socialization process of persons reared in deprived circumstances. Other researchers have supported the notion of the psychopathological effects of the culture of poverty. Hylan Lewis (1967) describes the dynamics of despair, defamation, and apathy, in relation to poverty behavior. Rome (1967) also supports Lewis' findings. He establishes the association between alienation, poverty and mental illness, and suggests that low self-esteem and minimal motivation are the prevailing attitudes observed among the socially and economically underprivileged. Gary's (1978) list of stressful events are closely related to Oscar Lewis' list of factors. It includes family instability, child abuse and neglect, inadequate nutrition, poor physical environment, considerable alcoholism, and poor self-concept. Gary argues for the interaction of those factors and mental health among lower socioeconomic groups. There is strong probability that similar psychopathological effects may be observed among people of third world countries such as Haiti. Unfortunately, they tend to remain unnoticed due to lack of research and resources to prevent or to reduce their prevalence.

According to the World Health Organization (WHO,1975), in developing countries more than 40 million men, women, and children suffer from serious untreated mental disorders. The factors which accounted for this include socioeconomic factors, lack of manpower in the mental health sector, lack of awareness of mental health needs both among professionals and the population, attribution of mental illnesses to physical illnesses, nondiagnosed mental disorders, lack of mental health services in a rural milieu, and lack of education on mental health or health in general among the population. The WHO also found that more than 90% of the population in developing countries is almost completely without any mental health care. Haiti, one of these developing countries, seems far from being an exception to the rule. In a recent study on Schizophrenic Syndrome in Haiti, Guillen (1986) found that there are only two public psychiatric centers in Port-au-Prince, the capital of Haiti, along with five private clinics dealing with severe mental disorders. Guillen also found that there was no psychiatric center in any other part of the country and that the physicians outside of the capital have to send their patients with mental disorders to the capital to be

cared for. There is an urgent need for mental health care and services in the provinces of Haiti. However, in order to plan for mental health services in those parts of the country, it seems imperative that needs assessment be conducted so as to allow the planner to evaluate what kinds of services will be appropriate to meet what kinds of need.

Needs assessment, according to Royse and Drude (1982), is an essential part of mental health planning; it is important information to the planning process (Siegel, 1977). The concept of needs assessment can be considered analogous to the first step in the scientific method, definition of the problem (Royse & Drude, 1982).

In light of the studies of developing countries in general by the WHO, and in light of the Guillen (1986) study in particular, there is a clear need for improved mental health services in Haiti as a whole and in the provinces in particular. A needs assessment is the first appropriate step that can be taken in planning for those services. This study will attempt to identify the mental health needs in Northern Haiti as perceived by the physicians and clergymen, along with the various factors that predispose to those needs.

Northern Haiti was chosen for this study because it has the second largest metropolitan area of the country after the capital and is the largest province of Haiti. It is hoped that this study can be replicated later on in other parts of the country.

Physicians and clergymen were chosen as key informants for the needs assessment because of their involvement and interaction with the population on a regular basis. They are said to be the first line of defense against mental illness, for it is to them that families usually go when there are troubles at home (Farnsworth & Braceland, 1969).

The clergy, because of the customs of their discipline, have certain innate advantages in dealing with human suffering. Their role is often perceived by laymen such that members of a clergyman's congregation are usually able to confide intimate details of their lives with no fear or shame facing them afterward. The individual does not feel himself or herself labeled as a "case" or a "sick-person".

The clergyman is concerned not only for the spiritual life of his parishioners and the larger population he is serving but also for their entire human situation.

Physicians, because of their expertise in medicine and diagnosis may be consulted regarding mental disorders as well as physical disorders. They are a community resource because of being exposed to both physical and mental health needs.

It has often been stated that more patients with mental illnesses are treated by general physicians than by mental health professionals; this is likely to continue (Usdin and Lewis 1979).

Particularly in a country like Haiti as in the third world countries in general, where the population may be unaware of mental health services and needs, people may be likely to attribute mental disorders or psychological ailments to physical causes and to consult physicians for their care (WHO, 1975).

Physicians and clergymen, because of their respective roles, have significant interaction and involvement with the people on a regular basis, and based on their experiences, expertise, and observations, will be able to provide valuable information that will help form an accurate picture of the mental health needs of the population.

In this next section literature will be reviewed in three particular areas: needs assessment strategies,

definition and use of the multidimensional approach, and health in Haiti.

Review of the Literature

Needs Assessment Strategies

Assessment of mental health needs in Western Society is said to have begun with Richard Powell's analysis of the Data in the Case Register started in 1775. In 1810, he reported that the number of cases of insanity had increased in the years between 1775 and 1809 (Schwab, 1976). Since Powell's initial endeavor, such studies have been conducted in a number of instances in an attempt to measure the extent of mental illness. Needs assessment has become an important concept in community mental health. Centers financed with Federal money under public law are required to assess needs before funding is given.

Pharis (1976) concluded after reviewing the literature that needs assessment is basically part of the planning and evaluation. There must be a need, a needs assessment, a program related to the need, and finally, evaluation of the effectiveness of the program

in meeting the need (Pharis, 1976). Assessment of needs according to Stewart (1975) refers to a range of different techniques by which conditions, needs, or resources may be identified (Stewart, 1975).

Needs assessment is an integral part of the planning process. Blum (1974) provides two distinct steps involved in a needs assessment: (a) the compilation of community needs data by the application of an appropriate assessment procedure, and (b) the analysis and interpretation of the obtained data in order to ascertain the most salient needs and to arrive at some prospectus for community planning.

Thus, the needs assessment should not merely collect data, but should also provide directives for future action, serving as a premeasure in a pre-post intervention design (Millord, 1976).

Various techniques or methodologies have been used in needs assessment: the epidemiologic survey, social indicators and analysis, surveys of opinions of residents, analysis of rates of persons being seen by helping agencies, and Key Informant interviews (Stewart, 1975). This study will focus on the last approach, using Key Informants. The first assessment in the United States utilized the Key Informants approach

(Bell & Siegel, 1983). In Connecticut in 1812, reports from physicians and officials throughout the States showed that there were 1,000 mentally ill persons, or 1 of every 262 inhabitants. The kind of Key Informants approach used back then, although limited, still has utility in modern America (Bell & Siegel, 1983). It focuses on information provided by individuals in the community who have had some significant long-standing involvement within the community. Informants can be anyone from physicians and clergymen to policemen and the local bartenders (Millord, 1976).

Schwab (1976) suggests another important aspect of mental health needs assessment. He states that mental disorders and the needs for mental health care seldom appear as isolated disturbances. Assessment of needs in the broad area of health and human services, therefore, will uncover evidence of overlapping physical, interpersonal, and spiritual needs. It is expected that an assessment of mental health needs would use an approach that would take into account the overlapping or interrelated factors involved in health in general and in mental health in particular. This approach could be termed a multidimensional approach

that will attempt to uncover the various dimensions that have reciprocal interaction with health needs.

Thus, needs assessment is a necessary step toward planning for health services and can involve a multidimensional approach for identifying complex needs prior to exploring strategies for meeting those needs. The Key Informants approach to assessing mental health needs is a legitimate approach for obtaining valuable information about the population. Because of their involvement and significant interaction with the population on a regular basis, physicians and clergymen are able to provide an approximation to an accurate picture of the mental health needs of the population.

Definition and Use of the Multidimensional Approach

Health, as defined by the Constitution of the World Health Organization (WHO), in 1946, is a state of complete physical, mental, and social well-being, and not merely the absence of disease and infirmity. Following that definition, numerous authors and researchers have attempted, quite successfully, to demonstrate the necessity of integrating the disciplines of psychology, sociology, and biology in

the search for meeting the various dimensions of the individual's needs. Thus a multidimensional approach takes into account the various factors, including psychological, sociological, cultural, physical and spiritual factors which may be involved in promoting and influencing health and in decreasing illness. As a basic assumption, it is posited that health and illnesses are multideterminant, caused or influenced by multiple factors and dimensions. Thus, models of care must also be multidimensional in their approach (Lupkin and Kupka, 1982).

According to Linn (1977), symptoms of all illnesses arise from three separate sources: biological factors, psychological and developmental factors, and social factors including the impact of school, work, recreation and the community.

Masserman (1955) has described man's three primary needs: (a) the biological requisites for survival, of water, food and shelter; (b) interpersonal needs for companionship and affection essential for a sense of identity, emotional expression and a meaningful existence; and (c) spiritual yearning for a faith or a metaphysic that gives a transcendent meaning to life. Masserman also states that when basic needs are not

fulfilled because of frustration, conflict and deprivation, mental illness often results. It has been observed in developing countries, similar to Haiti, that social and psychological components of health rarely receive attention from medical practitioners and social scientists (Lupkin & Kupka, 1982).

Biopsychosocial Factors in Health

Coleman (1984) states that although an illness may be primarily physical or primarily psychological, it is always a disorder of the whole person, not just the lungs or the psyche. For example, fatigue or a bad cold may lower resistance for psychological stress, and emotional upset may lower resistance to physical disease; maladaptive behavior, such as excessive use of alcohol, may contribute to the impairment of various organs such as the brain and liver. Furthermore, the overall life situation of an individual has much to do with the onset of a disorder, its form, duration and prognosis. In short, the individual is a biopsychosocial unit which has been described by many.

Jones (1977) has established the relationship between psychological factors and good health. He observed that positive emotions seem often to produce a certain immunity to physical disease and to to be

associated with speedy and uncomplicated recoveries when disease does strike. This relation between psychological state and health can also be observed in what has become known as the placebo effect. The patient who believes the treatment is going to be effective has a much better chance of improvement than does the patient who is neutral or pessimistic even when the treatment is subsequently shown to have no direct or relevant effect.

Psychosocioeconomic Factors in Health

There is evidence that socioeconomic factors play a great role in health in general and in mental health in particular. A strong emphasis on the necessity to approach the individual's needs from a psychosocioeconomic viewpoint has been promoted by a number of health care professionals. In the foreword of the twenty-seventh World Health Assembly report, Lambo of the WHO (1975) stated that "it has been made painfully clear in recent years that health services too frequently lack relevance to the total needs of people." In highly developed countries, increasingly complex and costly medical interventions yield decreasing returns in terms of relief in overall human suffering, while in many developing countries, even the

most basic elements of health care are not available to many people. Over a decade later the same statement is true for the majority of the world population for in the developing countries in particular. While the health care professionals of the developing countries would agree with the WHO constitution that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being (WHO, 1946), the ever present socioeconomic factors tend to keep them from maintaining that view even at the minimum applicable level.

For example, malnutrition continues to be one of the leading causes of illnesses and death among young children in most developing countries. In those who survive, a background of poor nutrition contributes to chronic debility and to impaired functional performance, both intellectual and physical (WHO, 1980). Thus the condition is not only a killer of children but can produce severe impairment of physical and mental function in those who survive.

Malnutrition not only reduces health status independently but also works synergestically with other diseases, such as diarrhea in children, to raise the level of needs (Akin, 1985).

There are other socioeconomic factors which affect the health condition of the individual along with malnutrition. Low standards of living and poverty may increase diseases, directly through lack of necessary means of living (e.g., poor houses, poor sanitation) and indirectly, by way of psychological processes (e.g., unemployment, relative deprivation, alienation). Mustafar (1973) also talks about migration from rural to urban areas which provokes massive demographic and behavioral changes--leaving family behind, social alienation, identity crises, anomie, and job pressures--that can predispose to serious mental illnesses. Moreover, along with the socioeconomic factors, family members, friends, workmates and the larger social groups in the community and neighborhood all make their contributions to the physical and psychological health or ill health of the individual.

Sociocultural Factors in Health

Akin (1985) observed that even when it can be ascertained that a person is suffering from the symptoms of physical illness, the decision to seek professional help and the simultaneous choice of provider are matters particularly determined by an individual's psychological and cultural predisposition.

Symptoms that might occasion panic in one culture or individual may go unnoticed in another culture or by a different person. The role of the individual perception of need can in the extremes result either in hypochondria or in total refusal to seek help. Socioeconomic and cultural factors may create a tolerance of disease or disaster which is seen as inevitable and uncontrollable.

Furthermore, it has been observed that some illnesses are culture-bound or rooted in culturally determined psychosocial stresses in which mechanistic medical intervention may prove to be a failure (Lupkin and Kupka, 1982).

Klein (1978) provides one example of the Latin American 'Susto', a malaise known locally as caused by fright and resulting in 'soul loss', the symptoms of which are nervousness, insomnia, loss of appetite, inability to urinate, depression, and introversion. Anthropological studies have established that 'Susto' is a product of a complex interaction of biological, environmental, cultural, and psychological factors (Rubel, 1977).

Weidman (1978) provides another example: 'Falling Out' (seizure-like episodes with no evidence of

organicity) found exclusively in black-Americans, Bahamians, and Haitians is another problem requiring therapeutic approaches that are both transdisciplinary (Social Science/Medicine) and transcultural.

The literature reviewed so far supports a multidimensional approach to health which embraces psychosocial factors, biological factors, socioeconomic factors, and sociocultural factors. However, there is yet another dimension to deal with: the spiritual dimension.

The definition of the spiritual dimension in this study refers to the beliefs and practices that relate the individual to a supernatural being: God or gods. The capacity to have a relationship with a deity is believed to be part of man's being created in the image of God (Genesis 1:26). Although the capacity was originally ascribed to man for fellowship with his Creator, God, its positive contribution to make and stimulate a hunger for God has been distorted by the Fall; still the internal appeal for fulfillment from and in a transcendent other was not completely destroyed (Anderson, 1982).

Since the term spiritual may convey metaphysical overtones it should be made clear that this study is

interested in the interaction it has with the other dimensions of the individual, how it affects them and is affected by them. To ignore this interaction would be to limit oneself to an incomplete view of man which would result in an inadequate approach to man's needs.

Thus this study suggests that a multidimensional approach should take into account the spiritual dimension if it is to treat man in his totality. Buckler (1986) talks about how biology, psychology, sociocultural influences and spiritual issues tie together. He calls this unity of issues the biopsychosocial/spiritual model. "We have to consider all those different areas before we can say one way or the other what is wrong with a given individual". He continues: "When we talk about counseling...I see it as the application of specialized knowledge in psychology and counseling and human services areas to problems of human behavior and human emotion with emphasis on balancing spiritual, psychological, physical and cultural factors".

Minirth and Meier (1982) talk about the holistic nature of man as being psychological, physical and spiritual and how all of these dimensions are intertwined. Physical diseases are at times involved

in psychological symptoms, psychological symptoms can produce physical diseases, and spiritual problems in many cases lie at the core of, or are caused by, physical and/or emotional conditions.

These authors are talking of the spiritual dimensions from a Judeo-Christian point of view. However the problem does not remain there. Akin (1985) alluded to a study done in Southeastern Nigeria in which 78% of the patients at spiritual healing homes were suffering from infertility, childbirth problems, mental problems, and disorders of the stomach. The researcher noted that many of those who complained of infertility, childbirth problems, mental problems, and diseases of the stomach, also saw themselves as victims of enemy machinations and supernatural powers. Thus, spirituality in those instances may interfere with taking responsibility for health or illness, may interfere with psychological and medical intervention and may favor high tolerance of the disease as inevitable and uncontrollable, as is repeatedly observed in third world or developing countries.

Man is thus not only a biopsychosocial unit, he is a biopsychosocial/spiritual unit. A multidimensional

approach embracing this entire unit is mandatory for his complete health.

The literature seems to confirm the complexity of the human phenomena and the necessity for a multifold approach to a mutifaceted problem. The neglect of one single dimension may jeopardize the entire initiative to solving human problems or may paralyze any long-term endeavor at reducing the incidence or prevalence of diseases.

Mental Health and Physical Health in Haiti

This study begins by assuming that all or most that has been learned about health in developing countries is also true of Haiti. The socioeconomic, sociocultural and spiritual factors of physical and mental health found in the literature about third world countries are very much descriptive of the situation in Haiti. It is believed, however, that Haiti may have more than it's share of these problems. One particular aspect of this may be related to religious practices in Haiti.

Romain (1970) found that in Haiti 15% of the population are Protestant and 85% are Catholics. But

the majority of Haitians believe in or practice Voodoo, a religion originated in Africa; the basic beliefs resemble those of spiritism, attributing power to the evil spirits to protect, to kill, or to make sick. Metraux (1958) stated that 90 to 95% of Haitians believe in Voodoo. There is a syncretism between Catholicism and some of the African religions. Montilus (1966), a Haitian Catholic priest, explains the relationship between beliefs in Voodoo and some peculiarities of behavior of some Haitians. He states that the Haitian 'vodouisant' is distrustful of others, thinking that others can use anything, even his clothes to harm him through evil spirits. Philippe (1985), a Haitian psychiatrist, treated a Protestant woman for sleep disorders. She had developed insomnia through worrying about losing one piece of clothing, thinking that someone might use that to harm her.

Bourguignon (1984) observing the Voodoo phenomenon in Haiti states that Voodoo is not only a religious system involving rituals of worship, it is also a system of dealing with practical problems, of which illness, infant mortality, and madness make up a significant part. For the great majority of Haitian people, the beliefs, rituals, and experiences

associated with Voodoo provide a system of explanation and of defense in a hostile world, and a means of striving for two difficult goals: health and wealth The same author further observes that according to Haitian traditional theory, illness, including madness, may be due to acts of God (maladie Bon Dieu), to punishment by the spirits, or to magic attacks by humans. In the first case nothing can be done, except perhaps to consult a physician or convert to Protestantism, which is often the case. In the case of spirit anger or human malevolence, however, the Voodoo priest can help. Even in cases of tuberculosis, an attempt may be made to approach the disease through magical means. Thus, interferences with or refusal of scientific means to treatment in the Haitian context are rather to be expected with the outcomes that might result from them. They can range from failure to follow doctor's instructions to a blunt refusal to consult a physician in case of illnesses.

The socioeconomic factors found in the literature about third world countries such as malnutrition, lower standards of living, and problems with sanitation are typical of those that have been observed in Haiti. In 1972, a survey of 1,300 Haitian children aged one to

three from 26 areas, revealed that 7% of those children suffered from florid kwashiorkor, 60% were malnourished according to the Gomez criteria, and 60% had abnormal arm circumferences. Local superstitions affect the diet considered appropriate for children, and prevent the administration of other available foods. It was found in some sectors that cow's milk is believed too strong for babies and that eggs will make a child's teeth fall out. Some people believe that no meat or fish generally should be given to a child under three years of age because it is considered bad for him. Although there may be some serious reservations about those findings, it is possible, however, that superstitious factors play a role in the socioeconomic aspects of the problem.

It is unfortunate that for the time being the review of the literature on the actual situation in Haiti is limited due to difficulties of access. The situation in Haiti is not much different from the rest of the third world countries, hence the necessity of approaching the complexity of the problems with the same basic assumptions of a multidimensional approach, embracing the biopsychosocial/spiritual aspects of the health needs in Haiti.

Summary of the Literature Review

The review of the literature on the various factors involved in health and disease strongly support the necessity for mental health needs assessment that includes the various dimensions that predispose to and influence those needs. The multidimensional approach is an essential aspect of health needs assessment for various reasons: (a) as supported by the literature, health and illnesses are multideterminant, so it would be naive to assess the needs and ignore the determining socioeconomic and sociocultural factors that interplay with those needs; and (b) since needs assessment is one essential part of the planning process, ignoring the factors that interact with those needs is likely to handicap the planning process. There is undeniable evidence that a multidimensional approach which takes into account the psychosocioeconomic, sociocultural, and psychological and spiritual factors involved in health and diseases, is necessary in assessing health needs in general and mental health needs in particular. It is also undeniable that there is great need for mental health services in Haiti as a whole and in the provinces in particular. Therefore assessing mental health needs in Northern Haiti is necessary and

requires that a multidimensional approach be used so as to permit an appropriate planning process for meeting those needs.

The Purpose of the Study

The purpose of this study is threefold: (a) to assess the current mental health needs in Northern Haiti by surveying the physicians and clergymen as key informants, (b) to assess the various factors that predispose to and interact with those mental health needs, and (c) to propose strategies for implementing mental health services in Northern Haiti.

Significance of the Study

As is shown in the review of the literature, there are clear needs for mental health services in third world countries in general and in Haiti in particular; these are greater than ever. Considering the various sociocultural, biopsychosocial/spiritual, and socioeconomic factors that predispose to mental illnesses in those countries, there are obvious needs for mental health services which are complex.

Currently, there are no mental health services provided in Northern Haiti or in any other province in that country. Planning mental health services requires a needs assessment. Using the Key Informants approach has been shown to be legitimate and appropriate. Thus the present proposal is to assess mental health needs in Northern Haiti as they are perceived by physicians and clergymen and to propose a plan of service provision and prevention for meeting those needs in light of the various factors that predispose to them.

Objectives of the Study

This study hopes to accomplish four things:

1. Provide a model that can be used in assessing mental health needs in Northern Haiti and other parts of Haiti.

2. Use the model to assess mental health needs in Northern Haiti by surveying physicians and clergymen.

3. Identify the current factors that predispose and interact with those mental health needs.

4. Explore strategies for implementing mental health services in Northern Haiti and, make practical recommendations based on the findings

CHAPTER II

METHOD

This chapter will present the basic information of the research process. The following three basic questions are addressed: first, who participated in the study? (i.e., the selection of subjects); second, what instruments were used in obtaining the information?; and third, how was the data actually collected?

Preliminary Survey Trip

The researcher visited Haiti in January 1987 to evaluate the possibility of assessing the mental health needs of that country. Several key health officials were contacted regarding this project. These included the representative of the World Health Organization and Pan-American Health in Haiti, the Director of the Psychiatric Center in Port-au-Prince, the Director of the Haitian Red Cross, the Director of the Haitian

Social Welfare (Bien-etre social), and several others. All these individuals made helpful recommendations and suggestions for this study.

The researcher had also the opportunity to interact with some physicians and clergymen of the capital, Port-au-Prince, and they also made suggestions contributing to the research process.

In addition, a contact with a prominent lawyer in the capital was very productive. He provided insight into the complexity of the mental health situation in the population with regards to criminal activities, and the Haitian judicial system and its relationships to mental health and illnesses. The lawyer strongly argued for a global and interdisciplinary approach to alleviate human suffering in the country.

A preliminary questionnaire was also distributed to many physicians in the capital. Constructive criticism (especially from the WHO representative) of the preliminary questionnaire contributed to a large extent to the design of the actual questionnaire used in this study.

Several attempts were made to contact officials in the National Public Health Department. However, the top level administrative changes that took place during

the same week made it impossible to discuss the research project with public health officials in Port-au-Prince or in Northern Haiti.

Subjects

The population chosen for this study consisted of all physicians and all clergymen in the province of Northern Haiti within an elliptical radius of 40 to 60 kilometers of Cap-Haitien, who could be contacted by the research associates. Cap-Haitien is the Capital city of the Northern Department and, as of 1986, has a population of 70,500. It should be noted that Haiti was experiencing one of its worst political crises during the period the research was being conducted (November 1987 to early 1988). Traveling in and out of the country and circulation through the country were at best risky, if not impossible. The research associates also reported that, because of the political atmosphere, many of the intended subjects-participants seemed to be over cautious and unwilling to participate in the research, even though it was explained that the research study would in no way put anyone in jeopardy.

Materials

Because no studies of this kind had been conducted in Haiti, no instrument was readily available to gather the information needed. Therefore, two questionnaires were designed: one for physicians and one for clergymen. The questionnaires were designed to assess the mental health needs perceived by physicians and clergymen, and also to assess the factors that are involved in those health needs. The questionnaires were designed for the most part to follow a scale of 1 to 6. Copies of the questionnaires in both English and French are in Appendices G and H.

The Physicians Questionnaire

The physicians questionnaire was designed as follows: For questions 4 to 12, each item had a scale of 1 to 6, and was delineated so that 1 = never; 2= almost never; 3= sometimes; 4= often; 5= almost always; and 6= always. Thus a Mean of 3.00 for any item indicates that the average response for that particular item is 'sometimes'. For question 13, each item had a scale of 1 to 6 and was delineated so that 1= absolutely not important; 2= not very important; 3=

somewhat important; 4= important; 5= very important; 6= absolutely very important. Thus a mean of 4.00, for any item for question 13 indicates that the average response for that particular item is 'important' and so forth for other response levels. For question 14, each item had a scale of 1 to 6 and was delineated so that 1= strongly disagree; 2= disagree; 3= moderately disagree; 4= moderately agree; 5= agree; and 6= strongly agree. Thus a mean of 5.00 for any item for question 14 indicates that the average response was 'agree' for that particular item.

The first three questions consisted of the demographic variables: 1) specialty 2) places of practice, and 3) number of years in practice.

Questions 4 to 12 ask for the frequency with which the respondents have observed certain attitudes, behaviors, and the frequency with which they have dealt with certain symptoms or disorders among the population. Question 13 asks information regarding the importance of some socioeconomic factors in predisposing to illnesses in the population. Question 14 asks the respondents to rate their opinion on specific statements related to mental health needs of the population and various factors that interplay with

these needs. Question 15 asks for the availability of certain mental health services and resources to the population. The respondents were then asked to list the top 3 public health needs and the top 3 mental health needs of the population in questions 16 and 17 respectively.

Question 4 deals primarily with attitudes and behaviors toward illnesses in the general population. Question 5 asks for the frequency with which the physicians receive non-medical complaints from their patients. Question 6 asks for the frequency with which the physicians have observed certain physical symptoms for which there is no apparent organic or pathophysiologic mechanism basis in their patients. Question 7 has to do with certain psychosexual disorders observed or reported among the general population. Question 8 asks the physicians to give the frequency of certain symptoms, including depressive symptoms, anxiety disorders, and personality disorders and psychotic symptoms, are observed among the population or among their patients. Question 9 asks for specific psychophysiological disorders they have either observed or treated among the population. Question 10 deals specifically with mental disorders

among the population. Question 11 asks information about substances that are abused. Question 12 asks the physicians to give the frequency with which they prescribe certain psychotropic medications.

The Clergymen's Questionnaire

The same format and principles were applied to the questionnaire for the clergymen. For questions 3 to 8, each item followed a scale of 1 to 6 (1= Never to 6= Always); question 9 also followed a scale of 1 to 6 (1= Absolutely not important, to 6= Absolutely Important). And question #10 followed a scale of 1 to 6 (1= Strongly Disagree to 6= Strongly agree).

The first two questions consisted of the demographic variables: (a) religious affiliation, and (b) number of years in the ministry.

Questions 3 to 8 ask the clergymen to give the frequency with which they have observed or dealt with certain behaviors, attitudes, and symptoms in the population. Question 9 deals with the socioeconomic factors that interact with illnesses among the population. Question 10 asks the clergymen to rate their opinion on specific statements related to mental health needs and the predisposing factors among the

population. Question 11 deals with the availability of certain mental health services or resources to the population. In question 12, the clergymen were asked to list the principal contributions of the church in promoting mental health among the population. Finally in questions 13 and 14 they were asked to list the top 3 public health needs and the top 3 mental health needs of the population.

Question 3 was designed to assess the frequency with which clergymen were consulted for certain social or emotional problems and difficulties by the population. Question 4 asks their observation of certain events in the population. Question 5 deals with specific psychophysiological illnesses observed or reported among the population. Question 6 asks the frequency with which certain attitudes and behaviors toward illnesses are observed among the population. Question 7 asks the clergymen for their observation of certain social and cultural problems of the population. Question 8 deals with a list of symptoms and asks the clergymen to give the frequency with which they are observed.

The questionnaires were reviewed by the dissertation committee before they were translated into

French which is the official language of Haiti. The French translation of the questionnaires was reviewed by a physician formerly from Haiti, who had practiced medicine in Haiti for a number of years before immigrating to the United States.

Items for Questions 7, 8, 10, 11 for the physicians, and items for question 8, for the clergymen were in part modeled on selected criteria as described in the Diagnostic and Statistical Manual of Mental Disorders, Third edition (DSM-III; American Psychiatric Association, 1985). The DSM-III is congruent with the International Classification of Diseases, ninth edition, (ICD-9; World Health Organization).

This present study has focused on certain disorders that appear in the Axis I category in the DSM-III, for example; such clinical syndromes as Organic Mental Disorders, Substance Abuse , Affective Disorders, Somatoform Disorders, Psychotic Disorders, and certain disorders that appear in Axis III, and finally Psychosocial Stressors that would appear in Axis IV.

Data Collection

Sixty physician questionnaires and 70 clergyman questionnaires were distributed; each had a cover letter and was in a separate envelope. The questionnaires were mailed to the two research associates who had been previously contacted and had agreed to carefully follow the procedures outlined. They both resided in Cap Haitien, Haiti and could contact the respondents. Letters and phone calls were exchanged regarding the details of the process of the data collection.

The following instructions were given and followed: (a) distribute all 130 questionnaires during a 3-week period, (b) send a reminder to the respondents either by phone or personal contact in case the 48 hour-deadline in the cover letter was not met, and (c) collect the envelopes available within a 4-week period and return them to the researcher.

A final letter was sent by the associates to the researcher detailing the proper handling of the data collection process.

Statistical Research Design

Descriptive statistics, including central tendency measures, were used to summarize and collate the data, with the use of tables, as appropriate (Gravetter & Wallnau, 1985; Isaac, 1985).

CHAPTER III

RESULTS

This chapter presents the Descriptive statistics of the data collected via questionnaires. The data is summarized in tables. The Statistical Package for the Social Sciences (SPSS/PC+) was used to analyze the data.

This chapter contains the analysis of the demographic variables and some descriptive statistics for each question for each group. It also contains the descriptive statistics for each category. Only those items with a mean of 3.00 and above were chosen, because of the nature of the study which was assessing areas of needs perceived by the physicians and the clergymen. On rare instances an item below a 3.00 average was chosen because of its significance if the Mode was 3 or above. The complete descriptive statistics can be found in Appendices I and J.

A brief analysis of salient items is made at the introduction of each table.

Subjects

The subjects-participants comprising the sample for this study were 60 physicians of which 27 (45%) completed the questionnaire, and 70 clergymen, of which 30 (42.8%) completed the questionnaire. The total sample (N) was 57 out of 130 (43.8%).

Demographic Variables for Each Group

Demographic Variables for the Physicians

The demographic variables for the physicians included the following: (a) specialty, (b) places of practice, (c) number of years in practice.

1. Specialty: Of the 27 physicians, 7 (25.9%) practiced OB-GYN, 6 (22.2%) were general practitioners, 4 (14.8%) were surgeons, and the remaining 10 (37.04%) physicians practiced other specialties such as internal medicine, pediatrics and ENT.

2. Places of practice: Of the 27 physicians, 25 (92.5%) worked at the state hospital, 2 (7.4%) in private hospitals, 12 (44.4%) in group practice and 5 (18.5%) in solo practice. Many physicians practiced in more than one place, as is reflected in the numbers.

3. Number of Years in Practice: The number of years in practice for the physicians ranged from 2 years to 35 years with a Mean of 7.5 years in practice.

Demographic Variables or the Clergymen

The demographic variables for the clergymen included the following: a) Religious affiliation, and b) Number of years in the Ministry.

1. Religious Affiliations: Of the the 30 clergymen who participated in the study, 19 (63.3%) were Baptist; 6 (20%) were Roman Catholic and the remaining 5 (16.6%) clergymen had other religious affiliations such as 7th Day Adventist, Evangelical Church of Haiti, and so forth.

2. Number of years in the ministry: The number of years in the ministry ranged from 2 to 40 with a Mean of 11.86 years in the ministry.

Descriptive Statistics for the Physicians for Each Question

For questions 4 to 12, the scale for each item ranged from 1 = Never to 6 = Always. For question 13, the scale ranged from 1 = Absolutely Not Important to 6 = Absolutely Very Important. For question 14, each scale ranged from 1 = Strongly Disagree to 6 = Strongly Agree.

Question #4: How often do you see the following attitudes and behaviors toward illnesses in the population you serve?

Table 1 presents some descriptive statistics for question #4. Item Q4H "Superstitious Behaviors" has the highest mean, 4.19, followed by item Q4C "Beliefs in supernatural Causes of Illness." The most frequent response for these 2 items was 4 'often.' Both items Q4E "Negligence toward personal care" and Q4F "Poor personal hygiene" have an equal mean of 3.50.

Table 1

Patients' attitudes and behaviors toward illnesses

Var.	Mean	Mode	SD	Min.	Max.	N	Label
Q4H	4.19	4	.85	3	6	26	SUPERSTITIOUS
Q4C	4.04	4	1.02	1	6	27	SUPRNATURL BELIEF
Q4E	3.50	3	.95	2	6	26	NEGLECT PERS CARE
Q4F	3.50	4	1.10	1	6	26	POOR HYGIENE
Q4A	3.48	4	1.23	1	6	25	TOLERANCE ILLNESS
Q4D	3.44	3	.89	2	5	27	NO FOLLW INSTRUCT

Question #5: How often do individuals bring these non-medical concerns to your office?

Table 2 presents some descriptive statistics for question #5. Item Q5F "Life Circumstances issues" has a mean of 3.32 followed by item Q5I "Work Related Problems" with a mean of 3.00. The most frequent response for both items was 3 "sometimes".

Table 2

Non-medical problems encountered

Var.	Mean	Mode	SD	Min.	Max.	N	Label
Q5F	3.32	3	.95	1	5	25	LIFE CIRCUMSTANCE
Q5I	3.00	3	1.07	1	6	27	WORK PROBLEMS

Question #6: How often do you see the following symptoms in patients without organic or pathophysiological mechanisms to account for the symptoms?

Table 3 presents some descriptive statistics for question # 6. Item Q6I "Painful Menstruation" has the highest mean, 3.48, followed by item Q6J "Irregular Menstrual Period with a Mean of 3.34. Most frequent response for both items was 4 "often". Item Q6H "Sexual Indifference" was included because of its significance. Although it has a mean of less than 3.00, the most frequent response was 3 'sometimes'. Of the 26 respondents, 17 (65.38%) gave a 3 to 6 response.

Table 3

Symptoms without organic causes

Var.	Mean	Mode	SD	Min.	Max.	N	Label
Q6I	3.48	4	1.42	1	6	27	DYSMENORRHEA
Q6J	3.35	4	1.29	1	5	26	IRREGU. MENSTRUA
Q6K	3.00	3	1.20	1	5	25	PMS
Q6H	2.88	3	1.24	1	6	26	SEX. INDIFFERENCE

Question #7: How often do the following sexual disorders occur in the population you serve?

Table 4 presents some descriptive statistics for question #7. Item Q7I "Premature Ejaculation" has the highest mean, 3.29, followed by item Q7H "Erectile Deficiency, 2.96, and item Q7J "Inhibited Male Orgasm".

Table 4

Sexual disorders in population

Var.	Mean	Mode	SD	Min.	Max.	N	Label
Q7I	3.30	4	1.17	1	6	27	PREMATURE EJACUL.
Q7H	2.96	3	.98	1	4	27	ERECTILE DEFIC.
Q7J	2.77	3	1.03	1	4	26	IMPOTENCE
Q7P	2.60	3	.96	1	4	25	DYSPAREUNIA

Question #8: How often do you see the following symptoms among your patients?

Table 5 presents some descriptive statistics for question #8. Item Q8F "Superstitious Behaviors" has the highest mean, 3.88, the mode being 4 'often'. It is followed by item Q8A "Shortness of Breath" with a mean of 3.69, and a mode of 4 'often'; item Q8T "Insomnia" has a mean of 3.60 with a mode of 4 'often'.

Table 5

Various symptoms seen in population

Var.	Mean	Mode	SD	Min.	Max.	N	Label
Q8F	3.88	4	1.03	2	6	26	SUPERSTITIONS
Q8A	3.69	4	.93	2	6	26	SHORT. OF BREATH
Q8T	3.60	4	1.29	1	6	25	INSOMNIA
Q8B	3.52	4	.89	2	6	27	DIZZINESS
Q8C	3.50	3	.71	2	5	26	TACHYCARDIA
Q8N	3.26	3	1.02	1	5	27	CONSTANT FATIGUE
Q8U	3.23	3	1.21	1	5	26	PESSIMISM
Q8I	3.04	4	.85	2	4	27	LOSS OF CONSCIOUS
Q8K	3.04	3	1.13	1	6	27	MEMORY LOSS
Q8L	3.04	3	1.00	1	4	26	IRRITABILITY
Q8E	3.00	3	.69	2	5	26	POLYURIA
Q8O	2.74	3	1.29	1	5	27	DELUSIONS
Q8BB	2.72	3	1.17	1	6	25	HALLUCINATIONS
Q8R	2.68	3	.95	1	4	25	LOSS INTEREST SEX
Q8G	2.44	3	1.22	1	5	27	OBSESSIONS

Question #9: How often do you see the following illnesses in the population you serve?

Table 6 presents some descriptive statistics for question #9. Item Q9J "Migraine Headaches" has the highest mean, 4.00, and a mode of 4 'often'. It is followed by item Q9B "Hypertension", mean 3.88 and a mode of 4 'often'; and item Q9A "Ulcer", mean 3.85, and a mode of 4 'often'. Item Q9D "Chronic Diarrhea" is also significant with mean of 3.61 and a mode 3 'sometimes'.

Table 6

Illnesses seen in Population

Var.	Mean	Mode	SD	Min.	Max.	N	Label
Q9J	4.00	4	.85	2	6	26	MIGRAINES
Q9B	3.88	4	.95	1	6	26	HYPERTENSION
Q9A	3.85	4	.92	2	5	26	ULCER
Q9D	3.62	3	.98	2	6	26	DIARRHEA
Q9G	3.50	4	1.14	1	6	26	G-I SYMPTOMS
Q9E	3.40	4	1.08	2	6	25	ANOREXIA
Q9K	3.29	3	.91	2	6	24	HEART DISEASE
Q9H	3.04	2	1.04	1	5	26	EPILEPSY
Q9L	3.00	3	1.18	1	5	24	HYPOCHONDRIASIS
Q9F	2.88	3	1.05	1	6	25	BULIMIA

Question #10: How often do the following psychological disorders occur among the population you serve?

Table 7 presents some descriptive statistics for question #10. Item Q10F "Sleep disorders" has the highest mean, 3.88, and a mode of 4 'often'. It is followed by item Q10C "Anxiety" which has a mean of

3.81 and a mode of 4 'often'; and Item Q10E "Hysteria" a mean of 3.25 and a mode of 4 'often'. Item Q10B "Depression" is also worth noting; it has a mean of 3.11 and a mode of 3 'sometimes'. The last item worth noting is item Q10H "Personality Disorder" which has a mean of 2.88, and a mode of 3 'sometimes'.

Table 7

Psychological Disorders in population

Var.	Mean	Mode	SD	Min.	Max.	N	Label
Q10B	3.11	3	1.01	1	6	27	DEPRESSION
Q10F	3.89	4	1.15	2	6	27	SLEEP DISORDERS
Q10C	3.81	4	1.04	1	6	27	ANXIETY
Q10E	3.26	4	1.16	1	5	27	HYSTERIA
Q10H	2.89	3	1.12	1	6	27	PERSONALITY DISOR
Q10G	2.84	3	1.14	1	5	25	SEXUAL DYSFUNCT
Q10D	2.78	3	.97	1	5	27	SUBSTANCE ABUSE

Question #11: How often do you see the abuse of the following substances in the population?

Table 8 presents the descriptive statistics for question #11. Item Q11E "Sugar" has the highest mean, 4.55, and a mode of 4 'often'. It is followed by item Q11B "Tobacco", a mean of 4.07 and a mode 4 of 'often'; and item Q11A "Alcohol" which has a mean of 3.85 and a mode of 4 'often'. Item Q11D "Caffeine" is also worth noting. It has a Mean of 3.25 and Mode of 4 'often'. The last item to be considered is item Q11C "Marijuana", which has a mean of 2.96 and a mode of 3 'sometimes'. It must also be noted that of the 27 respondents, 21 (77.78%) answered this item with a 3 to 4 scale response.

Table 8

Substance abuse in the population

Var.	Mean	Mode	SD	Min.	Max.	N	Label
Q11E	4.56	4	.93	3	6	27	SUGAR
Q11B	4.07	4	1.00	2	6	27	TOBACCO
Q11A	3.85	4	1.13	2	6	27	ALCOHOL
Q11D	3.26	4	1.10	1	6	27	CAFFEINE
Q11C	2.96	3	.94	1	4	27	MARIJUANA

Question #12: How often do you prescribe the following medications?

Table 9 presents some descriptive statistics for Question #12. Item Q12H, "Valium" has the highest mean, 3.63, and a mode of 4 'often'. It is followed by item Q12A, "Barbiturates", with a mean of 2.77 and a mode of 2 'almost never'. Item Q12G Phenothiazines," is also worth noting. It has a mean of 2.59, but has a mode of 3 'sometimes'.

Table 9

Medications prescribed

Var.	Mean	Mode	SD	Min.	Max.	N	Label
Q12H	3.63	4	1.11	1	6	27	VALIUM
Q12A	2.78	2	1.09	1	6	27	BARBITURATES
Q12G	2.59	3	.93	1	4	27	PHENOTHIAZINES

Question #13: How important are the following factors in predisposing to illnesses in the population?

Table 10 presents some descriptive statistics for question #13. All items of this question received a mean above a 3.00 and the lowest mode is 4 'often'. The items ranged from a mean of 3.81 to 5.40. The highest mean is 5.40 for item Q13E "Inadequate Sanitation" and has a mode of 6 'always important'. It is followed by item Q13D "Chronic Undernourishment", with a mean of 5.25 and a mode of 6 'always important'; and item Q13A "Crowded Quarters" with a mean of 5.07 and a mode of 5 'Nearly always important'. Item Q13C "Childhood Malnutrition" also has a mean of 5.07 and a mode of 6 'always important'. Item Q13H "Illiteracy"

is also worth noting. It has a mean of 4.88 and a mode of 5 'nearly always important'.

Table 10

Factors predisposing to illnesses

Var.	Mean	Mode	SD	Min.	Max.	N	Label
Q13E	5.41	6	1.01	3	6	27	INADEQ. SANITAT
Q13D	5.26	6	.90	3	6	27	UNDERNOURISHMENT
Q13A	5.07	5	.83	3	6	27	CROWDED QUARTERS
Q13C	5.07	6	1.07	2	6	27	MALNUTRITION
Q13B	4.96	5	1.02	2	6	27	OVERPOPULATION
Q13H	4.89	5	.89	3	6	27	ILLITERACY
Q13N	4.85	5	1.16	2	6	26	PUBLIC HEALTH
Q13L	4.41	4	1.42	1	6	27	UNEMPLOYMENT
Q13J	4.33	4	1.24	1	6	27	POOR HYGIENE
Q13O	4.26	4	1.35	2	6	27	NATURAL DISASTER
Q13F	4.15	5	1.23	1	6	27	ALCOHOLISM
Q13G	4.15	5	1.20	1	6	27	SMOKING
Q13M	4.07	5	1.17	1	6	27	BIRTH CONTROL
Q13K	3.92	4	1.04	1	6	25	SEXUAL ACTIVITY
Q13I	3.81	4	1.14	1	6	27	LACK OF EXERCISE

Question #14: Please indicate your opinion on the following statements.

Table 11 presents some descriptive statistics for Question #14. Item Q14D "Needs for Mental Health Education" has a mean of 5.11 and a mode of 6 'strongly agree'. It is followed by item Q14F "Mental Health Problems seen as Satanic Manifestations", with a mean of 4.92 and a mode 5 'agree'; and Item Q14C "Needs for Mental Health Services" mean of 4.85 and a mode of 5 'agree'. Item Q14E "Needs for Clinical Psychologists and Mental Health Specialists" is worth noting; it has a mean of 4.70 and a mode of 5 'agree'.

Table 11

Opinions expressed on following statements

Var.	Mean	Mode	SD	Min.	Max.	N	Label
Q14D	5.11	6	.89	3	6	27	NEED MH EDUCATION
Q14F	4.93	5	1.14	2	6	27	MH PRBLM SATANIC
Q14C	4.85	5	1.03	2	6	27	NEED MH SERVICES
Q14E	4.70	5	.99	2	6	27	NEED PSYCHOLOGIST
Q14I	4.31	4	1.16	1	6	26	CHILDHOOD ORIGINS
Q14K	4.19	6	1.55	1	6	27	VOODOO & HEALTH
Q14G	4.11	4	1.40	1	6	27	PSYCHOGENIC PRBLM
Q14B	3.74	3	1.46	1	6	27	TREAT EMOT PRBLM
Q14A	3.56	4	1.48	1	6	27	ALCOHOL & HEALTH
Q14J	3.12	4	1.51	1	6	25	CAN'T TREAT
Q14H	2.07	1	1.11	1	5	27	SUICIDE

Descriptive Statistics for the Clergymen for Each Question

For questions 3 to 8 the scale for each item has a range from 1 = Never to 6 = Always. For question 9 the scale ranges from 1 = Absolutely Not Important to 6 = Absolutely Very Important. For question 10 each item scale ranges from 1 = Strongly Disagree to 6 = Strongly Agree.

Question #3: How often do individuals bring the following concerns to you?

Table 12 presents some descriptive statistics for question #3 for the clergymen. Item Q3H "Life Circumstances in General" has the highest mean, 4.96, and a mode of 6 'always.' It is followed by item Q3D "Religious Concerns" which has a mean of 4.17 and a mode of 3 'sometimes;' and item Q3E "Advice Seeking for Decision Making" which has a mean of 3.79 and a mode of 3 'sometimes.'

Table 12

Concerns individuals bring to office

Var.	Mean	Mode	SD	Min.	Max.	N	Label
Q3H	4.97	6	1.16	2	6	30	LIFE CIRCUMSTANC.
Q3D	4.17	3	1.47	1	6	29	RELIG. CONCERNS
Q3E	3.79	3	1.25	1	6	29	ADVICE ON DECIS.
Q3G	3.78	3	1.28	2	6	27	HEALTH CONCERNS
Q3C	3.76	3	1.24	1	6	29	INTERPERS. CONFLI
Q3F	3.46	3	1.48	1	6	28	SEXUAL MATTERS
Q3B	3.28	3	1.46	1	6	29	PARENTING ISSUES
Q3A	3.10	3	.71	1	4	30	MARITAL DIFFICULT

Question #4: How often do the following situations occur in the general population?

Table 13 presents some descriptive statistics for Question #4. Items Q4D "Uncertainty About Life" and Q4F "Political Unrest" both have a mean of 4.96 and a mode of 6 'always'. These items are followed by item Q4E "Poor Physical Environment" which has a mean of 4.36 and a mode of 4 'often'; and also item Q4B "Heavy smoking" with a mean of 4.21 and a mode of 4 'often'.

Table 13

Situations which occur in the population

Var.	Mean	Mode	SD	Min.	Max.	N	Label
Q4D	4.96	4	1.02	3	6	27	LIFE UNCERTAINTY
Q4F	4.96	6	1.26	2	6	28	POLITICAL UNREST
Q4E	4.37	4	1.45	1	6	30	PHYSICAL ENVIRON.
Q4B	4.21	4	1.26	1	6	28	TOBACCO
Q4C	3.80	4	.92	2	6	30	MARITAL PROBLEMS
Q4A	3.61	3	1.37	1	6	28	ALCOHOLISM

Question #5: How often do the following diseases occur among the general population?

Table 14 presents some descriptive statistics for question #4. Items Q5D and Q5I "Hypertension" both have a mean of 4.50 and a mode of 4 'often'. They are followed by item Q5H "Migraines" which has a mean of 4.46 and a mode of 4 'often'; and also item Q5C "Sexually Transmitted diseases" which has a mean of 3.79 and a mode of 4 'often'.

Table 14

Diseases which occur among the population

Var.	Mean	Mode	SD	Min.	Max.	N	Label
Q5D	4.50	4	1.11	2	6	30	TUBERCULOSIS
Q5I	4.50	4	1.04	1	6	30	HYPERTENSION
Q5H	4.47	4	1.33	1	6	30	MIGRAINES
Q5C	3.79	3	1.35	1	6	29	STDS
Q5J	3.64	3	1.22	1	6	28	DIARRHEA
Q5F	3.60	4	1.22	1	6	30	ULCER
Q5A	3.50	3	1.04	1	6	30	HEART DISEASE
Q5E	3.03	3	1.09	1	6	29	TETANUS
Q5G	2.97	3	.87	1	5	29	EPILEPSY
Q5B	2.90	3	.99	1	6	30	CANCER

Question #6: How often do you see the following attitudes and behaviors among the general population?

Table 15 presents some descriptive statistics for question #6. Item Q6C "Beliefs in Supernatural Causes of Illnesses" has a mean of 5.23 and a mode of 5 'almost always.' It is followed by item Q6H "Superstitious Behaviors" which has a mean of 5.20 and

a mode of 5 'almost always' and also item Q6F "Poor personal Hygiene" which has a mean of 4.60 and a mode of 4 'often'.

Table 15

Patients' attitude and behavors toward illnesses

Var.	Mean	Mode	SD	Min.	Max.	N	Label
Q6C	5.23	5	.73	4	6	30	SPRNATURAL CAUSES
Q6H	5.21	5	.73	3	6	29	SUPERSTITIONS
Q6F	4.60	4	.97	3	6	30	POOR HYGIENE
Q6E	3.90	4	1.18	2	6	29	NEGLECTING HEALTH
Q6D	3.83	4	1.12	1	6	30	NO FOLLW INSTRUCT
Q6G	3.79	4	.96	2	6	28	EATING HABITS
Q6I	3.67	2	1.37	2	6	30	NOT TRUST DOCTORS
Q6A	3.66	4	1.40	1	6	29	ILLNESS TOLERANCE
Q6B	3.52	2	1.55	1	6	29	UNCONTROL ILLNES

Question #7: How often are the following reported in the general population?

Table 16 presents some descriptive statistics for Question #7. Item Q7H "Witchcraft Aiming at Harming

a mode of 5 'almost always' and also item Q6F "Poor personal Hygiene" which has a mean of 4.60 and a mode of 4 'often'.

Table 15

Patients' attitude and behavors toward illnesses

Var.	Mean	Mode	SD	Min.	Max.	N	Label
Q6C	5.23	5	.73	4	6	30	SPRNATURAL CAUSES
Q6H	5.21	5	.73	3	6	29	SUPERSTITIONS
Q6F	4.60	4	.97	3	6	30	POOR HYGIENE
Q6E	3.90	4	1.18	2	6	29	NEGLECTING HEALTH
Q6D	3.83	4	1.12	1	6	30	NO FOLLW INSTRUCT
Q6G	3.79	4	.96	2	6	28	EATING HABITS
Q6I	3.67	2	1.37	2	6	30	NOT TRUST DOCTORS
Q6A	3.66	4	1.40	1	6	29	ILLNESS TOLERANCE
Q6B	3.52	2	1.55	1	6	29	UNCONTROL ILLNES

Question #7: How often are the following reported in the general population?

Table 16 presents some descriptive statistics for Question #7. Item Q7H "Witchcraft Aiming at Harming

People" has the highest mean, 4.53, and a mode of 4 'often'. It is followed by item Q7A "Robbery" which has a mean of 4.43 and a mode of 4 'often'. Three additional items all have a mean of 4.30; item Q7F "Unpaid Debts" which has a mode of 4 'often' and item Q7G "Sorcery" which has a mode of 5 'almost always'; and also item Q7I "Prostitution" which has mode of 4 'often'. The last item to be considered here is item Q7M "Child Abuse" which has a mean of 4.13 and a mode of 3 'sometimes'.

Table 16

Situations reported among the general population

Var.	Mean	Mode	SD	Min.	Max.	N	Label
Q7H	4.53	4	1.07	3	6	30	EVIL WITCHCRAFTS
Q7A	4.43	4	1.14	1	6	30	ROBBERY
Q7G	4.41	5	1.08	3	6	27	SORCERY
Q7F	4.30	4	1.15	2	6	30	UNPAID DEBTS
Q7I	4.30	4	.95	3	6	30	PROSTITUTION
Q7M	4.13	3	1.01	3	6	30	CHILD ABUSE
Q7E	4.00	4	1.07	2	6	29	TRAFFIC ACCIDENTS
Q7K	3.69	3	1.20	1	6	29	PROMISCUITY
Q7D	3.57	4	1.53	1	6	28	ZOMBIFICATION
Q7L	3.52	3	1.09	1	6	29	ABORTION
Q7B	3.47	3	1.28	1	6	30	BURGLARY
Q7J	3.32	3	1.49	1	6	28	PORNOGRAPHY
Q7C	3.13	3	1.04	1	6	30	MURDER
Q7N	3.03	3	.94	2	6	29	RAPE

Question #8: How often do you observe the following symptoms in the population you serve?

Table 17 presents some descriptive statistics for question #8. Item Q8Z "Gossip" has the highest mean, 5.06, and a mode of 6 'always'. It is followed by item Q8Y "Lack of Trust in Others" which has a mean of 4.80 and a mode of 4 'often'; and also item Q8P "Constant Worry" which has a mean of 4.70 and a mode of 5 'almost always'. Additional items that are worth noting here are: item Q8C "Fear of the 'Loas'"(evil spirits) a mean of 4.69, and a mode of 5 'almost always'; item Q8U "Fear of Demonic Persecutions" a mean 4.63, and a mode of 5 'almost 'always'; item Q8N "Jealousy" which has a mean of 4.54, and a mode of 4 'often'; Item Q8M "Child Rearing issues" which has a mean of 4.31 and a mode of 5 'almost always'.

Table 17

Symptoms observed among the population

Var.	Mean	Mode	SD	Min.	Max.	N	Label
Q8Z	5.07	6	.92	3	6	29	GOSSIPS
Q8Y	4.80	4	.92	3	6	30	TRUST ISSUES
Q8P	4.70	5	1.07	2	6	27	CONSTANT WORRY
Q8C	4.69	5	1.00	3	6	29	FEAR OF DEMONS
Q8U	4.63	5	1.00	3	6	30	DEMONIC PERSECUT
Q8N	4.54	4	1.00	3	6	28	JEALOUSY
Q8W	4.50	5	1.32	1	6	28	RESIGNATION
Q8S	4.44	5	1.12	3	6	27	INFERIOR. COMPLEX
Q8D	4.31	4	1.07	2	6	29	DEATH OBSESSION
Q8M	4.31	5	1.04	3	6	29	CHILD REARING
Q8I	4.24	4	.91	2	6	29	INFIDELITY
Q8B	4.21	5	1.01	2	6	29	PESSIMISM
Q8V	4.18	4	1.06	2	6	28	INTROVERSION
Q8X	4.14	4	.99	2	6	29	KEEP RELATIONS
Q8O	4.13	4	.82	3	6	30	IN-LAWS
Q8E	4.07	5	1.00	1	5	29	ANGER CONTROL
Q8J	4.04	3	.92	3	6	28	MARITAL ROLES

(table continues)

Table 17 (continued)

Symptoms observed among the population

Var.	Mean	Mode	SD	Min.	Max.	N	Label
Q8G	4.03	4	.87	2	5	29	POOR COMMUNCATION
Q8R	4.00	4	.94	2	6	28	SLEEP DISORDERS
Q8K	3.82	3	1.12	2	6	28	FAMILY PLANNING
Q8T	3.73	4	1.04	2	6	26	FALSE GUILT
Q8H	3.68	4	1.09	1	6	28	SEX DISSATSFCTION
Q8F	3.61	3	1.13	2	6	28	OBSESSIONS
Q8L	3.04	3	.84	2	5	28	STERILITY
Q8Q	2.81	3	.96	1	5	27	SUICIDAL IDEATION

Question #9: How important are the following factors in predisposing to illnesses in the population?

Table 18 presents some descriptive statistics for Question #9. All the items for question #9 have a mean above 4.00. Item Q9E "Inadequate Sanitation" has the highest mean, 5.62, and a mode of 6 'absolutely very important.' It is followed by item Q9D "Chronic Undernourishment" which has a mean of 5.55, and a mode of 6 'always;' item Q9C "Malnutrition in Childhood"

which has a mean of 5.48, and a mode of 6 'always'. The additional items are item Q9G "Illiteracy" which has a mean of 5.25 and a mode of 6 'always'; both items Q9A "Crowded Quarters" and Q9B "Overpopulation" have a mean of 5.20 and a mode of 6 'always'. The last item Q9F "Lack of Vaccination" has a Mean of 4.90 and a mode of 5 'very important'.

Table 18

Factors predisposing to illnesses

Var.	Mean	Mode	SD	Min.	Max.	N	Label
Q9E	5.62	6	.56	4	6	29	INADQUAT SANITAT.
Q9D	5.55	6	.69	4	6	29	UNDERNOURISHMENT
Q9C	5.48	6	.83	3	6	29	MALNUTRITION
Q9G	5.25	6	.93	3	6	28	ILLITERACY
Q9A	5.20	6	.92	3	6	30	CROWDED QUARTERS
Q9B	5.20	6	.89	3	6	30	OVERPOPULATION
Q9F	4.90	5	1.06	2	6	30	LACK OF VACCIN

Question #10: Please indicate your opinion on the following statements.

Table 19 presents some descriptive statistics for question #10. Item Q10N "There is an important interaction between spiritual health, physical health, and mental health" has the highest mean, 5.90, and a mode of 6 'strongly Agree'. It is followed by item Q10C "Needs for Mental Health Services", which has a mean of 5.67, and a mode of 6 'strongly agree'; item Q10A "I wish I had more training to deal with some of the emotional issues people bring to my attention" has a mean of 5.63 and a mode of 6 'strongly agree'. Items Q10E "Needs for Psychologists and Mental Health Specialists" and Q10 "Needs for Mental Health Education for the Population" both have a mean of 5.43 and a mode of 6 'strongly agree'.

Table 19

Opinions expressed on following statements

Var.	Mean	Mode	SD	Min.	Max.	N	Label
Q10N	5.90	6	.31	5	6	30	MH INTERACTION
Q10C	5.67	6	.61	4	6	30	NEED MH SERVICES
Q10A	5.63	6	.67	4	6	30	MORE TRAINING
Q10E	5.43	6	.86	3	6	30	NEED PSYCHOLOGIST
Q10F	5.43	6	.73	3	6	30	NEED MH EDUCATION
Q10B	5.40	6	.67	4	6	30	CHURCH INVOLVMENT
Q10G	5.27	6	.78	4	6	30	TRAINING INTEREST
Q10K	5.07	5	.60	4	6	28	CHILDHOOD ORIGINS
Q10H	4.97	6	1.27	1	6	30	MH PRBLM SATANIC
Q10J	3.10	2	1.52	1	6	30	BIBLE ONLY ANSWER
Q10L	2.89	3	1.37	1	6	28	SUICIDE PROBLEM

Descriptive Statistics for Physicians for Selected Categories

Category medical concerns

Table 20 presents some descriptive statistics for the Medical concerns category for the physicians. Item Q4C "Beliefs in Supernatural Causes of Illnesses" has the highest Mean, 4.04 and a mode of 4 'often'. Item Q9J "Migraine Headaches" follows closely with a mean of 4.00, and a mode of 4 'often'. Item Q9B "Hypertension" is also significant with a mean of 3.88 and a mode of 4 'often'. It is followed by item Q9A "Ulcer" which has a mean of 3.85 and a mode of 4 'often'. Item Q8A "Shortness of Breath" comes next with a mean of 3.69, and a mode of 4 'often'. It is followed by item Q8T "Insomnia" which has a mean of 3.60 and a mode of 4 'often'. Three additional items each received a mean of 3.50: item Q4E "Polyuria" which has a mode of 3 'sometimes'; item Q4F " which has a mode of 4 'often'; and item Q8C "Tachycardia" which has a mode of 3 'sometimes'. The last two items to be mentioned here are items Q6I, "Dysmenorrhea", and Q4A, "High Tolerance of Illnesses"; they both have a mean of 3.48, and a mode of 4 'often'.

Table 20

Category medical concerns

Var.	Mean	Mode	SD	Min.	Max.	N	Label
Q4C	4.04	4	1.02	1	6	27	SUPERNATURAL
Q9J	4.00	4	.85	2	6	26	MIGRAINES
Q9B	3.88	4	.95	1	6	26	HYPERTENSION
Q9A	3.85	4	.92	2	5	26	ULCER
Q8A	3.69	4	.93	2	6	26	SHORT OF BREATH
Q9D	3.62	3	.98	2	6	26	DIARRHEA
Q8T	3.60	4	1.29	1	6	25	INSOMNIA
Q8B	3.52	4	.89	2	6	27	DIZZINESS
Q4E	3.50	3	.95	2	6	26	PERSONAL CARE
Q4F	3.50	4	1.10	1	6	26	PERSONAL HYGIENE
Q8C	3.50	3	.71	2	5	26	TACHYCARDIA
Q9G	3.50	4	1.14	1	6	26	G-I SYMPTOMS
Q4A	3.48	4	1.23	1	6	25	TOLERANCE ILLNESS
Q6I	3.48	4	1.42	1	6	27	DYSMENORRHEA
Q4D	3.44	3	.89	2	5	27	NOT FOLLOW INST.
Q9E	3.40	4	1.08	2	6	25	ANOREXIA

(table continues)

Table 20 (continued)

Category medical concerns

Var.	Mean	Mode	SD	Min.	Max.	N	Label
Q6J	3.35	4	1.29	1	5	26	IRR MENSTRUATION
Q9K	3.29	3	.91	2	6	24	HEART DISEASE
Q8N	3.26	3	1.02	1	5	27	CONSTANT FATIGUE
Q10E	3.26	4	1.16	1	5	27	HYSTERIA
Q8I	3.04	4	.85	2	4	27	LOSS OF CONSCIOUS
Q9H	3.04	2	1.04	1	5	26	EPILEPSY
Q6K	3.00	3	1.20	1	5	26	PMS
Q8E	3.00	3	.69	2	5	26	POLYURIA
Q9L	3.00	3	1.18	1	5	24	HYPOCHONDRIASIS
Q9F	2.88	3	1.05	1	6	25	BULIMIA
Q6C	2.81	4	1.20	1	5	26	CHEST PAIN
Q4I	2.63	3	1.04	1	5	27	LACK OF TRUST
Q4B	2.35	3	.94	1	4	26	UNCONTOLLABLE

Category sexual issues

Table 21 presents some descriptive statistics for the sexual issues category. Item Q7I "Premature Ejaculation" has the highest mean, 3.30 and a mode of

4 'often.' It is followed by item Q5G "Sexual Conflict Issues" which has a mean of 2.92, and a mode of 3 'sometimes.'

Table 21

Category sexual issues

Var.	Mean	Mode	SD	Min.	Max.	N	Label
Q7I	3.30	4	1.17	1	6	27	PREMAT. EJACULA.
Q7H	2.96	3	.98	1	4	27	ERECTIL DEFCIENCY
Q5G	2.92	3	.89	1	5	26	SEXUAL CONFLICTS
Q7J	2.77	3	1.03	1	4	26	IMPOTENCE
Q7P	2.60	3	.96	1	4	25	DYSPAREUNIA
Q7Q	2.59	3	1.05	1	5	27	RAPE

Category affective disorders and anxiety disorders

Table 22 presents some descriptive statistics for the category, "Affective Disorders and Anxiety Disorders." Item Q4G "Appetite Disorders" has the highest mean, 4.12, and a mode of 4 'often.' It is followed by item Q10F "Sleep Disorders" which has mean of 3.89 and a mode of 4 'often.' Item

Q8T "Insomnia" is also significant. It has a mean of 3.60 and a mode of 4 'often'. It is followed by item Q8N "Constant fatigue" with a mean of 3.26, and a mode of 3 'sometimes'. Item Q10B, "Depression," has a mean of 3.11 and a mode of 3 'sometimes'.

Table 22

Category affective disorders and anxiety disorders

Var.	Mean	Mode	SD	Min.	Max.	N	Label
Q4G	4.12	4	.91	2	6	26	EATING DISORDER
Q10F	3.89	4	1.15	2	6	27	SLEEP DISORDERS
Q10C	3.81	4	1.04	1	6	27	ANXIETY
Q8T	3.60	4	1.29	1	6	25	INSOMNIA
Q8N	3.26	3	1.02	1	5	27	CONSTANT FATIGUE
Q8U	3.23	3	1.21	1	5	26	PESSIMISM
Q10B	3.11	3	1.01	1	6	27	DEPRESSION
Q8K	3.04	3	1.13	1	6	27	MEMORY LOSS
Q8O	2.74	3	1.29	1	5	27	DELUSIONS
Q8AA	2.68	3	1.14	1	5	25	LOSS CONCNTRATION
Q8CC	2.32	3	1.18	1	5	25	PANIC ATTACKS

Category psychotic symptoms

Table 23 presents some descriptive statistics for the Psychotic Symptoms category. Item Q8Y "Delusions of Grandeur" has the highest mean, 2.88 and a mode of 3 'sometimes'. It is followed by item Q8O "Persecutory Delusions" which has a mean of 2.74 and a mode of 3 'sometimes', and item Q8BB "Hallucinations" which has a mean of 2.72 and a mode of 3 'sometimes'. The last item to be mentioned here is item Q8R "Loss of Interest in Pleasurable Activities" which has a mean of 2.68 and a mode of 3 'sometimes'.

Table 23

Category psychotic symptoms

Var.	Mean	Mode	SD	Min.	Max.	N	Label
Q8Y	2.88	2	1.40	1	6	26	UNUSUAL STRENGTH
Q8O	2.74	3	1.29	1	5	27	DELUSIONS
Q8BB	2.72	3	1.17	1	6	25	HALLUCINATIONS
Q8R	2.68	3	.95	1	4	25	ANHEDONIA
Q8Q	2.56	2	.58	2	4	25	RAPID MOOD SHIFTS
Q8Z	2.56	3	1.29	1	6	25	GRANDIOSITY

Category interpersonal issues

Table 24 presents some descriptive statistics for the category of interpersonal issues. Item Q10H "Personality Disorders" has the highest mean, 2.88 and a mode of 3 'sometimes'. It is followed by item Q5E "Personality Disorder Issues" which has a mean of 2.56, and a mode of 3 'sometimes'; and item Q5B "Marital Difficulties" which has a mean of 2.46 and a mode of 3 'sometimes'.

Table 24

Category interpersonal issues

Var.	Mean	Mode	SD	Min.	Max.	N	Label
Q10H	2.89	3	1.12	1	6	27	PERSONALIT DISORD
Q5E	2.56	3	.96	1	5	25	PERSONALIT DISORD
Q5B	2.46	3	.95	1	5	26	MARITAL PROBLEMS
Q5D	2.35	3	1.02	1	5	26	INTERPERS. CONFLI

Category substance abuse

Table 25 presents some descriptive statistics for the Substance Abuse category. Item Q11E "Sugar" has a

mean of 4.55 and a mode of 4 'often.' It is followed by item Q13F "Considerable Alcoholism" which has a mean of 4.14 and a mode of 4 'often;' and item Q11B "Tobacco" which has a mean of 4.07 and a mode of 4 'often.' Item Q11A "Alcoholic Beverages" has a mean of 3.85 and a mode of 4 'often.' It is followed by item Q14A "Alcoholism is a Major Health Problem among the Population", mean 3.55 and mode 4 'moderately agree.'

Table 25

Category substance abuse

Var.	Mean	Mode	SD	Min.	Max.	N	Label
Q11E	4.56	4	.93	3	6	27	SUGAR
Q13F	4.15	5	1.23	1	6	27	ALCOHOLISM
Q11B	4.07	4	1.00	2	6	27	TOBACCO
Q11A	3.85	4	1.13	2	6	27	ALCOHOL
Q14A	3.56	4	1.48	1	6	27	ALCOHOL & HEALTH
Q11D	3.26	4	1.10	1	6	27	CAFFEINE
Q11C	2.96	3	.94	1	4	27	MARIJUANA

Category superstitious issues

Table 26 presents some descriptive statistics for the Superstitious Issues. Item Q4H "Superstitious Behaviors" has the highest mean, 4.19, and a mode of 4 'often'. It is followed closely by item Q14K "Beliefs in Voodoo and Witchcraft have a negative influence on physical and mental health among the population" which has a mean of 4.18 and a mode of 6 'strongly agree'. Item Q4C "Beliefs in Supernatural Causes of Illnesses" has a mean of 4.03 and a mode of 4 'often'. It is followed by item Q8F "Superstitious Behaviors" which has a mean of 3.88 and a mode of 4 'often'.

Table 26

Category superstitious issues

Var.	Mean	Mode	SD	Min.	Max.	N	Label
Q4H	4.19	4	.85	3	6	26	SUPERSTITIONS
Q14K	4.19	6	1.55	1	6	27	VOODOO & HEALTH
Q4C	4.04	4	1.02	1	6	27	SPRNATURAL BELIEF
Q8F	3.88	4	1.03	2	6	26	SUPERST BEHAVIOR
Q8O	2.74	3	1.29	1	5	27	DELUSIONS

Category socioeconomic factors and issues

Table 27 presents some descriptive statistics for the Socioeconomic Factors and Issues category. Item Q13E "Inadequate Sanitation" has the highest mean, 5.40, and a mode of 6 'absolutely very important'. It is followed by item Q13D "Chronic Undernourishment" which has a mean of 5.25 and a mode of 6 'absolutely very important'. Item Q13A "Crowded Quarters" and item Q13C "Malnutrition in Childhood" each has a mean of 5.07; item Q13A has a mode of 5.00 'very important' and item Q13C has a Mode of 6 'absolutely very important'. They are followed by item Q13B "Overpopulation" which has a mean of 4.96 and a mode of 5 'very important'; and item Q13H "Illiteracy" which has a mean of 4.88 and a mode of 5 'very important'. Item Q13N "Lack of Public Health Education Programs" has a mean of 4.84 and a mode of 5 'very important'. It is followed by item Q13L "Unemployment" which has a mean of 4.40 and Mode of 4 'important', and item Q13J "Poor Personal Hygiene" which has a mean of 4.33 and a mode of 4 'important'. Two additional items are worth mentioning: item Q13F "Considerable Alcoholism" and item Q13G "Heavy Smoking"; each has a mean of 4.14 and mode of 5 'Very important'.

Table 27

Category socioeconomic issues and factors

Var.	Mean	Mode	SD	Min.	Max.	N	Label
Q13E	5.41	6	1.01	3	6	27	INADEQ. SANITAT
Q13D	5.26	6	.90	3	6	27	UNDERNOURISHMENT
Q13A	5.07	5	.83	3	6	27	CROWDED QUARTERS
Q13C	5.07	6	1.07	2	6	27	MALNUTRITION
Q13B	4.96	5	1.02	2	6	27	OVERPOPULATION
Q13H	4.89	5	.89	3	6	27	ILLITERACY
Q13N	4.85	5	1.16	2	6	26	PUBLIC HEALTH
Q13L	4.41	4	1.42	1	6	27	UNEMPLOYMENT
Q13J	4.33	4	1.24	1	6	27	POOR HYGIENE
Q13O	4.26	4	1.35	2	6	27	NATURAL DISASTER
Q13F	4.15	5	1.23	1	6	27	ALCOHOLISM
Q13G	4.15	5	1.20	1	6	27	SMOKING
Q13M	4.07	5	1.17	1	6	27	BIRTH CONTROL
Q13J	4.33	4	1.24	1	6	27	POOR HYGIENE
Q13L	4.41	4	1.42	1	6	27	UNEMPLOYMENT
Q13K	3.92	4	1.04	1	6	25	SEXUAL ACTIVITY
Q13I	3.81	4	1.14	1	6	27	LACK OF EXERCISE

Category medications

Table 28 presents some descriptive statistics for the medications category. Item Q12H "Valium" has the highest mean, 3.63 and a mode of 4 'often.' It is followed by item Q12A "Barbiturates" which has a mean of 2.77 and a mode of 2 'almost never,' and item Q12G "Phenothiazines" which has a mean of 2.59 and a mode of 3 'sometimes.'

Table 28

Category medications

Var.	Mean	Mode	SD	Min.	Max.	N	Label
Q12H	3.63	4	1.11	1	6	27	VALIUM
Q12A	2.78	2	1.09	1	6	27	BARBITURATES
Q12G	2.59	3	.93	1	4	27	PHENOTHIAZINES

Descriptive Statistics for the Clergyman for Selected Categories

Category medical concerns

Table 29 presents some descriptive statistics for the medical concerns category. Item Q6C "Beliefs in Supernatural Causes of Illnesses" has the highest mean, 5.23 and a mode of 5 'almost always.' It is followed by item Q6H "Superstitious Behaviors" which has a mean of 5.20 and a mode of 5 'almost always;' and item Q6F "Poor Personal Hygiene" which has a mean of 4.60 and a mode of 4 'often.' Two items have a mean of 4.50 each and a mode of 4 'often;' they are item Q5D "Tuberculosis" and item Q5I "Hypertension." These items are followed by item Q5H "Migraine Headaches" which has a mean of 4.46 and a mode of 4 'often' and item Q6E "Negligence Toward Care in General" which has a mean of 3.89 and a mode of 4 'often.'

Table 29

Category medical concerns

Var.	Mean	Mode	SD	Min.	Max.	N	Label
Q6C	5.23	5	.73	4	6	30	SPRNATURAL CAUSES
Q6H	5.21	5	.73	3	6	29	SUPERSTITIONS
Q6F	4.60	4	.97	3	6	30	POOR HYGIENE
Q5D	4.50	4	1.11	2	6	30	TUBERCULOSIS
Q5I	4.50	4	1.04	1	6	30	HYPERTENSION
Q5H	4.47	4	1.33	1	6	30	MIGRAINES
Q6E	3.90	4	1.18	2	6	29	NEGLECTING HEALTH
Q6D	3.83	4	1.12	1	6	30	NO FOLLW INSTRUCT
Q5C	3.79	3	1.35	1	6	29	STDS
Q6G	3.79	4	.96	2	6	28	EATING HABITS
Q6I	3.67	2	1.37	2	6	30	TRUST IN DOCTORS
Q6A	3.66	4	1.40	1	6	29	ILLNESS TOLERANCE
Q5J	3.64	3	1.22	1	6	28	DIARRHEA

(table continues)

Table 29 (continued)

Category medical concerns

Var.	Mean	Mode	SD	Min.	Max.	N	Label
Q5F	3.60	4	1.22	1	6	30	ULCER
Q6B	3.52	2	1.55	1	6	29	UNCONTROL ILLNESS
Q5A	3.50	3	1.04	1	6	30	HEART DISEASE
Q5E	3.03	3	1.09	1	6	29	TETANUS
Q5G	2.97	3	.87	1	5	29	EPILEPSY
Q5B	2.90	3	.99	1	6	30	CANCER

Category sexual issues

Table 30 presents some descriptive statistics for the Sexual Issues category. Item Q7I "Prostitution" has the highest mean, 4.30 and a mode of 4 'often'. It is followed by item Q5C "Sexually Transmitted Diseases" which has a mean of 3.79 and a mode of 3 'sometimes'; and also item Q7K "Promiscuity" which has a mean of 3.69 and a mode of 3 'sometimes'. The last item to be considered here is item Q8H "Sexual Dissatisfaction" which has a mean of 3.67 and a mode of 4 'often'.

Table 30

Category sexual issues

Var.	Mean	Mode	SD	Min.	Max.	N	Label
Q7I	4.30	4	.95	3	6	30	PROSTITUTION
Q5C	3.79	3	1.35	1	6	29	STDS
Q7K	3.69	3	1.20	1	6	29	PROMISCUITY
Q8H	3.68	4	1.09	1	6	28	SEX DISSTSFACTION
Q3F	3.46	3	1.48	1	6	28	SEXUAL MATTERS
Q7J	3.32	3	1.49	1	6	28	PORNOGRAPHY
Q7N	3.03	3	.94	2	6	29	RAPE

Category affective disorders and anxiety disorders

Table 31 presents some descriptive statistics for the Affective Disorders and Anxiety Disorders category. Item Q8P "Constant Worry" has the highest mean, 4.70 and a mode of 5 'almost always'. It is followed by item Q8W "Resignation" which has a mean of 4.50 and a mode of 5 'almost always'; and also item Q8S "Feelings of Inferiority" which has a mean of 4.44 and a mode of 5 'almost always'. Two additional items worth mentioning are item Q8D "Recurrent thoughts of Death"

which has a mean of 4.31 and a mode of 5 'almost always' and item Q8B "Negative View of the Future" which has a mean of 4.20 and a mode of 5 'almost always'. One last item to be considered here is item Q8T "False Guilt" which has a mean of 3.73 and a mode of 4 'often'.

Table 31

Category affective disorders and anxiety disorders

Var.	Mean	Mode	SD	Min.	Max.	N	Label
Q8P	4.70	5	1.07	2	6	27	CONSTANT WORRY
Q8W	4.50	5	1.32	1	6	28	RESIGNATION
Q8S	4.44	5	1.12	3	6	27	INFERIOR. COMPLEX
Q8D	4.31	4	1.07	2	6	29	DEATH OBSESSION
Q8B	4.21	5	1.01	2	6	29	PESSIMISM
Q8E	4.07	5	1.00	1	5	29	ANGER CONTROL
Q8R	4.00	4	.94	2	6	28	SLEEP DISORDERS
Q8T	3.73	4	1.04	2	6	26	FALSE GUILT
Q8A	3.73	3	1.05	2	5	30	WORTHLESSNESS
Q8F	3.61	3	1.13	2	6	28	OBSESSIONS
Q8Q	2.81	3	.96	1	5	27	SUICIDAL IDEATION

Category marriage and family

Table 32 presents some descriptive statistics for the Marriage and Family category. Item Q8N "Jealousy" has the highest mean 4.53 and a mode of 5 'almost always'. It is followed by item Q8M "Child Rearing Issues" which has a mean of 4.31 and a mode of 5 'almost always;' and also item Q8I "Infidelity" which as a mean of of 4.24 and a mode of 4 'often.' Item Q7M "Child Abuse" is significant with a mean of 4.13 and a mode of 3 'sometimes;' and also item Q8O "In laws" which has a mean of 4.13 and a mode of 4 'often.' Two additional items have a mean of 4.03, item Q8G "Poor Marital Communication" which has a mode of 4 'often' and item Q8J "Conflicts on the Spouse Role" which has a mode of 3 'sometimes.'

Table 32

Category marriage and family

Var.	Mean	Mode	SD	Min.	Max.	N	Label
Q8N	4.54	4	1.00	3	6	28	JEALOUSY
Q8M	4.31	5	1.04	3	6	29	CHILD REARING
Q8I	4.24	4	.91	2	6	29	INFIDELITY
Q7M	4.13	3	1.01	3	6	30	CHILD ABUSE
Q8O	4.13	4	.82	3	6	30	IN-LAWS
Q8J	4.04	3	.92	3	6	28	MARITAL ROLES
Q8G	4.03	4	.87	2	5	29	MARITAL COMMUNIC.
Q8K	3.82	3	1.12	2	6	28	FAMILY PLANNING
Q4C	3.80	4	.92	2	6	30	MARITAL PROBLEMS
Q8H	3.68	4	1.09	1	6	28	SEX DISSATISFACT.
Q3B	3.28	3	1.46	1	6	29	PARENTING ISSUES
Q3A	3.10	3	.71	1	4	30	MARITAL DIFFICUL.
Q8L	3.04	3	.84	2	5	28	STERILITY

Category interpersonal issues and personality disorders

Table 33 presents some descriptive statistics for the category of Interpersonal Issues and Personality

Disorders." Item Q8Z "Gossips" has the highest mean 5.06, and a mode of 6 'always.' It is followed by item Q8Y "Lack of Trust in Others (Paranoia)" which has a mean of 4.80 and a mode of 4 'often;' and also item Q8N "Jealousy" which has a mean of 4.53 and a mode of 4 'often.' Two additional items worth mentioning are item Q7F "Unpaid Debts" which has a mean of 4.30 and a mode of 4 'often;' and item Q8X "Difficulty in Maintaining Good Interpersonal Relationships" which has a mean of 4.13 and a mode of 4 'often.' One last item to mention here is item Q8E "Difficulty with Controlling Anger" which has a mean of 4.06 and a mode of 5 'almost always.'

Table 33

Category interpersonal issues and personality disorders.

Var.	Mean	Mode	SD	Min.	Max.	N	Label
Q8Z	5.07	6	.92	3	6	29	GOSSIPS
Q8Y	4.80	4	.92	3	6	30	TRUST ISSUES
Q7F	4.30	4	1.15	2	6	30	UNPAID DEBTS
Q8V	4.18	4	1.06	2	6	28	INTROVERSION
Q8X	4.14	4	.99	2	6	29	MAINTAIN RELATION
Q3C	3.76	3	1.24	1	6	29	INTRPERS CONFLICT

Category superstitious issues

Table 34 presents some descriptive statistics for the Superstitious Issues Category. Item Q6C "Beliefs in Supernatural Causes of Illnesses" has the highest mean, 5.23 and a mode of 5 'almost always'. It is followed by item Q6H "Superstitious Behaviors" which has a mean of 5.21 and a mode of 5 'almost always'. These items are followed by item Q10H "The Population Views Many of the Psychological Problems as Satanic Manifestations" which has a mean of 4.97 and a mode of

6 'always'; and item Q8C "Fear of the Loas" which has a mean of 4.69 and a mode of 5 'almost always'. Two additional items worth mentioning are items Q8U "Fear of Demonic Persecutions" which has a mean of 4.63 and a mode of 5 'almost always' and item Q7H "Witchcrafts Aiming at Harming People" which has a mean of 4.53 and a mode of 4 'often.'

Table 34

Category superstitious issues

Var.	Mean	Mode	SD	Min.	Max.	N	Label
Q6C	5.23	5	.73	4	6	30	SUPERNATU. CAUSES
Q6H	5.21	5	.73	3	6	29	SUPERSTIT. BEHAV.
Q10H	4.97	6	1.27	1	6	30	MH PROB. AS DEMON
Q8C	4.69	5	1.00	3	6	29	FEAR OF "Loas"
Q8U	4.63	5	1.00	3	6	30	DEMON PERSECUTION
Q7H	4.53	4	1.07	3	6	30	EVIL WITCHCRAFTS
Q7G	4.41	5	1.08	3	6	27	SORCERY
Q7D	3.57	4	1.53	1	6	28	ZOMBIFICATION

Category existential and religious issues

Table 35 presents some descriptive statistics for the Existential and Religious category. Items Q3H "Life Circumstances" and Q4D "Life Uncertainty" both have the highest mean, 4.96, and a mode of 6 'always.' These items are followed by item Q8D "Obsessive Thoughts of Death," which has a mean of 4.31, and a mode of 4 'often.' Item Q3D "Religious Preoccupations" has a mean of 4.17 and a mode of 3 'sometimes.' One additional item worth mentioning is Q7L "Abortion" which has a mean of 3.52 and a mode of 3 'sometimes.'

Table 35

Category existential and religious issues

Var.	Mean	Mode	SD	Min.	Max.	N	Label
Q3H	4.97	6	1.16	2	6	30	LIFE CIRCUMSTANC.
Q4D	4.96	4	1.02	3	6	27	LIFE UNCERTAINTY
Q8D	4.31	4	1.07	2	6	29	DEATH OBSESSION
Q3D	4.17	3	1.47	1	6	29	RELIG. CONCERNS
Q7L	3.52	3	1.09	1	6	29	ABORTION

Categorys socioeconomic issues and factors

Table 36 presents some descriptive statistics for the category of Socioeconomic Issues and Factors. Item Q9E "Inadequate Sanitation" has the highest mean 5.62, and a mode of 6 'absolutely very important.' It is followed by item Q9D "Chronic Undernourishment" which has a mean of 5.55 and a mode of 6 'absolutely very important;' and item Q9G "Illiteracy" which has a mean of 5.25 and a mode of 6 'absolutely very important.' Item Q9C "Malnutrition in Childhood" is also significant, it has a mean of 5.48 and a mode of 6. Two additional items Q9A "Crowded Quarters" and Q9B "Overpopulation" each has a mean of 5.20 and a mode of 6 'absolutely very important.'

Table 36

Category socioeconomic issues and factors

Var.	Mean	Mode	SD	Min.	Max.	N	Label
Q9E	5.62	6	.56	4	6	29	INADEQUA SANITAT
Q9D	5.55	6	.69	4	6	29	UNDERNOURISHMENT
Q9C	5.48	6	.83	3	6	29	MALNUTRITION
Q9G	5.25	6	.93	3	6	28	ILLITERACY
Q9A	5.20	6	.92	3	6	30	CROWDED QUARTERS
Q9B	5.20	6	.89	3	6	30	OVERPOPULATION
Q4F	4.96	6	1.26	2	6	28	POLITICAL UNREST
Q9F	4.90	5	1.06	2	6	30	LACK OF VACCIN
Q4E	4.37	4	1.45	1	6	30	POOR PHYS ENVIRON
Q7I	4.30	4	.95	3	6	30	PROSTITUTION
Q4B	4.21	4	1.26	1	6	28	TOBACCO
Q7E	4.00	4	1.07	2	6	29	TRAFFIC ACCIDENTS
Q8K	3.82	3	1.12	2	6	28	FAMILY PLANNING
Q4A	3.61	3	1.37	1	6	28	ALCOHOLISM
Q7J	3.32	3	1.49	1	6	28	PORNOGRAPHY

Summary

This chapter presented the descriptive statistical analysis of the questionnaire results. These results were portrayed in the following order: (a) descriptive statistics for the physicians and for the clergymen for each question, (b) descriptive statistics for the physicians and for the clergymen for each category. Except for rare instances, only those items which have a mean of 3.00 and above were selected. There were 8 categories noted for the physicians and 8 categories noted for the clergymen.

From the responses obtained from the 57 subjects-participants, several mental health needs were rated as important. They can be summarized under three basic headings in order of priority. First, the need for Mental Health Services: 20 out of the 27 physicians (74%) and 21 out of the 30 clergymen (70%) rated this first. The need for Mental Health practitioners was rated second by 17 of 27 physicians (62.9%) and 20 out of the 30 clergymen (66.6%). The need for Mental Health Education was rated third by 15 out of the 27 physicians (55.5%) and 18 out of the 30 clergymen (60%). The major factors that predispose to

or interact with the various mental disorders perceived by the key informants in the population are listed as follows in order of importance: (a) inadequate sanitation, (b) chronic undernourishment, (c) childhood malnutrition, (d) crowded quarters, (e) alcoholism, (f) superstitious beliefs and behaviors, (g) illiteracy, (h) lack of public health education.

CHAPTER IV

DISCUSSION

This discussion contains the following main sections: (a) interpretation and implications of the findings for mental health needs and the various factors involved (the interpretation and implications will be made for each group, clergymen and physicians), (b) interpretations and implications of the findings for both groups combined, (c) exploration of strategies for implementing mental health services in Northern Haiti and practical recommendations, (d) discussion of the objectives of the study in light of the findings and limitations of the study, and (e) conclusion.

Interpretation and Implications of the Findings for Each Group

This section interprets the statistical results presented in chapter three for each group. It will discuss the results for each question. The

implications of these results are discussed in light of the review of the literature presented in Chapter I and with additional literature review as appropriate.

Discussion of the Results for the Physicians

Question #4: How often do you see the following attitudes and behaviors toward illnesses in the population you serve?

The items with the highest Mean for this question are Q4H "Superstitious Behaviors" and item Q4C "Beliefs in Supernatural Causes of Illness". It can be readily observed that these two items are closely related. The influence of Voodoo and witchcraft on the behaviors and attitudes towards illness has already been documented by several authors. Bourguignon (1984) states that Voodoo is not only a religious system but also a system of dealing with practical problems including illnesses. Philippe (1985) also suggests that beliefs in voodoo and witchcraft have a particularly strong influence on the Haitians' attitudes and behaviors. However this phenomenon is not limited to the Haitian nor to the Haitian cultural context. It has been reported in several third world countries. In Northern Nigeria, for example, three

causes are generally given for illnesses: Allah or God; impersonal hazards such as the environment; and personal attacks from spirits and witchraft (Stock, 1980). Also, in India, it has been reported that a large percentage of health problems are attributed to the wrath of a goddess (Taylor, 1976). Another example is provided by Nurge (1977) who observed that in a Philippine village, illness was ascribed to either natural or supernatural causes: spirit-gods, witches, and sorcerers were responsible for most supernatural illness.

What may be expected in those countries is a lack of personal responsibility for one's health. And this is also true for Northern Haiti. Item Q4E "Negligence toward Personal Care" and Q4F "Poor Personal Hygiene" which follow the previous items may be the outcome of the beliefs in supernatural causes of illness which in turn leads to superstitious behaviors to alleviate suffering.

The attitude and behavior toward physical illness can be expected to be the same toward mental illness. The tendency to ascribe bizarre behaviors to evil spirits and to take mental disorders for demonic

manifestations can also be expected from those populations.

It needs to be firmly communicated in Haiti that personal responsibility for health and the use of scientific means to alleviate suffering should not be neglected. Illness is not always an uncontrollable process as is most often believed in third world or developing countries (Akin, 1985).

Question #5: How often do individuals bring these non-medical concerns to your office?

According to the physicians, people do not seem to take too many non-medical concerns to their offices. Only two items of significance were reported and at an average frequency. Item Q5F "Life Circumstances Issues" and item Q5I "Work Related Problems" are concerns that are sometimes brought to the physicians' attention. This may be because the role of the physician is so well defined that people do not bring other concerns, such as marital difficulties and interpersonal issues, to their offices. It might also be that the physicians do not have the time to deal with those concerns and therefore do not welcome them. Another explanation might be that the physicians do not feel sufficiently trained to deal with non-medical

concerns that may in fact be involved in the physical illnesses they treat. Hewetson (1963) has found that many patients would not hesitate to approach their family doctor with social, economic, family and sexual problems, providing however that the family physician makes himself available to those kinds of concerns.

It seems important that general physicians, particularly those who are practicing in places such as Northern Haiti where mental health services are lacking, would be very effective at diagnosing and dealing with psychiatric concerns that can be manifested through the medical concerns their patients are dealing with.

Question #6: How often do you see the following symptoms in patients without organic or pathophysiological mechanisms to account for the symptoms?

The item that received the highest mean is item Q6I "Dysmenorrhea" a mean of 3.48. Dysmenorrhea is characterized by painful menstrual periods. Item Q6J "Irregular Menstrual Period" is closely related to item Q6I. It is interesting to note that Dysmenorrhea is listed as a non-organic syndrome. This is no surprise since according to Gatchel and Baum (1983), many

physicians may still dismiss such symptoms as purely emotional, may merely prescribe painkillers, and may seldom look thoroughly for organic involvement. That may also be the case for the physicians in Northern Haiti. Although clinical accounts do suggest that emotional factors are involved in this disorder, there is a need for controlled research to delineate the interaction among the biochemistry, physiology, and emotional disturbances associated with menstruation (Gatchel & Baum, 1983).

Perhaps it would be helpful to inform the patients about what might be involved in the disorder so as to better deal with it. To simply dismiss the symptoms as purely emotional does nothing to alleviate the bothersome and sometimes painful process of menstruation.

Question #7: How often do the following sexual disorders occur in the population you serve?

There was no significant sexual disorder reported for the female population. Is it because sexual dysfunction is non-existent or is it because it is not reported? The other question worth asking is whether female sexual dysfunction is taken as seriously as male sexual disorder. For the moment there is no

ready answer for those questions which is rather curious. A tentative explanation might be that women in this particular culture, as may also be true in other cultures, are not too comfortable discussing their sexual life, and therefore their sexual problems are left unnoticed. Another tentative explanation is that women in this culture may be expected to be passive in sexual relationships, so that it does not make a difference whether they have a dysfunction or not. Research is needed in this area to validate or reject these preliminary speculations.

It was found that males in the region sometimes presented the following: Premature Ejaculation, Erectile Deficiency, and Inhibited Male Orgasm.

Premature Ejaculation, often psychologically related to Erectile Insufficiency, refers to an unsatisfactorily brief period between the commencement of sexual stimulation and the occurrence of ejaculation, the most serious result being the failure of the female partner to achieve satisfaction (Coleman, 1984). In a preliminary questionnaire for this study, 15 out of 15 physicians in Port-au-Prince, capital of Haiti, listed lack of sexual education as the primary cause for the sexual disorders patients have reported to

them. Research evidence supports the view that with few exceptions, such impairments occur in the absence of anatomical or physiological pathology and are based on faulty psychosexual adjustment and learning.

As for Northern Haiti, there might also be some cultural beliefs and taboos associated with the sexual disorders reported among the population. Specific studies are needed in this area before envisaging strategies to alleviate the symptoms and other sufferings that may result from misinformation about sexual activity.

Question #8: How often do you see the following symptoms among your patients?

The symptoms which received the highest frequency of responses were for item Q8A "Shortness of Breath" which was often seen among patients, and item Q8T "Insomnia". Shortness of Breath, which may result from a physical ailment, may also be a symptom of anxiety which may be accompanied by such symptoms as palpitations, profuse sweating and dizziness. It may occur in an actual anxiety attack or may be secondary to to other anxiety-based disorders, such as Hypertension. (Coleman, 1984). Since, as reported by the physicians, this disorder is often observed in their patients, it

can be expected that anxiety may be one of the disorders affecting that population. It would be interesting to find out what other Anxiety-based Disorders are also observed among the population. Items Q8B "Dizziness" and Q8C "Tachycardia" are also related to Anxiety Disorder. It may be valid to conclude that Anxiety Disorders are present among the population. Some later questions will also help to substantiate this conclusion.

The next item of significance for this particular question is item Q8T "Insomnia" which may also be related to Anxiety Disorders in patients. Insomnia may be related to several other symptoms: Major Depression, Alcohol and Drug usage, Sleep Deprivation, Post-Traumatic Stress Disorders, and Pychophysiolcgic Disorders.

To understand insomnia in the Northern Haitian context, all the disorders mentioned above must be carefully studied in the patient to determine the exact cause of that symptom. In addition, the physical setting must be taken into account. One of the factors that might interplay with insomnia is the poor living conditions of some patients whose sleep is often times disturbed by unwelcomed and inevitable

noise coming from the traffic, or perhaps the next door neighbors whose sleep schedule is different from others. Several other factors need to be considered before definite relationships can be established and specific remediation can be offered.

Question #9: How often do you see the following illnesses in the population you serve?

There are several psychophysiological disorders reported for this question. The first and foremost of such disorders is item Q9J "Migraine Headaches". Research evidence often indicates that the majority of headaches--about 9 out of 10-- seem to be related to emotional tension. Only a small minority of headaches result from a wide range of organic conditions (Coleman, 1984). Andrasik, Blanchard, & Arena (1982) found that tension headache sufferers showed greater psychopathology than the migraine headache sufferers. This however does not deny the fact that emotional tension might also be involved in migraine headaches. Item Q9B "Hypertension" is the next psychophysiological disorder reported. Related to the Anxiety Disorders noted earlier, Hypertension also appears to be very significant. Hypertension, because of the severity of its symptoms and complications, is a very serious

disorder. Research on factors predisposing to the disorder is not lacking. Alexander (1950) and Sapira, Scheib, Moriarty & Shapiro (1971) have suggested that the hypertensive patient is characterized by chronic yet inhibited hostility, together with a degree of anxiety and neuroticism. It has further been suggested that over a period of time the continued inhibition of hostile impulses leads to neuroendocrine and cardiovascular responses (norepinephrine and acute blood pressure increases), which culminate in a chronic elevation of the blood pressure (Shapiro, 1978). A variant of suppressed-rage hypothesis has been proposed by McClelland (1979). According to this view, the individual is driven not so much by rage and the need to suppress it as by power motives and the need to inhibit their expression thus leading to unexpressed anger and hostility.

After reviewing the literature on cardiovascular disease and hypertension, Herd (1984) concluded that the influence of behavior on cardiovascular disease and hypertension is evident in the pathogenesis of basic processes, the management of clinical disease, and the prevention of cardiovascular disease and hypertension. Recent progress in all these areas has come from

interdisciplinary research in which the interactions among physiological, psychological, and behavioral processes have been explored. In addition, basic neurobiological studies have indicated mechanisms whereby behavioral processes influence metabolic, endocrine, and hemodynamic processes (Herd, 1984).

It is clear that there is an established relationship between psychological factors and health. So in dealing with disorders such as hypertension, which is often reported among patients in Northern Haiti, one has to bear in mind the various behavioral and psychological factors which by no means should be discarded. Careful and comprehensive examination, and evaluation should be made in dealing with such disorders. This implies that the physician who is treating patients with such disorders would do best to deal with those emotional issues involved or make appropriate referrals in addition to his usual intervention.

What is true for dealing with hypertensive patients is also true of those who suffer from other psychophysiologic disorders such as ulcers, and other gastrointestinal disorders. Those disorders were also reported to occur often in Northern Haiti.

Question #10: How often do the following psychological disorders occur among the opulation you serve?

Among the psychological disorders reported, item Q10F "Sleep Disorders" appears to be the most prevalent. It relates well with item Q8T "Insomnia" discussed earlier in Question #8. It is followed by item Q10C "Anxiety". Much has already been said about Anxiety Disorders and Anxiety-related Disorders. So far Anxiety Disorders have stood out to be very prevalent among the population in Northern Haiti.

Depressive Disorders were surprisingly not listed as one of the major psychological disorders. Given the life stresses and environmental conditions which exist in the country of Haiti as a whole, one would expect a higher incidence of Depression than what has been reported. According to the findings, Depression occurs sometimes among the population, less often than Anxiety Disorders and Hysteria. Several questions can be raised in light of this. Do people manifest their Depression in their anxiety? Do people somatize their Depression and deal with it as a physical illness? Are people ignorant of depressive symptoms so much that they do not recognize them within themselves? Since

there are no clinical psychologists or other mental health practitioners available to treat those symptoms, people do not know where to turn for help and therefore have learned to deal with their Depression in ways that may sometimes be maladaptive. The high incidence of Sleep Disorders reported may strongly support the presence of Depressive symptoms among the population. Those questions raised above can possibly be answered in the affirmative. They may be all valid.

It is generally reported that higher incidence of Depression is reported among the population of industrialized countries than unindustrialized countries. In the latter, ignorance and societal disregard of such symptoms downplay their incidence. Schizophrenia was not reported as a major concern among the Northern Haitian population. In a phone conversation to one of the most prominent psychiatrists in Port-au-Prince, it was reported that patients suffering from psychotic symptoms were referred to the capital for treatment since there was no psychiatrist in Northern Haiti at that time. The psychiatrist observed that the Hallucinations of the patients from Northern Haiti, were different from those of the capital. More Delusions of Grandeur for Northern Haiti

patients were observed than for patients in the capital, who manifested more Delusions of Persecution. The causes of such differences are yet to be determined scientifically.

The Haitian Statistical Bureau reported that an average of four patients per month come from Northern Haiti to be treated in the Capital. A plausible explanation for the low incidence of this disorder may be that people have the tendency to confuse demonic manifestations with psychotic symptoms. This aspect of the problem will be dealt with later in this chapter.

Question #11: How often do you see the abuse of the following substances in the population?

One of the most abused substances in Northern Haiti is Alcohol along with Tobacco and Sugar. Philippe (1981) has commented on the causes of alcoholism in Haiti. In Her book, "Les causes des Maladies mentales in Haiti" (The Causes of Mental Disorders in Haiti), the author states that alcoholism must be understood in the context of the social group of the country. Philippe explains that alcohol abuse in Haiti is due to the national culture of sugar-cane. Since they cultivate sugar canes in all parts of the Carribean, the alcoholic beverage which they produce

from it is so cheap that a lot of people can drink it and enjoy it almost for free. The "clairin" or "tafia" is used sometimes as an appetizer, and for social occasions, and so the habit of drinking is developed.

Since alcohol is one of the psychoactive substances, that is one of the drugs that affect mental functioning, the abuse of alcohol among the Northern population can be said to be one of the indicators of mental health needs in that part of the country. Both the causes and the effects of alcoholism involved serious psychological factors.

The psychosocial factors contributing to alcohol use include:

1. Psychological vulnerability. Investigators have reported that potential alcoholics tend to be emotionally immature, to expect a great deal of the world, to require an inordinate amount of praise and appreciation, to react to failure with marked feelings of hurt and inferiority, to have low frustration tolerance, and to feel inadequate and unsure of their ability to play expected male or female roles (Coleman, 1984).

2. Stress, tension reduction, and reinforcement. A number of investigators have pointed out that the

typical alcoholic is discontented with his or her life situation and is unable or unwilling to tolerate tension and stress (AMA Commitee on Alcoholism and Drug Dependence, 1969).

The above psychosocial factors seem applicable to the context of Haiti, where life stresses are so overwhelming that people who have not developed appropriate coping skills may rely on alcohol as a means of relieving anxiety, resentment, depression, or other unpleasant feelings. Those life stresses may include unemployment, poor familial relationships, loneliness, political apathy, malnutrition, crowding, and other ever so present stressors.

The effects of alcoholism are no less serious. They include psychotic reactions, for example, Delirium Tremens which may present symptoms of restlessness, insomnia, vivid hallucinations, marked tremors of the hands and lips and other manifestations. The memory disturbance known as Korsakoff's Syndrome can also be very common. The most severe effects will be on the children of the alcoholics who may inherit the genes to either become alcoholic themselves or to develop a deficiency that may impact all their lives, such as

diminished intellectual capacity, memory impairment, and lowering of moral and ethical standards.

It must be acknowledged that the factors mentioned above and the effects of alcoholism among the abusers and their victims are still speculative, since no empirical evidence has yet been obtained about the syndrome in the Haitian cultural context. However there is valid probability that the factors and the effects are the same everywhere, although manifested in different manners.

Other substances that are abused in Northern Haiti are Marijuana and Tobacco, probably under the influence of the same psychosocial factors.

Question #12: How often do you prescribe the following medications?

Antianxiety medications are the most frequent psychotropic drugs prescribed by the physicians in Northern Haiti. This confirms once again the prevalence of anxiety disorders among the population according to physicians. Antidepressants are almost never prescribed, which also explains the low incidence of Depressive symptoms reported among the population by the physicians. The phenothiazines, antipsychotic medications, are sometimes prescribed.

Incidence of Schizophrenia was also reported low, and that coincides with the low frequency of antipsychotic prescriptions.

Question #13: How important are the following factors in predisposing to illnesses in the population?

Inadequate Sanitation is the first and foremost predisposing factor listed for this question. The term inadequate sanitation may refer to lack of potable water, lack of latrinization and poor physical environment that predispose to illnesses and serve also to maintain illnesses in the population.

The problem of inadequate sanitation must be understood in light of three other major deficits in the population: (a) The lack of resources to control ill effects of the physical environment in which conditions deteriorate over the years by natural disaster and lack of environmental control, (b) lack of economic resources to equip those who seek to create more sanitary conditions for the population, (c) lack of education about maintaining and securing sanitary conditions, (d) lack of personal responsibility toward health care in general. The latter may be influenced by the beliefs in Voodoo and Witchcrafts and beliefs in supernatural causes of

illnesses and the tendency to always view illnesses as an uncontrollable and inevitable processes as discussed earlier.

It has been observed that efforts to create a more sanitary environment have at times been sabotaged by the people themselves. Gruenberg (1986) has established the interaction between public health and health mentality. He stated that mental capabilities determine to a large extent a person's ability to protect health and to achieve maximum available health services. He went on to suggest that mental health plays an essential role in creating and maintaining important principles of hygiene and sanitation. The value of milk and water and food uncontaminated by the fecal waste of humans or of animals has long been recognized, but methods of organizing large scale availability of safe food and water for the medical benefits of the population require the organized work of highly developed, well organized people with intact mental health.

It was also found that some people with mental disorders violate community rules for personal hygiene. Some do it from stupidity, and others from hostility toward those around them or towards the government.

Even though not all people with mental disorders violate community sanitary conditions, the level of one's mental health seems to play a role in maintaining a safe and healthy environment. And, as stated earlier, others who would not admit to having a mental disorder per se sometimes violate the rules of sanitary conditions because they are ignorant, unconcerned, passive aggressive, or they have difficulty modifying their habits.

Another observation is that the belief that all illnesses are uncontrollable and inevitable may become a self-fulfilling prophecy which degenerates into lack of personal hygiene and failure to maintain an adequate sanitary environment.

The next socioeconomic factors to be considered are items: Q13D "Chronic Undernourishment" and Q13C "Childhood Malnutrition".

Malnutrition in childhood is an ever present calamity in third world countries. The finding about malnutrition and chronic undernourishment in Northern Haiti is confirmed in the literature review on malnutrition which continues to be one of the leading causes of illnesses and death among children in developing countries.

Jellife and Jellife (1960) reported that 7% of one to three year-old children in Haiti suffer protein-calorie malnutrition. They also observed that hair fragility and depigmentation, were the primary signs of protein-calorie malnutrition and incipient Kwashiokor. More recent literature on malnutrition seems to support this finding.

The acute conditions of Kwashiokor is usually precipitated by an infection or other stress situation. Blood findings include a low total serum protein and albumin (Schrimshaw, 1986).

Another syndrome of malnutrition is called Beriberi (Thiamine Deficiency). The symptoms of thiamine deficiency may be classified as neurologic, cardiac and gastrointestinal. The earliest symptoms are referable to the central nervous system. They include neurasthenia, loss of attention, irritability, vague fears, and emotional disturbance (Schrimshaw, 1986).

There seems to be a clear relationship between nutrition and the development of mental disorders in childhood which, if left untreated, will persist into adulthood in those who survive.

Commenting on the ecology of malnutrition in the Carribean, May and Mclellan (1973) sadly noted that it is not easy to draw an optimistic conclusion after viewing the situation in Haiti. The land is poor, eroded and overpopulated for its carrying capacity. As a consequence, the country is the home of too many malnourished children and adults. The usual consequences of malnutrition are therefore present; high rates of mortality among children and low productivity among adults.

There is no easy solution to the alarming and complex problem of malnutrition. However this should not detract from its importance in predisposing to both physical and mental illnesses among the population.

Among other factors predisposing to illnesses among the population of Northern Haiti, item Q13H "Illiteracy" seems to play a crucial role. Several comments were already made regarding the role that ignorance plays in failure to create and maintain healthy and sanitary conditions. Illiteracy may account for many of the maladaptive behaviors, attitudes and beliefs that pose a continued threat to health. Lack of education, interacting with the

beliefs in supernatural causes of illnesses, leads to neglect of personal care and neglect of personal responsibility in promoting health for the individual and the environment.

However, to simply state that people are illiterate does not stop one from trying to find appropriate educational methods. Recognizing illiteracy as a factor is not an excuse for lack of education on health and illnesses, but should be a motivation toward looking for appropriate methods of reducing illiteracy and educating people on crucial matters such as health and illness.

Item Q13N "Lack of Public Health Education" deserves some serious attention as a predisposing factor. It justifies the above observations regarding illiteracy. If promotion of health is to be adequate it must include appropriate methods of educating people about health and illnesses. The way in which people go about receiving and using the information may in itself be a factor that can be addressed in the educational approach that will be used. Where to begin will be an important issue to decide.

There are several other important factors that were listed. They include Smoking, Unemployment,

Natural Disaster, and Considerable Alcoholism. Those factors are no less important than the ones described above. They all are to be taken seriously, since their influence on health may be so crucial that any effort to promote health without taking them into consideration may prove futile.

Question #14: Please indicate your opinion on the following statements.

One of the most important parts of the questionnaire for the physicians was their expressed opinions on some important questions dealing with mental health needs and socioeconomic factors. This part of the questionnaire served to summarize the findings on mental health needs and also to suggest some general but appropriate intervention strategies in order to meet those needs. The items will be dealt with in order of importance.

Items Q14D "Needs for Mental Health Education" and Q14F "Mental Problems Seen as Satanic Manifestations" seem to relate to two previously discussed items which are items Q4C "Beliefs in Supernatural Causes of Illnesses and Q13N "Lack of Public Health Education". There is also item Q14K which deals specifically with the negative influence of

belief in Voodoo and Witchcraft on health among the population.

The need for mental health education is secondary to the need for public health education. If there were a comprehensive program of public health education to begin with, it would have embraced mental health education. It does not seem feasible to begin with mental health education and leave out public health education. To do that would seem to "mettre la charue devant les boeufs" (Put the cart before the horse). In other words public health education should create the readiness for mental health education or both can be done concurrently, with mental health being one part of the overall public health approach.

The beliefs in supernatural causes of illnesses and the view of mental illnesses as satanic manifestations are basically two related concepts. If the approach to health in general is influenced by beliefs in supernatural causes, it might be expected that symptoms associated with mental disorders will also be seen either as caused by demons or overt manifestations of demons in that particular cultural context.

The relationship between beliefs in supernatural causes of illness and lack of public health education can be established. Beliefs in Voodoo and witchraft may sometimes serve as schemas through which all facts or events are interpretated in the population. It can be expected that in a more general sense everything would come to have some kind of relationship with demonic influence and activity even when the manifestations are not that overt.

However, if it is admitted that beliefs and culture are learned, taught, and passed through generations, it can also be suggested that certain beliefs and cultural practices may be modified through new teaching and new learning.

Perhaps many of the superstitious beliefs and behaviors that interact with mental illness or illnesses in general may have been perpetuated because of lack of alternatives.

This study is suggesting that appropriate public health and mental health education may alter some of the beliefs, and consequently alter attitudes and behaviors toward health care.

It should be pointed out that the changes that can be brought through health education may have both

immediate and future social benefits. Immediate consequences may be manifested through personal responsibility for health care, better compliance with health care principles, better working relationships between physicians and patients, and appropriate behavior that will both prevent disease and speed up the healing process. Future consequences may be promotion of health through environmental sanitation, better health care for the next generation and better collaboration between health agents and community residents.

It is not suggested that education will automatically alter people's beliefs and behaviors. It may not change overnight the basic core of beliefs that people have developed through the years and throughout generations. However, education can provide alternatives with practical and applicable solutions to some of the distressing problems that people experience. Education can offer a new way of interpreting information; it may alter the schemas and make them more and more flexible to new structures and new learning which may result in new behaviors and new attitudes toward health and illness.

The relationship between health education needs and the beliefs and behaviors observed in the population cannot be overlooked without affecting the process by which health services will be provided to the population.

Item Q14C "Needs for Mental Health Services" and item Q14E "Needs for Clinical Psychologists and Mental Health practitioners" summarize the findings of the survey and represent logical conclusions to the question whether or not there are mental health needs in Haiti. Since the previous questions have revealed the mental health needs among the population, it follows that there are also needs for mental health services and mental health providers to meet those needs.

These are some additional statements to which the physicians have voiced their agreement. Item Q14G "A great number of illnesses among the population are psychogenic in nature". Their agreement on that particular statement supports the need for a biopsychological approach to health. This is also supported by the previous literature review.

Item Q14H states that "Most mental disturbances in adult life can be attributed to emotional

experiences in childhood." This calls for appropriate child rearing practices and child guidance centers for treating children with emotional disorders. It also puts a lot of responsibility on the familial environment in which those children are raised. This also implies that early diagnosis of mental disorders in children should be an important concern to health care providers. When one considers the family breakdown that may exist in third world countries, the number of children that are abandoned, the number of children suffering from untreated emotional disorders due to violence in child-rearing, and lack of familial education in third world countries, one has to wonder what the next generation will be like if there is no intervention.

The physicians agreement on the statements above strongly confirms the needs for mental health services, mental health service providers and a comprehensive or multidimensional approach to health care in Northern Haiti.

Discussion of the results for the Clergymen

Question #3: How often do individuals bring the following concerns to you?

The clergymen have reported that people in their population seem to bring all kinds of personal and social concerns to their offices. The concern that is brought most often to their attention is item Q3H "Life Circumstances in General". This item includes perhaps difficulties related to day by day living situations, decisions regarding financial or economic problems, and others. It seems as though people in the community have a lot of trust and confidence in a clergyman, to the point of confiding their personal concerns to them.

It has often been observed that a clergyman in a given Haitian community is one of the most respected personages, if not the most respected personages, of that community and often the most trusted individual. His unique position and qualification enables him to come in contact with those that are suffering from emotional distress.

Apart from Life Circumstances, an issue which covers most of the bases, the clergyman is often sought for advice on Religious Concerns, Interpersonal Conflicts, Marital Difficulties, Parenting Issues and even Health

Concerns. There is a great responsibility which falls on the clergyman's shoulders in the community. Needless to say, he needs to be prepared to meet these challenges. Sometimes he may be given too much credit and has to meet too many expectations, which can be frustrating both to him and to those who seek his help. Nevertheless the necessity to be prepared and equipped is great.

Question #4: How often do the following situations occur in the general population?

The clergymen have reported their observations on several incidents which occur in the population. Among those incidents item Q4F "Political Unrest" seems to be a serious threat to personal safety and security. Hopefully, this trend may last only for a short while, or take place only during certain periods of political agitation. Since Haiti was experiencing one of its worst political crises during the time this research was being conducted (November 1987 to Early 1988), it may have been the reason political unrest had such a high incidence among the population. Political unrest seems to create life uncertainty among the population who might be worrying about getting killed, having their hopes destroyed and not knowing what the

next day will bring. It may also be related to grief of seeing some loved one killed, and frustration over injustices and irresponsible behaviors of others. At any rate, a lot of emotional disturbances may result from political unrest both for minors and for adults in a given population. It was reported that a lot of children during those times of crises experienced high levels of anxiety, agitation, insomnia and fears. Those symptoms can be either learned from parents' reactions, parents' personal psychological upsets over the unrest, or they can be the direct effect of leaving "under the gun".

It is interesting to note that item Q4D "Uncertainty about Life" has received the same Mean of 4.96 and the same mode of 6 'always' as item Q4F "Political unrest".

Specific studies seem needed to evaluate the effects of political unrest on children so that appropriate measures might be taken to prevent or reduce the emotional disturbances that may result.

The clergymen have added to the list of the incidences that occur among the population item Q4B "Heavy Smoking", item Q4C "Marital Difficulties" and item Q4A "Alconolism".

Alcoholism was also reported by the physicians as a major health problem among the population. The agreement by the clergymen with the physicians on this item further confirms the need to intervene to alleviate the suffering that results from the abuse of alcohol. A drug and alcohol rehabilitation and treatment center was stated as one of the mental health service needs among the population. The causes and the effects of alcoholism were already explored in this chapter.

The clergymen report marital problems as one of the major concerns of the population. The exact nature of those marital conflicts is not yet determined; however, it can be speculated that lack of communication between spouses, life's frustrations due to socioeconomic factors, lack of sexual education, and lack of education about interpersonal relationships as a whole may play a role in those marital conflicts observed by the clergymen. This seems to indicate that there is a need for marriage and family counseling among the population.

Whenever one mentions marital problems, one has also to think of the children. The effects of marital problems on children can be more devasting to them than

to the parents. Since the divorce rate is not reportedly very high among the population, there might be a lot of unhappy married couples and consequently unhealthy child-rearing. One has to wonder how people react to all the emotional pain that involved with marital difficulties.

Question #5: How often do the following diseases occur among the general population?

The two foremost psychophysiological disorders reported by the physicians are also reported by the clergymen: item Q5I "Hypertension" and Q5H "Migraine Headaches. For a discussion on those disorders, the reader is referred to the discussion of Question #9 for the physicians.

The clergymen, however added item Q5C "Sexually Transmitted Diseases" (STDs) as being of high incidence among the population. The clergymen were not asked to specify the sexually transmitted diseases reported among the population. But more important is the effect that STDs might have on sexual activity among couples, knowing the wide social acceptance by the population of concubinage. It can be suspected that sexual anxiety may be one issue that some wives or husbands may

experience in their relationships due to high occurrence of STDs among the population.

Question #6: How often do you see the following attitudes and behaviors among the gener population?

Two items that were reported by the physicians as having high frequency among the population are also reported by the clergymen: items Q6C " Beliefs in Supernatural Causes of Illnesses" and Q6H "Superstitious Behaviors". For a discussion on those items, the reader is referred to the discussion on question #4 for the physicians.

Question #7 How often are the following reported in the general population?

The clergymen reported a number of incidents that are often reported among the population. Some of these incidents involved criminal and illegal activities observed on a frequent basis among the population.

Item Q7H "Witchcrafts Aiming at Harming People" is reported to be very prevalent. Item Q7G "Sorcery" is related to item Q7H. It can be seen from these two items that beliefs in Voodoo and superstitions are not only a way of dealing with practical matters or meeting personal needs, they are believed to be used for criminal purposes as well.

There seems to be a relationship between the beliefs in supernatural causes of illnesses and the beliefs that witchcraft can be used to harm an enemy. It is an accepted belief in Haiti that people can use witchcraft for all kinds of purposes. It can be used to make someone sick and even kill someone. Combined with Sorcery, this practice creates all kinds of phobias, Delusions of persecutions and lack of trust in others' motives among the population.

According to Philippe (1981) those symptoms affect people of all classes and are reported even among some Christians. The same author has found that people sometimes convert to Protestantism out of fear of demonic persecution, or the fear of being harmed with witchcraft by an enemy. So the fear of demonic persecution becomes more often than not the fear of one's fellow who might be so wicked as to use demonic power against someone. This leads to a lot of superstitious behaviors and over-cautious activities in trying to avoid those kinds of dangers.

The fear one experiences walking alone at night in a dark area in United States, thinking he or she might get robbed, shot at, or raped is no less than the fear

of being harmed by witchcraft in Haiti. Both fears can be at times realistic or unrealistic. The context is different, not the feelings or the beliefs. To understand the psychological processes involved, each situation has to be judged in light of the culture.

Another item of extreme importance that was listed by the clergymen is item Q7M "Child Abuse". It is not specified what kind of abuse might be involved: sexual abuse, physical abuse or emotional abuse. However, violence in training children has often been reported among Haitian families. This is one of the psychopathological effects that Nathan and Harris (1975) listed as characteristics of lower socioeconomic groups. Violence in training children is reported among some Haitian immigrants in the U.S who sometimes have to face legal penalties.

Child abuse may result from faulty education about child-rearing practices. Those practices that are passed through generations and have become accepted as cultural norms. Children may become the victims or the scapegoat in a dysfunctioning marital relationship. Children may also be victims of criminal activity among the population. Whatever the case may be, it is an alarming condition. The abuse of children should

never be tolerated or left unnoticed under the disguise of one's preference for child rearing. The abused children may develop emotional disturbances that may have long-lasting effects on their lives. They may in turn become abusers, delinquents, antiauthoritarian, alcoholic, or a vast majority of other disorders may result.

Question #8: How often do you observe the following symptoms in the population you serve?

There are a lot of symptoms that are given for this question. Symptoms of Depression, Anxiety, Interpersonal Conflicts and of Personality Disorders. One symptom that has received serious attention by the clergymen is item Q8Z "Gossip" which seems to always occur among the population. Gossip seems to relate to a certain type of personality disorder which is likely to interfere with interpersonal relationships. It may be related to Paranoia, for which the basic defense mechanism is projection. It may also be related to Passive-Aggressive Personality Disorder or to Jealousy. The jealous one usually experiences some kind of anxiety and feelings of insecurity or worthlessness, and feels pressured to gossip as a defensive devaluation of someone whose achievements,

accomplishment, looks, possessions, or reputation is a threat to personal adequacy and security. In fact, jealousy was listed as one of the often occurring problems among the population.

Another item which is also related to the disorders above is Q8Y "Lack of Trust in Others". This particular item may also be related to the fear of being harmed with witchcraft which also coincides with item Q8U "Fear of Demonic Persecutions", an issue that has already been dealt with.

Several Depressive symptoms were also reported: item Q8A "Feelings of Worthlessness"; item Q8B "Pessimism", item Q8P "Constant Worry", item Q8R "Sleep Disorders", item Q8T "False Guilt". It is interesting to note the difference in observation of the depressive symptoms between the physicians and the clergymen. This may be because the roles of the clergymen enable them to come in contact with those in personal distress among the population. They may be called upon when emotional distresses hit some one in the community or the family. Their role may facilitate more personal involvement in the lives of the parishioners than the physicians have in the lives of their patients.

Question #9: How important are the following factors in predisposing to illnesses in the population?

For the discussion on this question, the reader is referred to the discussion of Question #13 for the physicians. The same basic socioeconomic factors were reported in the same order of importance by the clergymen. They include inadequate sanitation, chronic undernourishment and malnutrition in childhood and all the rest. The consistency of reporting of those factors by both groups strongly supports their importance in predisposing to both physical and mental illnesses among the population.

Question #10: Please indicate your opinion on the following statements.

As for question #14 for the physicians, this question plays a very important part in the study. The clergymen expressed their agreement with some very important statements on the mental health needs and the socioeconomic factors that influence them, and implicitly suggest some ways in which those needs could be met.

The items that are similar for both physicians and clergymen have already been discussed under question #14 for the physicians and will not be re-discussed

here. The reader is referred to that particular section of this chapter. Those statements are as follows: item Q10C "There is a Great Need for Mental Health Services among the Population"; item Q10E "Needs for Psychologists and Mental Health Practitioners" item Q10F "Needs for Mental Health Education"; Item Q10H "The population Views Mental Health Problems as Satanic Manifestations"; item Q10K "Mental Health Disturbances in Adult Life Originated in Childhood".

There are also some statements that were particularly addressed to the clergymen that will be discussed here. The foremost statement agreed upon by the clergymen is of crucial importance to this study. Item Q10N states that "There is an important interaction between spiritual health, physical health, and mental health". This statement itself is a summary of the multidimensional approach which guided this study. In agreeing with this statement, the clergymen also agree that man is a biopsychosocial/spiritual unit as supported by many authors in the literature review of this study. This agreement also implies an agreement with a comprehensive and global approach to man's health. This multidimensional approach not only understands the interaction of the various factors

involved in health and illnesses, but also calls for an interdisciplinary intervention.

Another important agreement is to item Q10A: "I wish I had more training to deal with some of the emotional issues people bring to my attention", which also coincides with item Q10G "I would be interested in receiving some training to deal with the psychological problems people bring to me." Needless to say those clergymen understand well the burdens that are on their shoulders to meet the various and complex needs of their parishioners. They are also dedicated to finding ways in which they can better serve God and others. The clergymen also agree that the church's role in helping emotionally disturbed people should be enhanced.

Those findings are very important to this study. They promise a lot in terms of what can be accomplished with the help of some dedicated men such as those clergymen and the physicians of Northern Haiti. Although the overwhelming socioeconomic conditions tend to discourage any kind of intervention or implementation on a larger scale both the clergymen and the physicians offer hope for improving mental health conditions.

Summary of the Interpretations and Implications of the Findings for the Physicians Group and the Clergymen Group Combined

There is an overall agreement between the two groups with regard to the mental health needs in Northern Haiti, and the socioeconomic and sociocultural/religious factors predisposing to those mental health needs. Both groups similarly reported the following to be of importance: (a) the incidence of anxiety disorders and anxiety-related disorders; (b) effects of beliefs in supernatural causes of illnesses and superstitious behaviors; (c) inadequate sanitation, malnutrition in childhood, and chronic undernourishment as the primary factors predisposing to illnesses among the population; (d) the needs for mental health services, and for mental health service providers; and (e) needs for mental health education among the population. They also all agree on the following statements: "Most mental health disturbances in adult life can be attributed to emotional experiences in childhood" and "the population views mental health problems as satanic manifestations".

There were particular questions addressed to each group according to their field. Nevertheless the overwhelming consistency on major health needs and factors between the two groups strongly supports the validity of this study and the reliability of the questionnaires designed to assess the needs and the factors involved in those needs.

The needs and the factors assessed via those key informants fall under eight main categories for each group.

Categories for the Physicians

The categories for the physicians comprised

1. Medical concerns: The main medical concerns were those already discussed under question #9: Migraines, Hypertension, Ulcers, Shortness of breath, Dysmenorrhea, and Tachycardia. High tolerance of illness among the population was also cited. The above medical concerns are basically psychophysiological disorders that have already been addressed.

2. Sexual Issues: Main issues reported were premature Ejaculation, and Sexual Conflicts issues. No report on Sexual Dysfunction for women was given by the physicians.

3. Affective Disorders and Anxiety Disorders: Several Depressive related disorders were reported among the population. The most salient were Anxiety Disorders and Anxiety-based symptoms. Although the physicians reported low incidence of Depression among the population, they reported some other symptoms that can be closely related to Depression. They include: Sleep Disorders, Constant Fatique, Pessimism, Memory Loss, Loss of Interest in Pleasurable Activity.

4. Psychotic symptoms: Delusions of Grandeur, Persecutory Delusions, and Hallucinations. There was no high incidence of psychotic symptoms reported among the population. The above were only sometimes reported.

5. Interpersonal Issues and Personality Disorders: Some Interpersonal Issues were reported, but their prevalence was not high among the population. They include the broad category of Personality Disorders, and marital difficulties.

6. Substance Abuse: Sugar, Alcohol and Tobacco were the main substances abused among the population. Considerable alcoholism was particularly considered to be a major health problem. Another substance sometimes abused among the population is marijuana.

7. Superstitious Beliefs and Behaviors: Superstitious Behaviors, Beliefs in Voodoo and Witchcrafts, and Beliefs in Supernatural Causes of Illnesses were the main items under this category.

8. Socioeconomic factors and issues: Inadequate Sanitation, Chronic Undernourishment, Malnutrition in Childhood, Crowded Quarters, overpopulation, Lack of Public Health Education, Unemployment, Considerable Alcoholism were the main factors involved.

Categories for the Clergymen

The categories for the clergymen comprised

1. Medical Concerns: Poor personal hygiene, Hypertension, Migraine Headaches, and Negligence toward care in general, Sexually Transmitted Diseases, Chronic Diarrhea, Ulcer, and Tuberculosis were the main medical concerns reported. The psychophysiological disorders included were already discussed.

2. Sexual issues: Prostitution, Sexually Transmitted Diseases, Promiscuity, and Sexual Dissatisfaction were reported among the population.

3. Affective Disorders and Anxiety Disorders: Several Anxiety-based Disorders were reported and discussed earlier. There is also a high prevalence of depressive symptoms reported among the population:

Sleep Disorders, Pessimism, Feelings of Worthlessness, Constant Worry, False Guilt and Recurrent Thoughts of Death.

4. Marriage and Family: This is a distinct category for the clergymen. It includes: Infidelity, Child Rearing Issues, Child Abuse, Poor Marital Communication, Conflicts over the Spouse's Role in the home, and Sexual Dissatisfaction in Marriage. Those marital and familial concerns can constitute in themselves mental disorders as well as give rise to severe emotional disturbances.

5. Interpersonal issues and Personality Disorders: Gossip, Lack of Trust in others (Paranoia), Jealousy, Difficulty Maintaining Good Interpersonal Relationships, Difficulty Controlling one's Anger.

6. Superstitious issues and Behaviors: Superstitious Behaviors, Beliefs in Supernatural Causes of Illnesses, Mental Disorders seen as Satanic Manifestations, Fear of the 'Loas', Fear of Demonic Persecutions, Witchcrafts Aiming at Harming people.

7. Existential and Religious issues: This question is also unique to the clergymen. Life Circumstances, Life Uncertainty, Obsessive Thoughts of Death, Abortion, Religious preoccupations.

8. Socioeconomic issues and factors: Inadequate Sanitation, Malnutrition in Childhood and Chronic Undernourishment, Illiteracy, Crowded Quarters, and overpopulation were the most important factors involved.

These extensive categories present a consistent picture of the mental disorders in Northern Haiti as reported by these key informants. These two groups have proven to be very aware of the actual mental health situation in their community and have a very good sense of what it might take to reduce the incidence and reduce the prevalence of those needs. They have made careful observation and assessment in their respective roles in the community.

However, although they have attempted to present a comprehensive outlook of the mental health needs, they were to some extent restricted by their respective fields. Therefore, for more breadth and completeness, key informants from other fields such as school teachers, lawyers and judges, policemen, mayors, Voodoo priests, herbalists, and Community leaders along with population samples would need to be queried before a complete picture could be obtained about the mental health situations in Northern Haiti.

Exploration of Strategies for Implementing Mental Health Services in Northern Haiti and Practical Recommendations

This section of the study will explore some tentative strategies for implementing mental health services in Northern Haiti and will attempt to offer some practical recommendations that might be useful. Both the exploration of the strategies and the recommendations will be tentative at this point for the following reasons.

First, it is difficult to propose a definite plan until a complete picture of the situation can be presented. Shonick (1986) suggested that there are three basic questions that health planning strategists must attempt to answer: (a) what is the status quo here, (b) what is the desired final outcome, and (c) how can the status quo be transformed to the final outcome.

This study cannot fully respond to the first question. The information obtained although useful and valid does not represent the status quo since only twogroups were included in this study. Much of the complete picture is left to be presented through the

inclusion of other key informants of Northern Haiti and a representative sample of the actual population.

Second, all attempts that were made to obtain additional information from those who are actively involved in treating psychiatric conditions in Haiti were fruitless for reasons that are yet to be determined. There are several pieces of the puzzle that are missing.

Third, even if a complete picture were obtained about the mental health situation in Haiti, it would have been arrogant to propose a plan without studying the problem with those that have labored for so long in the midst of the needs and therefore have a better handle of exactly what can be done to meet those needs. However, since Needs Assessment is just one integral part of the planning strategy, the study would have been less than useful without it.

Using the model proposed by Shonick (1986) as an example, the desired outcome is clear: Provide mental health services to prevent and reduce mental illnesses among the population. However not having complete information about the status quo will inhibit the comprehensive approach that this study is advocating. Furthermore, the question as to how the

status quo can be transformed in the final outcome requires the input of those that observe and deal with the status quo on a daily basis. However, the following recommendations seem crucial to the implementation of any mental health services in Northern Haiti.

General Recommendations

A.- Inclusion of Mental health in the public health program of the population

Any effort to implement mental health services in the population must begin at the top. This includes legislation, careful assessment of needs, program implementation and program evaluation. If mental health is not accorded a certain priority in the National Public Health Chart for the provinces of Haiti, any attempt to improve mental health conditions in those areas might prove ill-fated for lack of resources and lack of collaboration with those in charge of public health of the country. According to Hanlon and Picket (1979) the failure to include mental health in a public health program results in three basic errors: (a) It ignores the complex mental and behavioral disorders that afflict a large proportion of

people, (b) it ignores the various mental and behavioral conditions that may have their genesis in physical illnesses, and (c) it ignores the fact that few if any physical illnesses or injuries are without a mental or behavioral component or consequence. The same authors went on to say that in terms of both incidence and prevalence on the one hand and the social and economic consequences on the other, mental illness is one of the most compelling public health problems.

Gruenberg (1986) stressed the importance of including mental health in the public health program when he stated that mental health and psychosocial concerns are becoming more important in the efforts of the public health movement to improve the quality of people's lives. This is because mental life is what makes lives valuable. Mental capabilities determine to a large extent a person's ability to protect health and to achieve maximum benefits from available services (Gruenberg, 1986). This author bases his argument on the ground that the value of a person's life is largely determined by his or her mental state, that a large proportion of people who now need medical care have mental or brain disorders, and that many physical disorders have an important mental component. The

World Health Organization has long supported the view that the national service of mental health is inseparable from other public health concerns and that many times mental health services could be organized to meet some of the general health needs and social welfare (WHO, 1975).

There is convincing argument for the inclusion of mental health in public health programs.

B.- Mental Education as part of Public health Education

The inclusion of mental health in public health programs will necessarily lead to mental health education as part of public health education. Lack of public health education has been reported as one of the factors predisposing to illnesses in Northern Haiti, therefore, it can also be deduced that there is no mental health education for the population either. The American National Conference on Preventive Medicine made the following recommendations for public health education: (a) Inform people about health, illness, disability, and ways in which they can improve and protect their own health, including more efficient use of the delivery system; (b) motivate people to want to change to more healthful practices; (c) help them to

learn the necessary skills to adopt and maintain healthful practices and lifestyles; (d) foster teaching and communication skills in all those engaged in educating consumers about health; (e) advocate changes in the environment that facilitate healthful conditions and healthful behaviors; (f) add to the knowledge via research and evaluation concerning the most objective ways of achieving the above objectives.

In the context of Northern Haiti where illiteracy is reported to be prevalent, as it is in a great percentage of the Haitian population, appropriate methods of education must be sought to inform the informers in such a way that illiteracy may not be a total block to health education. As argued earlier, illiteracy is not an excuse for lack of health education. It only demands that the people be educated at their level through appropriate means and methods.

Mental Health education to the public may also facilitate the development of mental health service providers. If the teachers are taught well, they will in turn be able to replicate their knowledge in others who will teach others until motivation grows for people to learn more about mental health and develop necessary skills to provide services.

C.- Manpower development.

As stated in the latter part of point B, mental health education may begin the process of developing manpower for providing services. There are several ways this can be accomplished:

1. Use of available resources to extend competence to meet mental health needs. Courses can be added to the curriculum of general practitioners to better equip them to provide mental health services to their population. The same thing can apply to nurses. They in turn can be involved in further manpower development.

2. If there is a national shortage for effective manpower development, available foreign ressources might be used either by having short term foreign teachers for seminars or conferences providing that the nationals can apply their teachings in the cultural context of their milieu. Also, students might be sent to study in other third world countries which have already developed mental health services, or to the United States where they can be trained and return to their homeland to train others.

3. The literature review has revealed that clergymen are a valuable resource of mental health

development. Therefore Bible schools and seminaries, can include in their curriculum courses to help church leaders to be better equipped to meet the total needs of their parishioners. There might be some missionaries who have mental health training who might be willing to invest three or five years in a mission field to develop manpower for mental health services among clergymen. There are nurse practitioners, social workers or even clinical psychologists who might be willing to contract for such activity.

D.- Decentralization of Mental Health Services

It has been repeatedly observed in developing countries that there is a tendency for services to be concentrated in one particular geographical area, thus creating a problem of accessibility to those who are in scattered regions. For example Guillen (1986) found that because there exist no mental health services centers in the provinces of Haiti, those who suffer from serious mental disorders are sent to the capital to be treated. It can be speculated that the condition of the patient might be worsened by such a move before the patient obtained the help needed, and that interventions would become more and more difficult.

Decentralization of services may be created by the development of manpower as discussed earlier. People could be chosen from their communities to receive training with the hope they will go back to serve that community.

One of the causes of centralization has been the lack of availability of resources and equipment needed outside of the capital. Another cause has to do with the mentality that has been created and fostered by the population and by service providers, that the capital or the cities are the ideal places to be. This may be because of socioeconomic development or other available resources or the belief that dwelling in the cities is associated with a sense of achievement or social status change.

Centralization of health services has been associated with centralization of other resources in the country. Thus decentralization of health services can be fostered by efforts to decentralize the other services, especially those that are closely related to health care.

E.-Integration of services

The multidimensional approach advocated by this study also favors creating a network of

interdisciplinary intervention. During the preliminary trip survey, several physicians in the capital and other professionals cited the lack of integration within the health service system itself.

Referrals to professionals by professionals is very rare in a country where lack of health insurance, poverty, financial obligations and difficulties have favored some covert and sometimes overt competition among providers. Many providers either in the health sectors or in other professions are sometimes forced to become a "toutiste" (can-do-it-all type) at the expense of the individual's needs for appropriate services.

Integration must begin within the health system first and then also extended to other resources in the community. This is in accordance with the needs for the comprehensive, global, or multidimensional approach that has been proposed.

Recommendations to the Key Informants who participated in this study

The following recommendations are made in light of the needs expressed by the respondents. They may tend to be too general in some instances for several

reasons: (a) The availability of certain resources is not clearly determined at the present, and b) there may be other aspects of the situations that have yet to be investigated. Nevertheless, it is hoped that some of these recommendations will be applicable and helpful to the respondents.

To the Physicians

The physicians who participated in the study are well aware of the mental health needs of their population and have reflected the desire to be more involved in treating the emotional/psychological concerns observed in their patients. Of the 27 physicians, 22 (81 %) have agreed that the treatment of emotional problems is an important part of their interventions (see item Q14B).

The involvement of physicians in treating psychological distress can be more effective by applying the following principles.

1. Become more and more sensitive to psychiatric or psychological needs of those with primarily physical problems and devote oneself to the care of the total person. This may be accomplished by making oneself available to attend to other non-medical concerns that the patients may bring to the offices. The

physician could also keep in mind that the physical illness he or she is treating may be just one part of a complex situation.

2. Sharpen one's skills in dealing with psychological disorders through continuing education, attending seminars and conferences on mental disorders in general practice. Read literature dealing with psychological disturbance or consult with trained mental health practitioners.

3. Know when to refer and use available resources that can best serve the patients presenting with primarily psychological symptoms.

4. Collaborate with other available resources: psychologists, clergymen, school teachers, parents, social workers, and community leaders in assisting the patients with psychological disturbances.

5. Participate actively in developing manpower training for the development of mental health services to the population.

6. Participate actively in the legislation process, of according certain priority to mental health services for the population by either making recommendations for such legislation or by voting for such legislation.

7. Encourage and participate in public health and mental education via the media, and by writing newspaper articles, or training others to do so.

Many of the above principles may have already been followed by those devoted professionals in their courageous efforts to serve their population. However, as is usually the case in health care, much is left to be done to improve the conditions of human suffering.

To the Clergymen

The researcher was particularly encouraged by the awareness that the clergy demonstrated of the mental health needs of the population and their understanding of their mission to care for the whole person. They have expressed strong agreement for the interaction of mental health, physical health and spiritual health. They have also emphasized that the role of the church in helping emotionally disturbed people should be enhanced. Last but not least, they have expressed a willingness and the hope to receive more training to deal with some of the emotional issues people bring to their attention.

The attitude of the clergymen vis-a-vis mental health needs in their community is in accordance with

the literature on the role of the clergy in promoting mental health. For example, Caplan (1972) stated that the clergy, because of the customs of their discipline, have certain innate advantages in dealing with human problems. They have several tools that make their contribution somewhat unique. They are preoccupied with individuals and families, and have a responsibility acknowledged both by themselves and by their congregations to care for everybody in their flock. The clergyman is known by his population. Unlike mental health workers, clergymen may be able to remain close to those they have once counseled.

In their article "Church and Community Mental Health: Unrealized potential", Bufford and Johnson (1982) underlined the mission of the church as uniquely suited to fostering prevention of mental illness. They provide two basic arguments for the involvement of the church in promoting mental health. First, a central focus of religious perspectives is to provide meaning for life and a conceptual framework within which to understand its experiences. Second, the church has great potential for fostering a community characterized by mutual caregiving, concern and social support (Bufford and Johnson, 1982).

The church's potential for contribution to positive mental health rests on its unique mission to care for the broken-hearted and the heavily burdened. Its call to minister to the whole person is exemplified by the head of the Church himself who cared for the physical needs of the five thousand and who wept with those who wept, thus showing concern for the physical and emotional as well as the spiritual needs of people.

The clergymen who participated in this study seemed to have embraced that particular philosophy of ministry. However many obstacles may tend to get in the way of transforming the philosophy into concrete action. Part of the problem may be related to lack of training to deal with some specific concerns that people bring to their offices, and it may also be related to failure to use existing resources to better equip themselves for the tasks of the ministry. This study will provide some tentative recommendations that can hopefully be applied in the context in which those courageous ministers serve.

1. The principle of using what-you-have in your hand. Sometimes one may be looking for solutions at the neglect of readily available solutions to existing

problems. Clergymen ordinarily possess some skills that enable them to guide, support and respond in various situations. They can make good use of those skills to alleviate many emotional problems brought to them. Their theological or Biblical training hopefully provides basic understanding of human nature, the nature of human suffering, and the value of man as being created in the image and the likeness of God.

In addition to their theological or Biblical training formation, their ministerial preparation offers them some unique advantages and opportunities to sharpen their skills and help those who seek their help.

The use of what-you-have principle implies that one seeks to use what is presently available while acknowledging its limitations and short comings and still seeking for more appropriate, adequate solutions.

The church is in a unique position to promote mental health by reducing isolation and loneliness, and by fostering fellowship, support, and the healthy relationships which are crucial to mental health.

2. Active community involvement. The fear of compromising their beliefs may create some kind of passivity in clergymen, and thus they miss the

opportunity to have the impact they could have in health and social improvement. By active participation and involvement in constructive community development, the church leaders may help reduce the factors that predispose to mental illnesses.

It can be readily admitted that many churches have already been involved in bringing about social changes and economic changes in their community. Although many clergymen should be commended for their efforts in that area, many others fail to grasp the importance of social involvement by the church and the impact it could have in promoting physical and mental health along with their role as promoters of spiritual health.

3. Additional training. The clergymen have already expressed their willingness to receive more training with a view to helping the emotionally disturbed they come in contact with. This can be achieved in many ways: a) Inclusion of courses on pastoral counseling and psychology in the curriculum of Bible schools and theological seminaries for those who are being trained to become priests or pastors, and b) Continuing education for those who are already in the

ministry, through workshops, seminars and reading of articles and books dealing with emotional issues.

Some obvious questions are raised on reading the latter recommendations. Education and training goals can be achieved in many ways: (a) the church can encourage mission agencies to recruit missionaries with backgrounds in psychological studies and theological studies, and who are trained in cross-cultural counseling psychology. Their goal may primarily be to 'help the helpers to help,' for example, to train actual and potential clergymen who will in turn train other nationals to be effective counselors; (b) the church can support or sponsor the education of students who might have the commitment and the vision to return to their homelands or communities; (c) lay counselor training in the church by mental health professionals can be carefully used as a preventive activity in that an increase in manpower and the extension of helpers into the community will help in reducing the prevalence of mental health problems (Uomoto, 1982).

4. Participation in public health and mental health education. The use of the pulpit, Sunday school, and pamphlets to promote health may find some

resistance among certain church leaders who might object on the basis that only the word of God should be used in sacred gatherings. However, if one takes seriously the interaction of physical health, mental health, and spiritual health and how one affects the other, public and mental health promotion through education must find their places in the pew. The church can provide the most trusted and legitimate information about health and illness, and about behaviors that affect either one.

5. Develop a consultation network. Any minister who is concerned about caring for the whole person should make use of availble resources of others in their community. To do this, he has to know the limits of his involvement, and his own limitations, and know those to whom he might have to refer or with whom he can confer when the burden seems beyond his capacity. This is also in keeping with the comprehensive approach to human care.

6. The church mission to promote relationship with God is, in itself, a mission of promoting mental health. The mission will be more and more effective if the church makes the necessary efforts to realize its full potential.

It is hoped that some of these tentative recommendations will prove useful to those are eager, and devoting body and soul to alleviate the ever present multifaceted sufferings that they face regularly in their pastoral duty.

Discussion of the Objectives and Limitations of the Study with Recommendations for Further Study

This study was designed to accomplish four things. Each one will be discussed in this section. This discussion will be followed by acknowledgement of the limitations of the study and recommendations for further study.

The Objectives of the Study

1. Provide a model that can be used in assessing mental health needs in Northern Haiti and other parts of Haiti.

The use of Key Informants approach in assessing health needs in a given community was supported by the literature (Bell & Siegel 1983; Millord, 1976; Stewart, 1975). While others have shown a preference for

epidemiologic surveys, the Key Informants approach has offered several advantages. It is less expensive, less time consuming and is likely to provide more helpful information than community surveys. Giel (1975) reported that epidemiological surveys are unlikely to provide important leads on how to solve the mental health problems of developing countries. He also suggested that governments may best rely on ideological rather than epidemiolcgical assessment.

A case can readily be made for the Key Informants approach, using qualified individuals who make objective and careful observation of the needs of their population.

The first objective seems to have been satisfied by using the clergymen and the physicians to assess the mental health needs in Northern Haiti. The consistency of observations reported by the two independent groups, and the overall agreement on the factors which predispose to those mental health needs support the legitimacy of the model.

However, due to limitations of funds and time, the study failed to include other key informants such as school teachers, policemen, community leaders, social workers, social agency leaders, and Voodoo priests,

all of whom would have contributed to the confirmation of the population needs with respect to their domain and level of involvement in the community.

2. Use the model to assess mental health needs in Northern Haiti by surveying physicians and clergymen. The model was used to assess the mental health needs in Northern Haiti by surveying physicians and clergymen. The findings were collated, analyzed and discussed.

3. Identify the current factors that predispose and interact with those mental health needs. Several socioeconomic and sociocultural factors were identified. These were consistent for both groups.

4. Explore strategies for implementing mental health services in Northern Haiti and make practical recommendations based on the findings.

Because of the lack of inclusion of other important groups or key informants in the study, several other domains in which mental health needs are manifested and observed remain to be studied. Therefore this study cannot claim to have the complete picture or the real status quo of mental health needs in Northern Haiti. Consequently it was difficult to offer critical and specific recommendations. Nevertheless, the participants were offered some

tentative recommendations that might prove useful in both in the immediate and in the long run.

Limitations of the Study

This study admits to two basic limitations:

1. Although the basic objectives of the study have been met, the lack of inclusion of other key informants such as school teachers, Voodoo priests, community leaders, and herbalists from the population makes the present research incomplete. There are certain groups that are not represented, since the physicians and the clergymen may likely be dealing with a select group in the population. They may not have observed or come in contact with those that are remote from their field or their particular geographic distribution.

Other key informants such as the Voodoo priests, the community leaders, lay preachers and the herbalists would be better observers of the groups not represented in this study.

2. The return rate, although satisfactory for a study like this, was relatively low. Out of 130 questionnaires distributed, only 57 (43.8%)

were completed and returned. However, given the circumstances and the political situation during the time of the study, this sample seems adequate. The attempt was made to include all clergymen and all physicians within the appropriate geographic area.

The above factors which involve completeness and representativeness, hence limit the generalizability of the findings.

Recommendations for Further Study

1. Using the same model, further study can include other groups or key informants (for example, school teachers, community leaders, lay preachers, social workers, herbalists) so as to have a more comprehensive picture of mental health needs in Northern Haiti as well as in other parts of Haiti.

2. Use of appropriate sampling techniques to assure a broader based sample and thus improve generalizibility. Also, the use of a random population sample might further expand the data obtained by the use key informants.

3. Use of appropriate Statistical design to support relationships between health needs and predisposing factors.

Conclusion

This study began by assuming that all or most of the mental health needs and factors found in the literature on third world countries were also true of Haiti and its provinces. The psychopathological effects of inadequate sanitation, malnutrition in childhood, crowded quarters, considerable alcoholism, beliefs in Voodoo and witchcraft, low level of education, and illiteracy, and so forth, were taken to be the general characteristics of the mental health situation in Haiti.

Using a Key Informants approach, clergymen and physicians were surveyed regarding the mental health needs they perceived among the population of Northern Haiti.

The findings strongly support the conclusion that the mental needs in Northern Haiti are similar to those frequently encountered in third world countries in general and in other groups that are affected by the culture of poverty. The socioeconomic, sociocultural factors, were similar to those cited above. They include Inadequate Sanitation, Malnutrition and Chronic Undernourishment, Considerable Alcoholism,

Crowded Quarters, Illiteracy, Beliefs in Voodoo and in supernatural causes of illnesses. Those factors influence such psychopathology as anxiety and anxiety-based disorders, personality disorders, depressive symptoms, serious psychophysiological disorders, such as peptic ulcers and hypertension, and additional symptoms include uncertainty about life, sleep disorders and all the rest.

There was consistency of reporting of both the need and the contributing factors among the two respondent groups.

Several needs have emerged and were summarized under three particular headings: (a) need for mental health services, (b) need for mental health service providers, and (c) need for public and mental health education.

Several general recommendations were made about what can be done in this area. The most important of all was the necessity to include mental health programs in the public health chart. This was done in light of the evidence which supports a multidimensional and comprehensive approach to health care delivery. Recommendations were also made to each group of

respondents, respective their particular field of involvement.

Although limited by lack of inclusion of other key informants in the population, and somewhat lower than optimal return rate, the data presented in this study is both valid and helpful. It provides a picture of mental health needs in Northern Haiti and the factors, predisposing to these needs.

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Appendix A

Raw Data File--Physicians

Key of Raw Data by Columns

1-3=ID 1-3
4 = SPEC 4
5-6= YEARS 5-6
7 = Q3A
8 = Q3B
9 = Q3C
10 = Q3D
11 = Q4A
12 = Q4B
13 = Q4C
14 = Q4D
15 = Q4E
16 = Q4F
17 = Q4G
18 = Q4H
19 = Q4I
21 = Q5A
22 = Q5B
23 = Q5C
24 = Q5D
25 = Q5E
26 = Q5F
27 = Q5G
28 = Q5H
29 = Q5I
32 = Q6A
33 = Q6B
34 = Q6C
35 = Q6D
36 = Q6E
37 = Q6F
38 = Q6G
39 = Q6H
40 = Q6I
41 = Q6J
42 = Q6K
44 = Q7A
45 = Q7B
46 = Q7C
47 = Q7D
48 = Q7E
49 = Q7F
50 = Q7G
51 = Q7H
52 = Q7I
53 = Q7J
54 = Q7K
55 = Q7L
56 = Q7M
57 = Q7N
58 = Q7O
59 = Q7P
60 = Q7Q
61 = Q7R
63 = Q8A
64 = Q8B
65 = Q8C
66 = Q8D
67 = Q8E
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70 = Q8H
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75 = Q8M
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77 = Q8O
78 = Q8P
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83 = Q8U
84 = Q8V
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91 = Q8C
92 = Q8D
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96 = Q9A
97 = Q9B
98 = Q9C
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101 = Q9F
102 = Q9G
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158 = Q14I
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Raw Data By Columns: Id with columns 44-95 (Q7A - Q8FF)

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117	113131244412121411 443335412334344334344433444445322
118	322222234334212222 434233233322332332222322224363332
119	134232134222222333 433122112113232121112112111111121
120	344343244423322343 544334334333332334444333233333332
121	13 111133313331333 443254113444445133364131433311111
122	132222222332332253 4 65 4 44445 5 5 4
123	234232134222222333 543122112231111
124	32223343333222233 443334313333333333432333333333333
125	233232223333322332 444334414434233233443233433334434
126	131112142111411121 665636114161151131165114665213 64
127	232124444433223324 444434424444444444444433244444433

Raw Data By Columns: Id with columns 96-124 (Q9A-Q11E)

ID	Columns
101	551423312433 133214111 44135
102	542422344343 434344343 44344
103	453433434544 345445533 44445
104	431343433323 223254332 24243
105	443443433444 334344432 44535
106	2315444343 1 234255141 66434
107	211331221231 111112111 22213
108	442322344434 133133222 44336
109	542554424541 233355421 45325
110	442343523434 334234432 22124
111	222566654442 226336253 66426
112	343322323433 234434332 33334
113	433221422332 234322221 34345
114	44334334443 344434332 44344
115	441322333433 234344332 44345
116	444334223322 133234222 44144
117	552432343524 234232221 44325
118	4435332224 244333 23 34344
119	442232232422 122322221 33344
120	442343434443 434244333 44444
121	543333544533 113315521 55416
122	4434 444445 334344 32 44344
123	255422262 55436
124	442343534534 334245433 44345
125	443343424432 234244332 23234
126	262654156665 366546343 66466
127	443443444444 444444443 44433

Raw Data By Columns: Id with columns 125-168
(Q12A-Q15G)

ID	Columns
101	212111312645665654434544 22465541555 0000000
102	21211144156[illegible]4454543465 46665532215 0000000
103	4241114435455665564665566 65555553646 1000010
104	3111123416[illegible]23632445263[illegible] 34666551453 0000001
105	3331123524455665545443345 64555442433 0000000
106	4121111516666655546465[illegible] 56655642346 0001010
107	2111112215556665525 1356 31242221411 1001111
108	2131113516666644664 6462 66664411414 0000011
109	31311224 555553332243332 32444442 2 0000010
110	3111113345666655544544[illegible] 44556654546 1000010
111	4121112616636655546465 5 24566543663 0000010
112	2132533433545533644466[illegible] 246663525 5 1000010
113	4121112415544323543455[illegible] 26664551343 1000100
114	3222222425656544544464[illegible] 43334522436 0000010
115	3111113424545542534434[illegible] 23454541434 0000010
116	1111111313334411311111156 14555641422 1000011
117	1121112314456644434454[illegible] 45555654535 1000110
118	422 334 444354443444454 43444542354 0000000
119	2111111215665334643453[illegible] 33444331512 1000011
120	31111123 6646634646532332 42565642644 1000111
121	61111135 556665566455646 11444561146 0000000
122	2222223326666655655345[illegible] 53555662555 1000000
123	2111111215665334443453[illegible] 33443315512 1000011
124	3121123325556655545555[illegible] 43666663425 0000000
125	2131114426666655435344[illegible] 45564543434 1010011
126	2141133526566666566563[illegible] 65666661426 1000110
127	21424444 556554443434553 34556553526 0000000

Appendix B

Raw Data File--Clergymen

Key of Raw Data by Columns

1-3= ID
5 = REL
7-8= YEARS
10 = Q3A
11 = Q3B
12 = Q3C
13 = Q3D
14 = Q3E
15 = Q3F
16 = Q3G
17 = Q3H
19 = Q4A
20 = Q4B
21 = Q4C
22 = Q4D
23 = Q4E
24 = Q4F
26 = Q5A
27 = Q5B
28 = Q5C
29 = Q5D
30 = Q5E
31 = Q5F
32 = Q5G
33 = Q5H
34 = Q5I
35 = Q5J
37 = Q6A
38 = Q6B
39 = Q6C
40 = Q6D
41 = Q6E
42 = Q6F
43 = Q6G
44 = Q6H
45 = Q6I
47 = Q7A
48 = Q7B
49 = Q7C
50 = Q7D
51 = Q7E
52 = Q7F
53 = Q7G
54 = Q7H
55 = Q7I
56 = Q7J
57 = Q7K
58 = Q7L
59 = Q7M
60 = Q7N
62 = Q8A
63 = Q8B
64 = Q8C
65 = Q8D
66 = Q8E
67 = Q8F
68 = Q8G
69 = Q8H
70 = Q8I
71 = Q8J
72 = Q8K
73 = Q8L
74 = Q8M
75 = Q8N
76 = Q8O
77 = Q8P
78 = Q8Q
79 = Q8R
80 = Q8S
81 = Q8T
82 = Q8U
83 = Q8V
84 = Q8W
85 = Q8X
86 = Q8Y
87 = Q8Z
89 = Q9A
90 = Q9B
91 = Q9C
92 = Q9D
93 = Q9E
94 = Q9F
95 = Q9G
97 = Q10A
98 = Q10B
99 = Q10C
100 = Q10D
101 = Q10E
102 = Q10F
103 = Q10G
104 = Q10H
105 = Q10I
106 = Q10J
107 = Q10K
108 = Q10L
109 = Q10M
110 = Q10N
112 = Q11A
113 = Q11B
114 = Q11C
115 = Q11D
116 = Q11E
117 = Q11F
118 = Q11G

Raw Data By Columns: Columns 1-46 (ID - Q6I)

Columns

```
201 8 16 34454466 663 66 3366364645 546456362
202 2 08 31436124 153412 433344366  556456453
203 2 02 36566536 453366 5336644666 546545635
204 2 04 313656 6 145666 2163121542 426156462
205 2 13 12533126 453522 3143222653 214345252
206 2 17 43553343 334644 3244443542 345355453
207 1 02 33454345 442556 3454353454 445344454
208 1 35 42232243 314446 3334343333 545434262
209 1 11 3 3 2  3 4 4 54 3344333343 114324353
210 8 08 32254455 565566 4334343444 556546566
211 2 04 32354326 65465  4346434645 466566465
212 2 22 34663466 445565 3344543653 435434353
213 2 07 44324236 555324 4424233655 435455554
214 2 02 36354346 544666 2212212111 466556456
215 8 01 23666636 332646 6666342463 655565455
216 2 07 44555346 454565 3356554565 556555465
217 2 03 43633656  66645 4125123152 255544365
218 1 20 33343235 344556 3334243443 425223452
219 2 20 43464434 345545 4444335454 335445454
220 2 08 411116 6 66464  3366333446 1164 4 66
221 2 20 46433566 343654 4344343443 335333353
222 2 28 23463455 243626 4235331543 656655465
223 2 18 34365465 442 25 1224252454 235533255
224 7 08 32334234 343466 3335 23443 325324562
225 4 13 33343235 354435 3335423453 425223452
226 2 04 3453 234   4556 4334443444 566445454
227 2 02 34433422 454545 4444344554 224434 44
228 1 03 24343334 324645 3344453444 224434353
229 2 40 36 36 45 133342 63 623 64    63354 3
230 1 10 32324345 424455 4366363565 344344542
```

Raw Data By Columns: Id with columns 47-88 (Q7A-Q8Z)

ID	Columns
201	66625566666553 56665653655 36653464646466
202	4244354533325 55565 4554245645255454544 4
203	65454555434343 335443333453464334 4 545356
204	63466666556562 556543454542354613636466 66
205	41232244523352 3343124243626535243253124 5
206	23233333333342 455544543542544434444444 54
207	54354465544543 4354445454 354564453565656
208	432 4534314332 22624 44443 444 6 5444
209	43213543413342 546554445554534344334565 65
210	54364465445444 546553444553363634646565 46
211	64366366645465 465453536432446446665 6 566
212	54443354443443 355454453332544533354455 65
213	4343444415233 554433534553444525545364 55
214	665366566665363 555556365323664626656655 66
215	5332535433533 456654334352545532555465566
216	55345555555453 555555545332555635556555 66
217	533233 3434453 355334555444344554545555 54
218	43345435422342 245433545553555553443544456
219	54332554444432 434433344333344423335433 45
220	1116 666611143 333434445553633 2435353456
221	44334344553433 434642434233544534534344
222	33343333313333 333312233335233633333336533
223	54514445354135 4544432144525 421232324335
224	433534 3522656 244653522524353643535343 4
225	43345435422342 245436455535555443544454 56
226	32224434434433 5544524 4 335 5 5 54 55
227	5434444443 433 344 434343333444345444444 4
228	43344666454433 343333444443333423433343 44
229	563 46 44 3 33 3 4 5 3 644 4 1444
230	322144334 4453 443352434343454424523443 55

Raw Data By Columns: Id With columns 89-118 (Q9A-Q11G)

ID	Columns
201	6666666 66626646125316 0000000
202	4565554 66646666115526 0000000
203	6666645 66626664144316 0000000
204	6666656 66616666135216 0000001
205	4356646 66656551136215 1000000
206	5545456 65545555145316 0000000
207	6554656 65636552144526 1100111
208	445554 65616556125115 0000000
209	443455 55616666116116 0000000
210	5566645 66666666156416 0000000
211	5645666 4564664615 316 0000000
212	4565546 5651556523 526 0000000
213	6666655 66614545125216 0000000
214	6666666 66646666124316 0000000
215	4555544 65646666145326 0000000
216	6666666 66616666125316 0000000
217	4566666 66525566116 16 0000000
218	6566654 65615545135216 0000000
219	6366666 45533355245325 0000000
220	6565 26 66646664155126 0000000
221	5664656 64645653265526 0000000
222	6656556 56546664155426 0000000
223	6646653 66433664145616 0000000
224	6566654 65615545135216 0000000
225	5666654 65615656135216 0000000
226	5666666 66646666126216 0000000
227	3356554 54626555115226 1000001
228	6566665 45415544166326 1100111
229	64 565 65516455125 26 0000000
230	5566525 54615555114116 0000000

Appendix C

Variable Labels And Value Labels---Physicians

VARIABLE LABELS

SPEC "SPECIALTY"/YEARS "YEARS IN PRACTICE"
Q3A "STATE HOSPITAL"/Q3B "PRIVATE HOSPITAL"
Q3C "GROUP PRACTICE"/Q3D "SOLO PRACTICE"
Q4A "HIGH TOLERANCE"/Q4B "UNCONTOLLABLE"
Q4C "SUPERNATURAL"Q4D "NOT FOLLOWING INST"
Q4E "PERSONAL CARE"/Q4F "PERSONAL HYGIENE"
Q4G "EATING DISORDER"/Q4H "SUPERSTITIOUS"
Q4I "LACK OF TRUST"Q5A "LEGAL PROBLEMS"
Q5B "MARITAL PROBLEMS"/Q5C "PARENTING PROBLEMS"
Q5D "INTERPERSONAL CONFLICTS"
Q5E "PERSONALITY DISORDERS"/Q5F "LIFE CIRCUMSTANCES"
Q5G "SEXUAL CONLICTS"/Q5H "POLITICAL ISSUES"
Q5I "WORK PROBLEMS"/Q6A "VOMITING"/Q6B "LOSS OF VOICE"
Q6C "CHEST PAIN"/Q6D "PARTIAL BLINDNESS"
Q6E "DOUBLE VISION"/Q6F "TEMPORARY PARALYSIS"
Q6G "URINARY RETENTION"/Q6H "SEXUAL INDIFFERENCE"
Q6I "DYSMENORRHEA"/Q6J "IRREGULAR MENSTRUATION"
Q6K "PMS"/Q7A "PEDOPHILIA"/Q7B "PEDERASTY"
Q7C "VOYEURISM"/Q7D "INCEST"/Q7E "EXHIBITIONISM"
Q7F "MASOCHISM"/Q7G "SADISM"/Q7H "ERECTILE DEFICIENCY"
Q7I "PREMATURE EJACULATION"/Q7J "IMPOTENCE"
Q7K "FRIGIDITY"/Q7L "VAGINISMUS"
Q7M "EXCESSIVE MASTURBATION"/Q7N "BISEXUAL CONFLICTS"
Q7O "BEASTIALITY"/Q7P "DYSPAREUNIA"/Q7Q "RAPE"
Q7R "SODOMY"/Q8A "SHORTNESS OF BREATH"/Q8B "DIZZINESS"
Q8C "TACHYCARDIA"/Q8D "PHOBIAS"/Q8E "POLYURIA"
Q8F "SUPERSTITIOUS BEHAVIOR"/Q8G "OBSESSIONS"
Q8H "KLEPTOMANIA"/Q8I "LOSS OF CONSCIOUSNESS"
Q8J "OBSCENE LANGUAGE"/Q8K "MEMORY LOSS"
Q8L "IRRITABILITY"/Q8M "INFANTILE BEHAVIOR"
Q8N "CONSTANT FATIGUE"/Q8O "PERSECUTORY DELUSIONS"
Q8P "INAPPROPRIATE AFFECT"/Q8Q "RAPID MOOD SHIFTS"
Q8R "LOSS OF INTEREST IN PLEASURABLE ACTIVITIES"
Q8S "SOCIAL WITHDRAWAL"/Q8T "INSOMNIA"/Q8U "PESSIMISM"
Q8V "INAPPROPRIATE GUILT"/Q8W "DEATH OBSESSION"
Q8X "FEELING WORTHLESS"/Q8Y "SUPERNATURAL STRENGTH"
Q8Z "GRANDIOSITY"/Q8AA "DIFFICULTY CONCENTRATING"
Q8BB "HALLUCINATIONS"/Q8CC "PANIC ATTACKS"
Q8DD "FIXATIONS"/Q8EE "MENTAL RETARDATION"
Q8FF "DEPERSONALIZATION"/Q9A "ULCER"/Q9B "HYPERTENSION"
Q9C "COLITUS"/Q9D "DIARRHEA"/Q9E "ANOREXIA"
Q9F "BULIMIA"/Q9G "G-I SYMPTOMS"/Q9H "EPILEPSY"
Q9I "DIABETES"/Q9J "MIGRAINES"/Q9K "HEART DISEASE"
Q9L "HYPOCHONDRIASIS"/Q10A "SCHIZOPHRENIA"
Q10B "DEPRESSION"/Q10C "ANXIETY"/Q10D "SUBSTANCE ABUSE"

VARIABLE LABES (CON.T)

Q10E "HYSTERIA"/Q10F "SLEEP DISORDERS"
Q10G "SEXUAL DYSFUNCTION"/Q10H "PERSONALITY DISORDERS"
Q10I "MULTIPLE PERSONALITIES"/Q11A "ALCOHOL"
Q11B "TOBACCO"/Q11C "MARIJUANA"/Q11D "CAFFEINE"
Q11E "SUGAR"/Q12A "BARBITURATES"/Q12B "LITHIUM"
Q12C "ANTI-DEPRESSANT"/Q12D "NAVANE"/Q12E "ELAVIL"
Q12F "HALDOL"/Q12G "PHENOTHIAZINES"/Q12H "VALIUM"
Q12I "OTHER MEDS"/Q13A "CROWDED QUARTERS"
Q13B "OVERPOPULATION"/Q13C "MALNUTRITION"
Q13D "UNDERNOURISHMENT"/Q13E "INADEQUATE SANITATION"
Q13F "ALCOHOLISM"/Q13G "SMOKING"/Q13H "ILLITERACY"
Q13I "LACK OF EXERCISE"/Q13J "POOR HYGIENE"
Q13K "SEXUAL ACTIVITY"/Q13L "UNEMPLOYMENT"
Q13M "BIRTH CONTROL"/Q13N "PUBLIC HEALTH"
Q13O "NATURAL DISASTER"/Q14A "ALCOHOL AND HEALTH"
Q14B "TREATING EMOTIONAL PROBLEMS"
Q14C "NEED FOR MENTAL HEALTH SERVICES"
Q14D "MENTAL HEALTH ED."
Q14E "NEED FOR PSYCHOLOGISTS"
Q14F "PROBLEMS AS SATANIC"
Q14G "PSYCHOGENIC PROBLEMS"/Q14H "SUICIDE"
Q14I "CHILDHOOD ORIGINS"/Q14J "CAN'T TREAT"
Q14K "VODOO & HEALTH"/Q15A "PSYCHOLOGISTS"
Q15B "CHILD GUIDANCE"/Q15C "MARRIAGE AND FAMILY"
Q15D "DRUG/ALCOHOL TREATMENT"
Q15E "REHABILITATION"/Q15F "PSYCHIATRISTS"
Q15G "PERSONALITY DIS. TREATMENT".

VALUE LABELS

SPECIALTIES:
1 = "GENERAL MEDICINE"
2 = "INTERNAL MEDICINE"
3 = "PEDIATRICS"
4 = "PSYCHIATRY"
5 = "SURGERY"
6 = "OB-GYN"
7 = "NEUROSURGERY"
8 = "O-R-L"
9 = "PUBLIC HEALTH"

Q3A TO Q3D & Q15A TO Q15G: 1 = "YES" 0 = "NO"

Q4A TO Q12H:
1 = "NEVER"
2 = "ALMOST NEVER"
3 = "SOMETIMES"
4 = "OFTEN"
5 = "ALMOST ALWAYS"
6 = "ALWAYS"

Q13A TO Q13O:
1 = "ABSOLUTELY NOT IMPORTANT"
2 = "NOT VERY IMPORTANT"
3 = "SOMEWHAT IMPORTANT"
4 = "IMPORTANT"
5 = "VERY IMPORTANT"
6 = "ABSOLUTELY IMPORTANT"

Q14A TO Q14K:
1 = "STRONGLY DISAGREE"
2 = "DISAGREE"
3 = "MODERATELY DISAGREE"
4 = "MODERATELY AGREE"
5 = "AGREE"
6 = "STRONGLY AGREE".

Appendix D

Variable Labels and Value Labels---Clergymen

VARIABLE LABELS

REL "RELIGIOUS AFFILIATION"/YEARS "YEARS IN MINISTRY"
Q3A "MARRIAGE DIFFICULTIES"/Q3B "PARENTING ISSUES"
Q3C "INTERPERSONAL CONFLICTS"/Q3D "RELIGIOUS CONCERNS"
Q3E "ADVICE ON DECISIONS"/Q3F "SEXUAL MATTERS"
Q3G "HEALTH CONCERNS"/Q3H "LIFE CIRCUMSTANCES"
Q4A "ALCOHOLISM"/Q4B "TOBACCO"/Q4C "MARITAL PROBLEMS"
Q4D "LIFE UNCERTAINTY"/Q4E "PHYSICAL ENVIRONMENT"
Q4F "POLITICAL UNREST"/Q5A "HEART DISEASE"/Q5B "CANCER"
Q5C "SEX TRANS DIS"/Q5D "TUBERCULOSIS"/Q5E "TETANUS"/
Q5F "ULCER"/Q5G "EPILEPSY"/Q5H "MIGRAINES"
Q5I "HYPERTENSION"/Q5J "DIARRHEA"
Q6A "ILLNESS TOLERANCE"
Q6B "UNCONTROLLABLE ILLNESS"/Q6C "SUPERNATURAL CAUSES"
Q6D "NOT FOLLOWING INSTRUCTIONS"
Q6E "NEGLECTING HEALTH"/Q6F "PERSONAL HYGEINE"
Q6G "EATING HABITS"/Q6H "SUPERSTITIOUS BEHAVIOR"
Q6I "TRUST IN DOCTORS"/Q7A "ROBBERY"/Q7B "BURGLARY"
Q7C "MURDER"Q7D "ZOMBIFICATION"/Q7E "TRAFFIC ACCIDENTS"
Q7F "UNPAID DEBTS"/Q7G "SORCERY"/Q7H "EVIL WITCHCRAFTS"
Q7I "PROSTITUTION"/Q7J "PORNOGRAPHY"/Q7K "PROMISCUITY"
Q7L "ABORTION"/Q7M "CHILD ABUSE"/Q7N "RAPE"
Q8A "WORTHLESSNESS"/Q8B "PESSIMISM"
Q8C "FEAR OF DEMONS"/Q8D "DEATH OBSESSION"
Q8E "ANGER CONTROL"Q8F "OBSESSIONS"
Q8G "MARITAL COMMUNICATION"
Q8H "SEXUAL DISSATISFACTION"/Q8I "INFIDELITY"
Q8J "MARITAL ROLES"Q8K "FAMILY PLANNING"
Q8L "STERILITY"/Q8M "CHILD REARING"/Q8N "JEALOUSY"
Q8O "IN-LAWS"/Q8P "CONSTANT WORRY"
Q8Q "SUICIDAL IDEATION"/Q8R "SLEEP DISORDERS"
Q8S "INFERIORITY COMPLEX"/Q8T "FALSE GUILTS"
Q8U "DEMONIC PERSECUTION"/Q8V "INTROVERSION"
Q8W "RESIGNATION"/Q8X "MAINTAINING RELATIONSHIPS"
Q8Y "TRUST ISSUES"/Q8Z "GOSSIPS"/Q9A "CROWDED QUARTERS"
Q9B "OVERPOPULATION"/Q9C "CHILDHOOD MALNUTRITION"
Q9D "CHRONIC UNDERNOURISHMENT"
Q9E "INADEQUATE SANITATION"/Q9F "LACK OF VACCINATION"
Q9G "ILLITERACY"/Q10A "MORE TRAINING"
Q10B "CHURCH INVOLVEMENT"/Q10C "NEED FOR SERVICES"
Q10D "SIN CAUSES MH PROBLEMS"
Q10E "NEED FOR PSYCHOLOGISTS"/Q10F "M.H. EDUCATION"
Q10G "INTEREST IN TRAINING"
Q10H "MH PROBLEMS ARE DEMONIC"
Q10I "PSYCHIATRY/PSYCHOLOGY SECULAR"

VARIABLE LABELS CON'T

Q10J "BIBLE ONLY ANSWER"
Q10K "CHILDHOOD SOURCE OF PROBLEMS"
Q10L "SUICIDE PROBLEM"
Q10M "CLERGY SHOULD NOT GET INVOLVED"
Q10N "SPIRITUAL/PHYSICAL/MENTAL INTERACTION"
Q11A "PSYCHOLOGISTS"/Q11B "CHILD GUIDANCE"
Q11C "MARRIAGE & FAMILY"/Q11D "DRUG/ALCOHOL TREATMENT"
Q11E "REHABILITATION"/Q11F "PERSONALITY DISORDERS"
Q11G "PSYCHIATRIC CLINIC".

VALUE LABELS

RELIGIOUS AFFILIATIONS:

1 = "ROMAN CATHOLIC"
2 = "BAPTIST"
3 = "METHODIST"
4 = "ADVENTIST"
5 = "CHURCH OF GOD"
6 = "ASSEMBLY OF GOD"
7 = "NAZARENE"
8 = "EVANCELICAL"

Q3A TO Q8Z:
1 = "NEVER"
2 = "ALMOST NEVER"
3 = "SOMETIMES"
4 = "OFTEN"
5 = "ALMOST ALWAYS"
6 = "ALWAYS"

Q9A TO Q9G:
1 = "ABSOLUTELY NOT IMPORTANT"
2 = "NOT VERY IMPORTANT"
3 = "SOMEWHAT IMPORTANT"
4 = "IMPORTANT"
5 = "VERY IMPORTANT"
6 = "ABSOLUTELY IMPORTANT"

Q10A TO Q10N:
1 = "STRONGLY DISAGREE"
2 = "DISAGREE"
3 = "MODERATELY DISAGREE"
4 = "MODERATELY AGREE"
5 = "AGREE"
6 = "STRONGLY AGREE"

Q11A TO Q11G: 1 = "YES" 2 = "NO".

Appendix E

Cover Letter For The Physicians:

English And French Versions

WTS
Western Seminary

Portland, November 12 1988

Dear Doctor,

As you are well aware, according to the latest findings of the World Health Organization (WHO), there is an increasing need for mental health services in the third world countries in general. The need is such that in developing countries more than 40 million men, women, and children suffer from serious untreated mental disorders.

As a physician, you have undoubtedly observed and dealt with many of those mental needs in the population you serve. Therefore, you have been chosen to participate in the assessment of the mental health needs of your community.

Would you be so kind as to take up to 20 minutes to fill out the following questionnaire. Knowing how busy you are, we want to thank you in advance for your participation and your prompt attention to this. The questionnaire will be collected within approximately 48 hours.

Be assured that the results will be made available to you, with necessary recommendations and suggestions that will assist you in your courageous efforts to serve your population.

Sincerely,

Robert E. Buckler, M D, MPH Chairman of the research Committee, Associate Professor of Psychiatry	Jean Abede Alexandre Director of the research project Graduate Student in Clinical Psychology

Western Seminary

Portland, 12 Novembre 1987

Cher Docteur,

Comme vous le savez, et selon les données des dernières enquêtes de l'Organisation Mondiale de la Santé (OMS), il existe un grand besoin de services de santé mentale dans les pays en voie de développement. Ceci est d'autant plus vrai que dans les pays du tiers monde, comme Haïti, plus de 40 millions d'hommes, de femmes, et d'enfants souffrent de troubles mentaux non traités.

En tant que médecins, il est inévitable que vous avez observé et traité la plupart des troubles mentaux ou psychiatriques de votre population. C'est pourquoi, vous avez été choisi pour participer à une enquête sur les besoins de santé mentale de votre communauté.

Nous vous saurions gré de bien vouloir mettre 15 à 20 minutes pour remplir le questionnaire ci-inclus. Sachant combien votre temps est précieux, nous tenons à vous remercier à l'avance de votre participation et votre attention immédiate à ce sujet. Le questionnaire sera recueilli aux environs de 48 heures.

Soyez assuré que les résultats seront mis à votre disposition avec l'espoir que les informations seront utiles à vos interventions médicales. Aussi, nous permettrons-nous de vous faire part des suggestions et recommandations qui contribueront à vos efforts courageux pour servir votre population.

Avec nos sincères remerciements,

Dr. Robert E. Buckler, M D, M P H
Président du comité de recherches,
Professeur de Psychiatrie

Jean Abède Alexandre
Directeur du projet de
recherches, étudiant de
doctorat en Psychologie
Clinique.

Appendix F

Cover Letter For the Clergymen:

English And French Versions

WS
Western Seminary

Portland, November 12 1988

Dear Reverend,

As you are well aware, according to the latest findings of the World Health Organization (WHO), there is an increasing need for mental health services in the third world countries in general. The need is such that in developing countries more than 40 million men, women, and children suffer from serious untreated mental disorders.

As a clergyman, you have undoubtedly observed and dealt with many of those mental needs in the population you serve. Therefore, you have been chosen to participate in the assessment of the mental health needs of your community.

Would you be so kind as to take up to 20 minutes to fill out the following questionnaire. Knowing how busy you are, we want to thank you in advance for your participation and your prompt attention to this. The questionnaire will be collected within approximately 48 hours.

Be assured that the results will be made available to you, with necessary recommendations and suggestions that will assist you in your courageous efforts to serve your population.

Sincerely,

Robert E. Buckler, M D, MPH
Chairman of the research Committee, Associate Professor of Psychiatry

Jean Abede Alexandre
Director of the research project
Graduate Student in Clinical Psychology

Western Seminary

Portland, 12 Novembre 1987

Cher Reverend,

Comme vous le savez, et selon les données des dernières enquêtes de l'Organisation Mondiale de la Santé (OMS), il existe un grand besoin de services de santé mentale dans les pays en voie de développement. Ceci est d'autant plus vrai que dans les pays du tiers monde, comme Haïti, plus de 40 millions d'hommes, de femmes, et d'enfants souffrent de troubles mentaux non traités.

En tant que Pasteur/Prêtre, il est inévitable que vous ayez observé et traité la plupart des troubles mentaux ou psychiatriques de votre population. C'est pourquoi, vous avez été choisi pour participer à une enquête sur les besoins de santé mentale de votre communauté.

Nous vous saurions gré du bien vouloir mettre 15 à 20 minutes pour remplir le questionnaire ci-inclus. Sachant combien votre temps est précieux, nous tenons à vous remercier à l'avance de votre participation et votre attention immédiate à ce sujet. Le questionnaire sera recueilli aux environs de 48 heures.

Soyez assuré que les résultats seront mis à votre disposition avec l'espoir que les informations seront utiles à vos interventions pastorales. Aussi, nous permettrons-nous de vous faire part des suggestions et recommendations qui contribueront à vos efforts courageux pour servir votre population.

Avec nos sincères remerciements,

Dr. Robert E. Buckler, M D, M P H
Président du comité de recherches,
Professeur de Psychiatrie

Jean Abede Alexandre
Directeur du projet de recherches, étudiant de doctorat en Psychologie Clinique.

Appendix G

Physician Questionnaire

English And French Versions

THE PHYSICIANS' QUESTIONNAIRE

Please circle the number or letter of your answer or fill in the blank as appropriate.

1. Please indicate your field of practice

1 General practice
2 Internal medicine
3 Pediatrics
4 Psychiatry
5 Surgery
6 OBGYN
7 Neurosurgery
8 ENT
9 Public Health specialist
10 Other (please specify)_____

2. How long have you been in practice_____Years

3. Do you work in the following:

State Hospital	yes	no
Private Hospital	yes	no
Polyclinic	yes	no
Private clinic	yes	no
Other (please specify)_____		

For questions 4 to 12, use the following scales:
1 = never; 2 = almost never; 3 = sometimes;
4 = often; 5 = nearly always; 6 = always

4. How often do you see the following attitudes and behaviors toward illness in the population you serve?

	Never.....Always
High tolerance of illness	1 2 3 4 5 6
Illnesses are uncontrollable	1 2 3 4 5 6
Beliefs in supernatural causes of illnesses	1 2 3 4 5 6
Failure to follow doctors' instructions	1 2 3 4 5 6
Negligence toward personal care	1 2 3 4 5 6
Poor personal Hygiene	1 2 3 4 5 6
Appetite disorders	1 2 3 4 5 6
Superstitious behaviors	1 2 3 4 5 6
Lack of trust in doctors	1 2 3 4 5 6
Others (please specify)_____	1 2 3 4 5 6

5. How often do individuals bring these non-medical concerns to your office?

	Never.....Always
Legal issues	1 2 3 4 5 6
Marital difficulties	1 2 3 4 5 6
Problems in parenting	1 2 3 4 5 6
Interpersonal conflicts	1 2 3 4 5 6
Personality disorders issues	1 2 3 4 5 6
Life circumstances issues	1 2 3 4 5 6
Sexual conflicts issues	1 2 3 4 5 6
Political issues	1 2 3 4 5 6
Work-related problems	1 2 3 4 5 6

6. How often do you see the following symptoms in patients without organic or pathophysiological mechanisms to account for the symptoms?

	Never.....Always
Vomiting (not in pregnancy)	1 2 3 4 5 6
Aphony (Loss of voice)	1 2 3 4 5 6
Chest pain	1 2 3 4 5 6
Partial blindness	1 2 3 4 5 6
Double vision	1 2 3 4 5 6
Temporary paralysis	1 2 3 4 5 6
Urinary retention	1 2 3 4 5 6
Sexual indifference	1 2 3 4 5 6
Dysmenorrhea	1 2 3 4 5 6
Irregular menstrual syndrome	1 2 3 4 5 6
Pms	1 2 3 4 5 6

7. How often do the following sexual disorders occur among the population you serve?

	Never.....Always
Pedophilia	1 2 3 4 5 6
Pederasty	1 2 3 4 5 6
Voyeurism	1 2 3 4 5 6
Incest	1 2 3 4 5 6
Exhibitionism	1 2 3 4 5 6
Sexual masochism	1 2 3 4 5 6
Sexual sadism	1 2 3 4 5 6
Erectile deficiency	1 2 3 4 5 6
Premature ejaculation	1 2 3 4 5 6
Inhibited male orgasm	1 2 3 4 5 6
Inhibited female orgasm	1 2 3 4 5 6
Vaginismus	1 2 3 4 5 6
Excessive masturbation	1 2 3 4 5 6
Homosexual conflicts	1 2 3 4 5 6
Bestiality	1 2 3 4 5 6
Dyspareunia	1 2 3 4 5 6
Rape	1 2 3 4 5 6
Sodomy	1 2 3 4 5 6

8. How often do you see the following symptoms among your patients?

	Never.....Always
Shortness of breath	1 2 3 4 5 6
Dizziness	1 2 3 4 5 6
Tachycardia	1 2 3 4 5 6
Phobias	1 2 3 4 5 6
Frequent urination (not in Pregnancy)	1 2 3 4 5 6
Superstitious behaviors	1 2 3 4 5 6
Fighting obsessive thoughts	1 2 3 4 5 6
Kelptomania	1 2 3 4 5 6
Loss of consciousness	1 2 3 4 5 6
Indecency in Language	1 2 3 4 5 6
Loss of Memory	1 2 3 4 5 6
Irritability	1 2 3 4 5 6
Infantile Behavior in adult	1 2 3 4 5 6
Constant fatigue	1 2 3 4 5 6
Persecutory delusions	1 2 3 4 5 6
Inappropriate affect	1 2 3 4 5 6
Rapid mood shifts	1 2 3 4 5 6
Loss of interest in pleasure	1 2 3 4 5 6
Social withdrawal	1 2 3 4 5 6
Insomnia	1 2 3 4 5 6
Pessimism	1 2 3 4 5 6
False Guilt	1 2 3 4 5 6
Death obsession	1 2 3 4 5 6
Inferiority complex	1 2 3 4 5 6
Temporary Supernatural Strength	1 2 3 4 5 6
Delusions of grandeur	1 2 3 4 5 6
Inability to concentrate	1 2 3 4 5 6
Hallucinations	1 2 3 4 5 6
Panic	1 2 3 4 5 6
Delirium	1 2 3 4 5 6
Mental retardation	1 2 3 4 5 6
Depersonalisation	1 2 3 4 5 6

9. How often do you see the following illnesses in the population you serve?

	Never.....Always
Peptic ulcer	1 2 3 4 5 6
Hypertension	1 2 3 4 5 6
Ulcerative Colitus	1 2 3 4 5 6
Chronic diarrhea	1 2 3 4 5 6
Anorexia nervosa	1 2 3 4 5 6
Bulimia	1 2 3 4 5 6
G-I symptoms	1 2 3 4 5 6
Epilepsy	1 2 3 4 5 6
Diabetes	1 2 3 4 5 6
Migrtaine headaches	1 2 3 4 5 6
Heart diseases	1 2 3 4 5 6
Hypochondriasis	1 2 3 4 5 6

10. How often do the following psychological disorders occur among the population you serve?

	Never.....Always
Schizophrenia	1 2 3 4 5 6
Depression	1 2 3 4 5 6
Anxiety	1 2 3 4 5 6
Substance abuse	1 2 3 4 5 6
Hysteria	1 2 3 4 5 6
Sleep disorders	1 2 3 4 5 6
Sexual dysfunction	1 2 3 4 5 6
Personality disorders	1 2 3 4 5 6
Multiple personalities	1 2 3 4 5 6

11. How often is the abuse of the following subtances reported among the population you serve?

	Never.....Always
Alcohol	1 2 3 4 5 6
Tobacco	1 2 3 4 5 6
Marijuana	1 2 3 4 5 6
Caffeine	1 2 3 4 5 6
Sugar	1 2 3 4 5 6
Other drugs (specify)_____	1 2 3 4 5 6

12. How often do you prescribe the following medications?

	Never.....Always
Barbiturates	1 2 3 4 5 6
Lithium	1 2 3 4 5 6
Antidepressants	1 2 3 4 5 6
Navane	1 2 3 4 5 6
Elavil	1 2 3 4 5 6
Haldol	1 2 3 4 5 6
Phenothiazines	1 2 3 4 5 6
Valium	1 2 3 4 5 6
Other psychotropic drugs_____	1 2 3 4 5 6

13. How important are the following factors in predisposing to illness in the poopulation? (1=Absolutely not important; 2=Not very important; 3=somewhat important; 4=important; 5=very important; absolutely important).

Crowded quarters	1 2 3 4 5 6
Overpopulation	1 2 3 4 5 6
Childhood Malnutrition	1 2 3 4 5 6
Chronic under nourishment	1 2 3 4 5 6
Inadequate sanitation	1 2 3 4 5 6
Considerable alcoholism	1 2 3 4 5 6
heavy smoking	1 2 3 4 5 6
Illiteracy	1 2 3 4 5 6
Lack of exercize	1 2 3 4 5 6
Sexual activities	1 2 3 4 5 6
Unemployment	1 2 3 4 5 6
Lack of planning program	1 2 3 4 5 6
Lack of public health education	1 2 3 4 5 6
Natural disaster	1 2 3 4 5 6

14. Please indicate your opinion on the following statements by circling one of the numbers as follow: 1=Strongly disagree; 2=disagree; 3=moderately disagree; 4=moderately agree; 5=Agree; Strongly agree.

Alcoholism is a major public health problem among the population	1 2 3 4 5 6
The treatment of emotional problems is a major part of my medical interventions	1 2 3 4 5 6
There is a great need for mental health services in the population	1 2 3 4 5 6
There is a great need for mental health education in the population	1 2 3 4 5 6
There is a great need for clinical psychologists and mental health specialists in the population	1 2 3 4 5 6
The population views many of the psychological problems as satanic manifestations	1 2 3 4 5 6
A great number of diseases in the population psychogenic in nature	1 2 3 4 5 6
Suicide is a major problem among the population	1 2 3 4 5 6
Most mental disturbances among the population can be attributed to Emotional experiences in childhood	1 2 3 4 5 6
Some people have basically inadequate personalities and medical treatment can never change them	1 2 3 4 5 6
Beliefs in voodoo and witchcraft have a negative influence on physical and mental health among the population	1 2 3 4 5 6

15. Are the following resources available in the community?

Clinical Psychologists	yes	no
Child guidance clinic	yes	no
Marriage and family counseling center	yes	no
Drug and alcohol treatment program	yes	no
Rehabilitation center	yes	no
Personality disorders treatment center	yes	no

16. What are the three most important health needs among the population you serve?

1 _____
2 _____
3 _____

17. What are the three most important mental health needs among the population you serve?

1 _____
2 _____
3 _____

18. Please add any comment, suggestion, or recommendation in the space below.

Thank you!

Le Questionnaire des médecins

Veuillez encercler le nombre ou la lettre correspondant à votre réponse, ou remplissez l'espace vide selon qu'il est indiqué.

1. Indiquez, s.v.p., votre specialité médicale

   1 Médecine générale
   2 Médecine interne
   3 Pédiatrie
   4 Psychiatrie
   5 Chirurgie
   6 Obstétrique/Gynécologie
   7 Neurochirurgie
   8 Oto-Rhino-Laryngologie (O R L)
   9 Santé Publique/Epidémiologie
   10 Autre (spécifiez, s.v.p.)_____

2. Depuis combien de temps pratiquez-vous la médecine? _____Années

3. Indiquez, s.v.p. le ou les types d'établissement dans lequel ou lesquels vous pratiquez

Hôpital d'état	Oui	Non
Hôpital privé	Oui	Non
Polyclinique	Oui	Non
Clinique privée	Oui	Non
Autre(spécifiez, s.v.p._____		

Pour les questions numérotées 4 à 14 inclusivement, utilisez l'échelle suivante: 1=Jamais; 2=Presque jamais; 3=Parfois; 4= Souvent;; 5= Presque toujours; 6= Toujours

4. Dans la population que vous servez, avec quelle fréquence observez-vous les attitudes et les comportements suivants vis-à-vis de leur(s) maladie(s)?

	Jamais.....Toujours
Une haute tolérancevis-à-vis des maladies en général	1 2 3 4 5 6
Croyance que toute maladie est un processus incontrolable	1 2 3 4 5 6
Croyance dans les causes supernaturelles pour leurs maladies	1 2 3 4 5 6
Négligence les instructions du médecin	1 2 3 4 5 6
Négligence vis-à-vis des soins personels en général	1 2 3 4 5 6
Hygiène individuelle inadéquate	1 2 3 4 5 6
Troubles d'appétit	1 2 3 4 5 6
Comportements superstitieux	1 2 3 4 5 6
Manque de confiance dans les médecins	1 2 3 4 5 6
Autres (spécifiez, s.v.p.)_____	1 2 3 4 5 6

5. Indiquez la fréquence avec laquelle des patients sollicitent votre avis sur des problèmes non-médicaux.

	Jamais.....Toujours
Problèmes d'ordre légal	1 2 3 4 5 6
Difficultés dans leur mariage	1 2 3 4 5 6
Problèmes relatifs à l'éducation des enfants	1 2 3 4 5 6
Conflits dans les relations interpersonnelles	1 2 3 4 5 6
Problèmes en rapport avec des troubles de la personalité	1 2 3 4 5 6
Problèmes concernant les circonstances de la vie en général	1 2 3 4 5 6
Problemes en rapport avec leurs conflits sexuels	1 2 3 4 5 6
Sujets d'ordre politique	1 2 3 4 5 6
Problèmes en rapport avec leur travail	1 2 3 4 5 6

6. Avec quelle fréquence observez-vous les symptômes suivants chez certains patients sans aucune base organique ou mécanisme physiopathologique pour justifier leur existence.

	Jamais.....Toujours
Vomissement (non en rapport avec la grossesse)	1 2 3 4 5 6
Aphonie (perte de la voix)	1 2 3 4 5 6
Douleur thoracique	1 2 3 4 5 6
Cécité partielle	1 2 3 4 5 6
Diplopie (Vision double)	1 2 3 4 5 6
Paralysie temporaire	1 2 3 4 5 6
Rétention urinaire	1 2 3 4 5 6
Indifférence sexuelle(perte de la libido)	1 2 3 4 5 6
Dysménorrhée	1 2 3 4 5 6
Irrégularité du cycle menstruel	1 2 3 4 5 6
Syndrôme prémenstruel	1 2 3 4 5 6

7. Avec quelle fréquence observez-vous les troubles sexuels suivants sont-ils rapportés dansla population.

	Jamais.....Toujours
Pédophilie	1 2 3 4 5 6
Pédérastie	1 2 3 4 5 6
Voyeurisme	1 2 3 4 5 6
Inceste	1 2 3 4 5 6
Exhibitionisme	1 2 3 4 5 6
Masochisme sexuel	1 2 3 4 5 6
Sadisme sexuel	1 2 3 4 5 6
Troubles de l'érection	1 2 3 4 5 6
Ejaculation précoce	1 2 3 4 5 6
Impuissance sexuelle masculine	1 2 3 4 5 6
Impuissance sexuelle féminine	1 2 3 4 5 6
Vaginisme	1 2 3 4 5 6
Masturbation excessive	1 2 3 4 5 6
Tendence homosexuelle avec conflits	1 2 3 4 5 6
Bestialité	1 2 3 4 5 6
Dyspareunie	1 2 3 4 5 6
Viols	1 2 3 4 5 6
Coït anal	1 2 3 4 5 6

8. Avec quelle fréquence observez-vous les symptômes suivants chez vos patients?

	Jamais.....Toujours
Essoufflement/ dyspnée	1 2 3 4 5 6
Vertige	1 2 3 4 5 6
Tachycardia	1 2 3 4 5 6
Peurs sans cause réelle ou apparente	1 2 3 4 5 6
Besoin d'uriner très souvent (grossesse exclue)	1 2 3 4 5 6
Comportements superstitieux	1 2 3 4 5 6
Lutte contre une pensée obsessive	1 2 3 4 5 6
Lutte contre le désir de voler	1 2 3 4 5 6
Perte de conscience	1 2 3 4 5 6
Langage obscène	1 2 3 4 5 6
Perte de mémoire	1 2 3 4 5 6
Irritabilité/ sautes d'humeur	1 2 3 4 5 6
comportement inapproprié à l'age adulte	1 2 3 4 5 6
Fatique incessante	1 2 3 4 5 6
Délires de persécution	1 2 3 4 5 6
Perception inappropriée	1 2 3 4 5 6
Changements rapides d'humeur	1 2 3 4 5 6
Perte d'intérêt pour les amusements	1 2 3 4 5 6
Retrait de toute activité sociale	1 2 3 4 5 6
Insomnie	1 2 3 4 5 6
Pessimisme	1 2 3 4 5 6
Obsession de culpabilité	1 2 3 4 5 6
Pensée obsessive de la mort	1 2 3 4 5 6
Sentiments de n'avoir aucune valeur intrinsèque	1 2 3 4 5 6
Manifestation temporaire d'une force surnaturelle	1 2 3 4 5 6
Délire de grandeur	1 2 3 4 5 6
Difficulté de concentrer la pensée sur un sujet à la fois	1 2 3 4 5 6
Hallucinations pathologiques	1 2 3 4 5 6
Panique	1 2 3 4 5 6
Arriération affective	1 2 3 4 5 6
Débilité mentale	1 2 3 4 5 6
Dépersonalisation	1 2 3 4 5 6

9. Avec quelle fréquence observez-vous les maladies suivantes dans la population que vous soignez.

	Jamais.....Toujours
Ulcère gastro-duodénal	1 2 3 4 5 6
Hypertension artérielle	1 2 3 4 5 6
Colite ulcéreuse	1 2 3 4 5 6
Diarrhée chronique	1 2 3 4 5 6
Anorexie nerveuse	1 2 3 4 5 6
Boulimie	1 2 3 4 5 6
Troubles du tranait gastro-intestinal	1 2 3 4 5 6
Epilepsie ('mal caduc')	1 2 3 4 5 6
Diabète	1 2 3 4 5 6
Maux de tête type migraine	1 2 3 4 5 6
Maladies cardiaques	1 2 3 4 5 6
Peur ou complainte d'une maladie sans existence réelle de la maladie(hyponchondriose/maladies imaginaires)	1 2 3 4 5 6

10. Avec quelle fréquence les troubles psychologiques suivants sont-ils rapportés dans la population que vous soignez.

	Jamais.....Toujours
Schizophrénie	1 2 3 4 5 6
Dépression nerveuse	1 2 3 4 5 6
Anxiété	1 2 3 4 5 6
Usage de substances psychoactives	1 2 3 4 5 6
Hystérie	1 2 3 4 5 6
Troubles de sommeil	1 2 3 4 5 6
Troubles sexuels	1 2 3 4 5 6
Troubles de personnalité	1 2 3 4 5 6
Manifestation de personnalités multiples	1 2 3 4 5 6

11. Avec quelle fréquence l'usage excessive des substances suivantes sont-ils rapportés dans la population.

	Jamais.....Toujours
Boissons alcooliques	1 2 3 4 5 6
Tabac	1 2 3 4 5 6
Marijuana	1 2 3 4 5 6
Caffeine	1 2 3 4 5 6
Sucres	1 2 3 4 5 6
Autres stupéfiants (spécifiez, s.v.p)_____	1 2 3 4 5 6

12. Avec quelle fréquence prescrivez-vous les médicaments suivants.

	Jamais.....Toujours
Barbituriques	1 2 3 4 5 6
Lithium	1 2 3 4 5 6
Antidépressants	1 2 3 4 5 6
Navane	1 2 3 4 5 6
Elavil	1 2 3 4 5 6
Haldol	1 2 3 4 5 6
Phenothiazines	1 2 3 4 5 6
Valium	1 2 3 4 5 6
Autres médicaments Psychiatriques	1 2 3 4 5 6

13. Indiquez selon vous, l'importance relative avec laquelle les facteurs suivants prédisposent à des maladies dans la population? 1= Absolument pas important; 2=Pas très important; 3=Peu important; 4= Important; 5= Très important; 6=Absolument très important.

Maisons surchargées	1 2 3 4 5 6
Surpopulation	1 2 3 4 5 6
Malnutrition dans l'enfance	1 2 3 4 5 6
insuffisances alimentaires chroniques	1 2 3 4 5 6
Insalubrité/ conditions sanitaires inadéquates	1 2 3 4 5 6
Alcoholisme appréciable	1 2 3 4 5 6
Abus du tabac	1 2 3 4 5 6
Analphabétisme/ignorance	1 2 3 4 5 6
Manque d'exercice physique	1 2 3 4 5 6
Hygiène individuelle déficiente	1 2 3 4 5 6
Activités sexuelles	1 2 3 4 5 6
Chômage	1 2 3 4 5 6
Manque de programmes sur la planification familiale	1 2 3 4 5 6
Manque de programmes d'instruction sur la santé publique	1 2 3 4 5 6
Une catastrophe naturelle dans la communauté	1 2 3 4 5 6

14. Veuillez indiquer votre opinion sur les déclarations suivantes en encerclant le nombre correspondant à votre réponse: 1= Désaccord total; 2=Désaccord; 3=Désaccord modéré; 4= Accord modéré; 5= Accord; 6= Accord total.

L'alcoolisme est un problème majeur de santé publique dans la population	1 2 3 4 5 6
Le traitement des problèmes émotionnels occupe une place important dans mes interventions médicales	1 2 3 4 5 6
Il existe un grand besoin dans la population pour des services et programmes sur la santé mentale	1 2 3 4 5 6
La population nécessite des programmes d'éducation sur les maladies mentales	1 2 3 4 5 6
Il existe un grand besoin dans la population pour des psychologues cliniciens et spécialistes de santé mentale	1 2 3 4 5 6
La population considère beaucoup de problèmes psychologiques comme des manifestations sataniques	1 2 3 4 5 6
Un grand nombre de maladies dans la population sont d'origine psychique	1 2 3 4 5 6
Le suicide est un problème majeur dans la population	1 2 3 4 5 6
La plupart des maladies mentales de l'adulte peuvent être attribuées à des expériences émotionnelles néfastes dans l'enfance	1 2 3 4 5 6
Certaines personnes ont une personnalité essentiellement inadéquate et aucun traitement médical ne pourra les changer	1 2 3 4 5 6
Les croyances dans le vaudou et la sorcellerie ont une influence négative sur la santé physique et mentale dans la population	1 2 3 4 5 6

15. Les ressources suivantes existent-elles dans la communauté?

Psychologues cliniciens donnant des consultations privées	Oui	Non
Cliniques d'orientation pour enfants	Oui	Non
Cliniques d'intervention pour les problèmes du mariage et de la famill	Oui	Non
Programmes de traitement pour les alcooliques et les drogués	Oui	Non
Centres de réhabilitation mentale	Oui	Non
Cliniques psychiatriques	Oui	Non
Centres de traitement pour les troubles de personalité	Oui	Non

16. Quels sont selon vous les trois besoins de santé publique les plus prioritaires dans la population que vous soignez.

1 _____
2 _____
3 _____

17. Selon vous, quels sont les trois besoins de santé mentale les plus prioritaires dans la population que vous soignez.

1 _____
2 _____
3 _____

18. Veuillez ajouter tout commentaire, suggestion ou recommendation dans l'espace ci-dessous.

Merci

Appendix H

Clergyman Questionnaire

English And French Versions

THE QUESTIONNAIRE FOR THE CLERGY

Please circle the number or letter of your answer or fill in the blank as appropriate.

1. Please indicate your religious affiliation

   A Roman catholic church
   B Baptist (please specify)_____
   C Methodist
   D Seventh day adventist
   E Church of God
   F Assembly of God
   G Nazarene
   H Evangelical Church of Haiti
   I Other (please specify)_____

2. How long have you been in the ministy?_____Years

   For questions 3 to 8, use the following scales:
   1 = never; 2 = almost never; 3 = sometimes;
   4 = often; 5 = nearly always; 6 = always.

3. How often do individuals bring the following concerns to you?

	Never.....Always
Marital difficulties	1 2 3 4 5 6
Problems in parenting	1 2 3 4 5 6
Interpersonal conflicts	1 2 3 4 5 6
Religious concerns	1 2 3 4 5 6
Advice seeking in decision making	1 2 3 4 5 6
Sexual conflicts issues	1 2 3 4 5 6
Medical concerns	1 2 3 4 5 6
Life circumstances issues	1 2 3 4 5 6
Other (please specify)_____	1 2 3 4 5 6

4. How often do the following situations occur in the general population?

	Never.....Always
Considerable alcoholism	1 2 3 4 5 6
Heavy smoking	1 2 3 4 5 6
Marital difficulties	1 2 3 4 5 6
Uncertainty about life	1 2 3 4 5 6
Poor physical environment	1 2 3 4 5 6
Political unrest	1 2 3 4 5 6
Other (please specify)_____	1 2 3 4 5 6

5. How often do these diseases occur among the general population?

	Never.....Always
Heart disease	1 2 3 4 5 6
Cancer	1 2 3 4 5 6
Sexually transmitted diseases	1 2 3 4 5 6
Tuberculosis	1 2 3 4 5 6
Tetanus	1 2 3 4 5 6
Ulcer	1 2 3 4 5 6
Epilepsy	1 2 3 4 5 6
Migraine headaches	1 2 3 4 5 6
Hypertension	1 2 3 4 5 6
Chronic diarrhea	1 2 3 4 5 6
Other (please specify)_____	1 2 3 4 5 6

6. How often do you see the following attitudes and behaviors toward illness in the population you serve?

	Never.....Always
High tolerance of illness	1 2 3 4 5 6
Illnesses are uncontrollable	1 2 3 4 5 6
Beliefs in supernatural causes of illnesses	1 2 3 4 5 6
Failure to follow doctors' instructions	1 2 3 4 5 6
Negligence toward personal care	1 2 3 4 5 6
Poor personal Hygiene	1 2 3 4 5 6
Appetite disorders	1 2 3 4 5 6
Superstitious behaviors	1 2 3 4 5 6
Lack of trust in doctors	1 2 3 4 5 6
Others (please specify)_____	1 2 3 4 5 6

7. How often are the following incidents reported in the general population?

	Never.....Always
Robbery	1 2 3 4 5 6
Burglary	1 2 3 4 5 6
Murder	1 2 3 4 5 6
Zombification	1 2 3 4 5 6
Traffic accident due to negligence	1 2 3 4 5 6
Unpaid debt	1 2 3 4 5 6
Sorcery	1 2 3 4 5 6
Witchcrafts aiming at harming people	1 2 3 4 5 6
Prostitution	1 2 3 4 5 6
Pornography	1 2 3 4 5 6
sexual promiscuity	1 2 3 4 5 6
Criminal abortion	1 2 3 4 5 6
Child abuse	1 2 3 4 5 6
Rapes	1 2 3 4 5 6
Other (Please specify)_____	1 2 3 4 5 6

8. How foten do you observe the following symptoms in the general population?

	Never.....Always
Feelings of worthlessness	1 2 3 4 5 6
pessimism	1 2 3 4 5 6
Fear of the "Loas"	1 2 3 4 5 6
Recurrent thoughts of death	1 2 3 4 5 6
Difficulty to control anger	1 2 3 4 5 6
Fighting obsessive thoughts	1 2 3 4 5 6
Poor marital communication	1 2 3 4 5 6
Sexual dissatisfaction	1 2 3 4 5 6
Infidelity	1 2 3 4 5 6
Concerns related to spouse's role	1 2 3 4 5 6
Birth control issues	1 2 3 4 5 6
Sterility	1 2 3 4 5 6
Child rearing issues	1 2 3 4 5 6
Jealousy	1 2 3 4 5 6
In-laws problems	1 2 3 4 5 6
Constant worry	1 2 3 4 5 6
Suicidal ideation	1 2 3 4 5 6
Sleep disorders	1 2 3 4 5 6
False guilt	1 2 3 4 5 6
Fear of demonic persecution	1 2 3 4 5 6
Difficulty to initiate relationships	1 2 3 4 5 6
Resignation	1 2 3 4 5 6
Difficulty to maintain relationships	1 2 3 4 5 6
Lack of trust in others	1 2 3 4 5 6
Gossip	1 2 3 4 5 6

9. How important are the following factors in predisposing to illness in the poopulation? (1=Absolutely not important; 2=Not very important; 3=somewhat important; 4=important; 5=very important; absolutely important).

Crowded quarters	1 2 3 4 5 6
Overpopulation	1 2 3 4 5 6
Childhood Malnutrition	1 2 3 4 5 6
Chronic under nourishment	1 2 3 4 5 6
Inadequate sanitation	1 2 3 4 5 6
Lack of Vaccination	1 2 3 4 5 6
Illiteracy	1 2 3 4 5 6
Other (please specify)_____	1 2 3 4 5 6

10. Please indicate your opinion on the following statements by circling one of the numbers as follow: 1=Strongly disagree; 2=disagree; 3=moderately disagree; 4=moderately agree; 5=Agree; Strongly agree.

I wish I had more training to deal with some of the emotional issues people bring to my attention	1 2 3 4 5 6
The church role in helping the emotionally disturbed should be enhanced	1 2 3 4 5 6
There is a great need for mental health services in the population	1 2 3 4 5 6
Mental illness results from personal sins	1 2 3 4 5 6
There is a great need for clinical psychologists and mental health specialists in the population	1 2 3 4 5 6
There is a great need for mental health education in the population.	1 2 3 4 5 6
I would be interested in receiving some training to deal with psychological problems people bring to me	1 2 3 4 5 6
The population views many of the psychological problems as satanic manifestacions	1 2 3 4 5 6
Psychology and Psychiatry are seculare and anti-christian and should not be used or practice by christians	1 2 3 4 5 6
The Word of God is the sole remedy to emotional problems	1 2 3 4 5 6
Most mental disturbances among the population can be attributed to Emotional experiences in childhood	1 2 3 4 5 6
Suicide is a major problem among the population	1 2 3 4 5 6
Clergymen should not be involved in solving mental health problems	1 2 3 4 5 6
There is an important interaction between spiritual health, physical health, and mental health	1 2 3 4 5 6

11. Are the following resources available in the community?

Clinical Psychologists	yes	no
Child guidance clinic	yes	no
Marriage and family counseling center	yes	no
Drug and alcohol treatment program	yes	no
Rehabilitation center	yes	no
Personality disorders treatment center	yes	no

12. Please indicate the top three contributions of the church to health promotion among the population?

1 _____
2 _____
3 _____

13. What are the three most important health needs among the population you serve?

1 _____
2 _____
3 _____

14. What are the three most important mental health needs among the population you serve?

1 _____
2 _____
3 _____

15. Please add any comment, suggestion, or recommendation in the space below.

Thank You!

LE QUESTIONNAIRE POUR LE CLERGE

Veuillez encercler le nombre ou la lettre correspondant à votre réponse, ou remplissez l'espace vide selon qu'il est indiqué.

1. Indiquez, s.v.p., votre affiliation religieuse.

   A Eglise Catholique Romaine
   B Eglise Baptiste (Specifiez la denomination s.v.p._____
   C Methodiste
   D Adventiste du septième jour
   E Eglise de Dieu
   F Assemblée de Dieu
   G Nazareen
   H Eglise Evangélique d'Haiti
   I Autre (specifiez, s.v.p.)_____

2. Depuis combien de temps etes vous dans le ministère _____ Années.

   Pour les questions numerotées 3 à 8 inclusivement, utiliser l'échelle suivante: 1= Jamais; 2=Presque jamais; 3= Parfois; 4= Souvent; 5= Presque toujours; 6= Toujours

3. Avec quelle fréquence des personnes sollicient-elles votre avis sur les problemes suivants:

	Jamais.....Toujours
Difficultés dans leur mariage	1 2 3 4 5 6
Sujets en rapport avec l'education des enfant	1 2 3 4 5 6
Sujets en rapport avec des conflits interpersonnels	1 2 3 4 5 6
Préoccupations religieuses	1 2 3 4 5 6
Conseils sur une decision à prendre	1 2 3 4 5 6
Sujets en rapport avec la sexualité	1 2 3 4 5 6
Préoccupations sur leur santé	1 2 3 4 5 6
Circonstances de la vie en général	1 2 3 4 5 6
Autres (speciez, s.v.p.)_____	1 2 3 4 5 6

4. Avec quelle fréquence les situations suivantes sont-elles observées dans la population générale.

	Jamais.....Toujours
Alcoolisme appréciable	1 2 3 4 5 6
Abus du tabac	1 2 3 4 5 6
Difficultés conjugales	1 2 3 4 5 6
Incertitude sur la vie	1 2 3 4 5 6
Environnement physique de mauvaise qualité	1 2 3 4 5 6
Pertubations politiques	1 2 3 4 5 6
Autres (specifiez, s.v.p.)_____	1 2 3 4 5 6

5. Avec quelle fréquence les maladies suivantes sont-elles observées dans la population générale.

	Jamais ..... Toujours					
Maladies du coeur	1	2	3	4	5	6
Cancer	1	2	3	4	5	6
Maladies sexuellement transmises	1	2	3	4	5	6
Tuberculose	1	2	3	4	5	6
Tétanos	1	2	3	4	5	6
Ulcères	1	2	3	4	5	6
Epilepsie ("mal caduc")	1	2	3	4	5	6
Maux de tete type migraine	1	2	3	4	5	6
Hypertension artérielle	1	2	3	4	5	6
Diarrhée chronique	1	2	3	4	5	6
Autres (spécifiez, s.v.p.)_____	1	2	3	4	5	6

6. Avec quelle fréquence observez-vous les attitudes et comportements suivants dans la population générale.

	Jamais ..... Toujours					
Une haute tolérance vis-à-vis des maladies en général	1	2	3	4	5	6
Croyance que toute maladie est un processus incontrolable	1	2	3	4	5	6
Croyance dans les causes surnaturelles des maladies	1	2	3	4	5	6
Négligence de suivre les instructions du médecin	1	2	3	4	5	6
Négligence vis-à-vis des soins personnels en général	1	2	3	4	5	6
Hygiène individuelle inadéquate	1	2	3	4	5	6
Troubles d'appétit	1	2	3	4	5	6
Comportements superstitieux	1	2	3	4	5	6
Manque de confiance dans les médecins	1	2	3	4	5	6
Autres (specifiez, s.v.p)_____	1	2	3	4	5	6

7. Avec quelle fréquence les événements suivants sont-ils rapportés dans la population générale

	Jamais ..... Toujours					
Vols	1	2	3	4	5	6
Cambriolages	1	2	3	4	5	6
Meurtres	1	2	3	4	5	6
Transformation en "zombies"	1	2	3	4	5	6
Accident de la circulation consécutif à une négligence	1	2	3	4	5	6
Dette non payée	1	2	3	4	5	6
Magie noire	1	2	3	4	5	6
Sorcelleries destinées à faire du mal à autrui	1	2	3	4	5	6
Prostitution	1	2	3	4	5	6
Pornographie	1	2	3	4	5	6
Promiscuité sexuelle	1	2	3	4	5	6
Avortement criminel	1	2	3	4	5	6
Mauvais traitement infligés aux enfants	1	2	3	4	5	6
Viols	1	2	3	4	5	6
Autres (specifiez, s.v.p.)_____	1	2	3	4	5	6

8. Avec quelle fréquence les symtomes suivants sont-ils observés dans la population?

	Jamais.....Toujours					
Sentiment de n'avoir aucune valeur intrinsèque	1	2	3	4	5	6
Pessimisme	1	2	3	4	5	6
Peur des 'Loas'	1	2	3	4	5	6
Pensées obsessives de la mort	1	2	3	4	5	6
Difficulté à contenir la colère	1	2	3	4	5	6
Lutte pour éloigner une pensée de l'esprit	1	2	3	4	5	6
Mauvaise communication entre époux	1	2	3	4	5	6
Insatisfaction sexuelle	1	2	3	4	5	6
Infidélité conjugale	1	2	3	4	5	6
Préoccupations sur le role des époux dans le foyer	1	2	3	4	5	6
Préoccupations sur la planification familiale (planning)	1	2	3	4	5	6
Stérilité	1	2	3	4	5	6
Préoccupations sur l'éducation des enfants	1	2	3	4	5	6
Jalousie	1	2	3	4	5	6
Problèmes avec les beaus-parents	1	2	3	4	5	6
Inquiétude incessante	1	2	3	4	5	6
Pensées de suicide	1	2	3	4	5	6
Troubles de sommeil	1	2	3	4	5	6
Complexe d'infériorité	1	2	3	4	5	6
Sentiments inappropriés de culpabilité	1	2	3	4	5	6
Peur de persécutions diaboliques	1	2	3	4	5	6
Difficulté à débuter des relations interpersonnelles	1	2	3	4	5	6
Resignation	1	2	3	4	5	6
Difficulté à maintenir de bonnes relations interpersonnelles	1	2	3	4	5	6
Méfiance	1	2	3	4	5	6
Tripotage	1	2	3	4	5	6

9. Indiquez, selon vous, l'importance avec laquelle les facteurs suivants prédisposent à des maladies dans la population: 1=Absolument pas important; 2=Pas très important; 3=Peu important; 4=Important; 5=Très important ; 6=Absolument très important.

Maisons surchargées	1	2	3	4	5	6
Surpopulation	1	2	3	4	5	6
Malnutrition dans l'enfance	1	2	3	4	5	6
Insuffisances alimentaires chroniques	1	2	3	4	5	6
Insalubrité/ mauvaises conditions sanitaires	1	2	3	4	5	6
Manque de programmes de vaccination	1	2	3	4	5	6
Analphabétisme/ ignorance	1	2	3	4	5	6
Autres (spécifiez, s.v.p.)_____	1	2	3	4	5	6

10. Veuillez indiquer votre opinion sur les declarations suivantes en encerclant le nombre correspondant à votre réponse : 1=Désaccord total; 2=Désaccord; 3= Désaccord Modéré; 4=Accord modéré; 5= Accord; 6=Accord total.

J'aurais aimé avoir plus de préparation pour faire face à certains des problèmes sur lesquels des gens me consultent	1	2	3	4	5	6
L'église devrait jouer un plus grand role dans le traitement ou la réhabilitation des malades mentaux	1	2	3	4	5	6
Il existe un grand besoin pour des services de santé mentale dans la population	1	2	3	4	5	6
Les maladies mentales sont le résultat de péchés personels	1	2	3	4	5	6
Il existe un grand besoin pour des psychologues et des spécialistes sur la santé mentale dans la population	1	2	3	4	5	6
La population a besoin des programmes d'éducation sur la santé mentale	1	2	3	4	5	6
J'aimerais participer à un stage d'entrainement pour apprendre à mieux faire face aux problèmes psychologiques sur les quels des personnes me consultent	1	2	3	4	5	6
La population considère beaucoup de problèmes psychologiques comme des manifestations sataniques	1	2	3	4	5	6
La psychologie et la psychiatrie sont des sciences seculaires et anti-chretiennes; et parconséquent ne devraient pas etre pratiquéespar les chrétiens	1	2	3	4	5	6
La parole de Dieu est le seul remède pour les problèmes émotionels	1	2	3	4	5	6
La plupart des troubles mentaux de l'adulte peuvent etre attribués à des expériences émotionelles survenues dans l'enfance	1	2	3	4	5	6
Le suicide est un problème majeur dans la population	1	2	3	4	5	6
Le clergé ne devrait pas participer dans la solution des problèmes de santé mentale	1	2	3	4	5	6
Il existe une relation étroite entre santé spirituelle, santé physique, et santé mentale	1	2	3	4	5	6

11. Les ressources suivantes existent-elles dans la communauté?

Psychologues donnant des consultations privées	Oui	Non
Cliniques d'orientation pour enfants	Oui	Non
Cliniques d'intervention pour les problèmesdu mariage et de la famille	Oui	Non
Programmes de traitement pour les alcooliques et les personnes adonnées à la drogue	Oui	Non
Centres de rehabilitation mentale	Oui	Non
Centres de traitement pour les troubles de la personalité	Oui	Non
Cliniques psychiatriques	Oui	Non

Autres (specifiez, s.v.p.)_____

12. Indiquez, s.v.p. les trois contributions principales de l'Eglise vers la promotion de la santé dans la population.

1 _____
2 _____
3 _____

13. Selon vous, quels sont les trois besoins de santé publique les plus prioritaires dans la population générale.

1 _____
2 _____
3 _____

14. Selons vous, quels sont les trois besoins de santé mentale les plus prioritaires dans lapopulation générale.

1 _____
2 _____
3 _____

15. Veuillez ajouter tout commentaire, suggestion ou recommendation supplémentaires dans l'espace ci-dessous.

Merci

APPENDIX I

DESCRIPTIVE STATISTICS FOR PHYSICIAN QUESTIONNAIRE

Descriptive Statistics: PHYSICIANS QUESTIONNAIRE

Var.	Mean	Mode	SD	Min.	Max.	N	Label
SPEC	3.87		2.26	1	8	23	SPECIALTY
YEARS	8.04		6.74	2	35	26	YEARS IN PRACTICE
Q3A	.96	1	.19	0	1	27	STATE HOSPITAL
Q3B	.07	0	.27	0	1	27	PRIVATE HOSPITAL
Q3C	.44	0	.51	0	1	27	GROUP PRACTICE
Q3D	.19	0	.40	0	1	27	SOLO PRACTICE
Q4A	3.48	4	1.23	1	6	25	HIGH TOLERANCE
Q4B	2.35	3	.94	1	4	26	UNCONTOLLABLE
Q4C	4.04	4	1.02	1	6	27	SUPERNATURAL
Q4D	3.44	3	.89	2	5	27	NOT FOLLOW INST
Q4E	3.50	3	.95	2	6	26	PERSONAL CARE
Q4F	3.50	4	1.10	1	6	26	PERSONAL HYGIENE
Q4G	4.12	4	.91	2	6	26	EATING DISORDER
Q4H	4.19	4	.85	3	6	26	SUPERSTITIOUS
Q4I	2.63	3	1.04	1	5	27	LACK OF TRUST
Q5A	2.04	1	1.04	1	4	24	LEGAL PROBLEMS
Q5B	2.46	3	.95	1	5	26	MARITAL PROBLEMS
Q5C	2.40	2	.96	1	5	25	PARENTING PROBLEM
Q5D	2.35	3	1.02	1	5	26	INTERPERS. CONFLI
Q5E	2.56	3	.96	1	5	25	PERSONALIT DISORD
Q5F	3.32	3	.95	1	5	25	LIFE CIRCUMSTNCES
Q5G	2.92	3	.89	1	5	26	SEXUAL CONLICTS
Q5H	2.78	2	1.31	1	6	27	POLITICAL ISSUES
Q5I	3.00	3	1.07	1	6	27	WORK PROBLEMS
Q6A	2.54	1	1.39	1	5	26	VOMITING
Q6B	1.92	1	1.23	1	6	26	LOSS OF VOICE
Q6C	2.81	4	1.20	1	5	26	CHEST PAIN
Q6D	1.42	1	.70	1	3	26	PARTIAL BLINDNESS
Q6E	1.54	1	.76	1	3	26	DOUBLE VISION
Q6F	1.88	1	1.07	1	4	26	TEMPORARY PARALYS
Q6G	2.19	1	1.44	1	5	26	URINARY RETENTION
Q6H	2.88	3	1.24	1	6	26	SEXUAL INDIFFEREN
Q6I	3.48	4	1.42	1	6	27	DYSMENORRHEA
Q6J	3.35	4	1.29	1	5	26	IRREGUL. MENSTRUA
Q6K	3.00	3	1.20	1	5	26	PMS
Q7A	1.64	1	.76	1	3	25	PEDOPHILIA
Q7B	2.48	3	.94	1	4	27	PEDERASTY
Q7C	2.04	1	1.14	1	4	25	VOYEURISM
Q7D	1.74	2	.71	1	3	27	INCEST
Q7E	2.04	1	1.06	1	5	27	EXHIBITIONISM
Q7F	2.04	1	1.06	1	5	27	MASOCHISM
Q7G	1.96	1	1.02	1	4	27	SADISM
Q7H	2.96	3	.98	1	4	27	ERECTIL DEFICIENC

PHYSICIANS QUESTIONNAIRE (CONT.)

Var.	Mean	Mode	SD	Min.	Max.	N	Label
Q7I	3.30	4	1.17	1	6	27	PREMATU EJACULATI
Q7J	2.77	3	1.03	1	4	26	IMPOTENCE
Q7K	2.07	1	.92	1	4	27	FRIGIDITY
Q7L	2.41	3	1.12	1	5	27	VAGINISMUS
Q7M	2.27	3	.96	1	4	26	EXCESSIVE MASTURB
Q7N	1.93	1	.83	1	3	27	BISEXUAL CONFLICT
Q7O	1.58	1	.76	1	4	26	BEASTIALITY
Q7P	2.60	3	.96	1	4	25	DYSPAREUNIA
Q7Q	2.59	3	1.05	1	5	27	RAPE
Q7R	2.31	3	.88	1	4	26	SODOMY
Q8A	3.69	4	.93	2	6	26	SHORTNESS BREATH
Q8B	3.52	4	.89	2	6	27	DIZZINESS
Q8C	3.50	3	.71	2	5	26	TACHYCARDIA
Q8D	2.65	2	1.29	1	6	26	PHOBIAS
Q8E	3.00	3	.69	2	5	26	POLYURIA
Q8F	3.88	4	1.03	2	6	26	SUPERSTIT BEHAV
Q8G	2.44	3	1.22	1	5	27	OBSESSIONS
Q8H	1.31	1	.55	1	3	26	KLEPTOMANIA
Q8I	3.04	4	.85	2	4	27	LOSS CONSCIOUSNES
Q8J	2.69	3	1.05	1	4	26	OBSCENE LANGUAGE
Q8K	3.04	3	1.13	1	6	27	MEMORY LOSS
Q8L	3.04	3	1.00	1	4	26	IRRITABILITY
Q8M	2.48	3	.98	1	4	27	INFANTIL BEHAVIOR
Q8N	3.26	3	1.02	1	5	27	CONSTANT FATIGUE
Q8O	2.74	3	1.29	1	5	27	PERSECUT DELUSION
Q8P	2.12	2	.83	1	4	25	INAPPROPR AFFECT
Q8Q	2.56	2	.58	2	4	25	RAP. MOOD SHIFTS
Q8R	2.68	3	.95	1	4	25	LOSS INTERES PLEA
Q8S	2.48	3	1.08	1	4	25	SOCIAL WITHDRAWAL
Q8T	3.60	4	1.29	1	6	25	INSOMNIA
Q8U	3.23	3	1.21	1	5	26	PESSIMISM
Q8V	1.92	1	.95	1	4	25	INAPPROPR GUILT
Q8W	2.13	3	.95	1	4	24	DEATH OBSESSION
Q8X	2.32	2	1.07	1	5	25	FEEL WORTHLESS
Q8Y	2.88	2	1.40	1	6	26	SUPERNAT STRENGTH
Q8Z	2.56	3	1.29	1	6	25	GRANDIOSITY
Q8AA	2.68	3	1.14	1	5	25	DIFFICUL CONCENTR
Q8BB	2.72	3	1.17	1	6	25	HALLUCINATIONS
Q8CC	2.32	3	1.18	1	5	25	PANIC ATTACKS
Q8DD	2.35	3	.98	1	4	26	FIXATIONS
Q8EE	2.52	3	1.08	1	6	25	MENTAL RETARDAT
Q8FF	2.04	2	.89	1	4	25	DEPERSONALIZATION
Q9A	3.85	4	.92	2	5	26	ULCER

PHYSICIANS QUESTIONNAIRE (CONT.)

Var.	Mean	Mode	SD	Min.	Max.	N	Label
Q9B	3.88	4	.95	1	6	26	HYPERTENSION
Q9C	2.27	2	.83	1	4	26	COLITUS
Q9D	3.62	3	.98	2	6	26	DIARRHEA
Q9E	3.40	4	1.08	2	6	25	ANOREXIA
Q9F	2.68	3	1.05	1	6	25	BULIMIA
Q9G	3.50	4	1.14	1	6	26	G-I SYMPTOMS
Q9H	3.04	2	1.04	1	5	26	EPILEPSY
Q9I	3.38	4	1.02	1	6	26	DIABETES
Q9J	4.00	4	.85	2	6	26	MIGRAINES
Q9K	3.29	3	.91	2	6	24	HEART DISEASE
Q9L	3.00	3	1.18	1	5	24	HYPOCHONDRIASIS
Q10A	2.26	2	.94	1	4	27	SCHIZOPHRENIA
Q10B	3.11	3	1.01	1	6	27	DEPRESSION
Q10C	3.81	4	1.04	1	6	27	ANXIETY
Q10D	2.78	3	.97	1	5	27	SUBSTANCE ABUSE
Q10E	3.26	4	1.15	1	5	27	HYSTERIA
Q10F	3.89	4	1.15	2	6	27	SLEEP DISORDERS
Q10G	2.64	3	1.14	1	5	25	SEXUAL DYSFUNCT
Q10H	2.89	3	1.12	1	6	27	PERSONALIT DISORD
Q10I	2.00	2	.78	1	3	27	MULTIPL PERSONALI
Q11A	3.85	4	1.13	2	6	27	ALCOHOL
Q11B	4.07	4	1.00	2	6	27	TOBACCO
Q11C	2.96	3	.94	1	4	27	MARIJUANA
Q11D	3.26	4	1.10	1	6	27	CAFFEINE
Q11E	4.56	4	.93	3	6	27	SUGAR
Q12A	2.78	2	1.09	1	6	27	BARBITURATES
Q12B	1.19	1	.48	1	3	27	LITHIUM
Q12C	2.07	2	1.00	1	4	27	ANTI-DEPRESSANT
Q12D	1.15	1	.37	1	2	26	NAVANE
Q12E	1.27	1	.72	1	4	26	ELAVIL
Q12F	1.56	1	.85	1	4	27	HALDOL
Q12G	2.59	3	.93	1	4	27	PHENOTHIAZINES
Q12H	3.63	4	1.11	1	6	27	VALIUM
Q12I	1.64	1	.73	1	3	22	OTHER MEDS
Q13A	5.07	5	.83	3	6	27	CROWDED QUARTERS
Q13B	4.96	5	1.02	2	6	27	OVERPOPULATION
Q13C	5.07	6	1.07	2	6	27	MALNUTRITION
Q13D	5.26	6	.90	3	6	27	UNDERNOURISHMENT
Q13E	5.41	6	1.01	3	6	27	INADEQUAT SANITAT
Q13F	4.15	5	1.23	1	6	27	ALCOHOLISM
Q13G	4.15	5	1.20	1	6	27	SMOKING
Q13H	4.89	5	.89	3	6	27	ILLITERACY
Q13I	3.81	4	1.14	1	6	27	LACK OF EXERCISE

PHYSICIANS QUESTIONNAIRE (CONT.)

Var.	Mean	Mode	SD	Min.	Max.	N	Label
Q13J	4.33	4	1.24	1	6	27	POOR HYGIENE
Q13K	3.92	4	1.04	1	6	25	SEXUAL ACTIVITY
Q13L	4.41	4	1.42	1	6	27	UNEMPLOYMENT
Q13M	4.07	5	1.17	1	6	27	BIRTH CONTROL
Q13N	4.85	5	1.16	2	6	26	PUBLIC HEALTH
Q13O	4.26	4	1.35	2	6	27	NATURAL DISASTER
Q14A	3.56	4	1.48	1	6	27	ALCOHO AND HEALTH
Q14B	3.74	3	1.46	1	6	27	TREAT EMOTION PRO
Q14C	4.85	5	1.03	2	6	27	MENTAL HEALT SERV
Q14D	5.11	6	.89	3	6	27	MENTAL HEALTH ED.
Q14E	4.70	5	.99	2	6	27	NEED PSYCHOLOGIST
Q14F	4.93	5	1.14	2	6	27	M H PROBL SATANIC
Q14G	4.11	4	1.40	1	6	27	PSYCHOGENIC PROBL
Q14H	2.07	1	1.11	1	5	27	SUICIDE
Q14I	4.31	4	1.16	1	6	26	CHILDHOOD ORIGINS
Q14J	3.12	4	1.51	1	6	25	CAN'T TREAT
Q14K	4.19	6	1.55	1	6	27	VODOO & HEALTH
Q15A	.48	0	.51	0	1	27	PSYCHOLOGISTS
Q15B	.00	0	.00	0	0	27	CHILD GUIDANCE
Q15C	.04	0	.19	0	1	27	MARRIAGE/ FAMILY
Q15D	.07	0	.27	0	1	27	DRUG/ALCOHL TREAT
Q15E	.19	0	.40	0	1	27	REHABILITATION
Q15F	.63	1	.49	0	1	27	PSYCHIATRISTS
Q15G	.30	0	.47	0	1	27	PERSON DIS. TREAT

APPENDIX J

DESCRIPTIVE STATISTICS FOR THE CLERGYMAN QUESTIONNAIRE

DESCRIPTIVE STATISTIC: CLERGYMEN QUESTIONNAIRE

Var.	Mean	Mode	SD	Min.	Max.	N	Label
REL	2.63		2.13	1	8	30	RELIGIOU AFFILIA
YEARS	1.87	1	0.06	1	40	30	YEARS IN MINISTRY
Q3A	3.10	3	.71	1	4	30	MARRIAGE DIFFICUL
Q3B	3.28	3	1 1.46	1	6	29	PARENTING ISSUES
Q3C	3.76	3	1.24	1	6	29	INTERPER CONFLICT
Q3D	4.17	3	1.47	1	6	29	RELIGIOUS CONCERN
Q3E	3.79	3	1.26	1	6	29	ADVICE MAKE DECIS
Q3F	3.46	3	1.48	1	6	28	SEXUAL MATTERS
Q3G	3.78	3	1.28	2	6	27	HEALTH CONCERNS
Q3H	4.97	6	1.16	2	6	30	LIFE CIRCUMSTANCE
Q4A	3.61	3	1.37	1	6	28	ALCOHOLISM
Q4B	4.21	4	1.26	1	6	28	TOBACCO
Q4C	3.80	4	.92	2	6	30	MARITAL PROBLEMS
Q4D	4.96	4	1.02	3	6	27	LIFE UNCERTAINTY
Q4E	4.37	4	1.45	1	6	30	PHYSICAL ENVIRONM
Q4F	4.96	6	1.26	2	6	28	POLITICAL UNREST
Q5A	3.50	3	1.04	1	6	30	HEART DISEASE
Q5B	2.90	3	.99	1	6	30	CANCER
Q5C	3.79	3	1.35	1	6	29	SEX TRANS DIS
Q5D	4.50	4	1.11	2	6	30	TUBERCULOSIS
Q5E	3.03	3	1.09	1	6	29	TETANUS
Q5F	3.60	4	1.22	1	6	30	ULCER
Q5G	2.97	3	.87	1	5	29	EPILEPSY
Q5H	4.47	4	1.33	1	6	30	MIGRAINES
Q5I	4.50	4	1.04	1	6	30	HYPERTENSION
Q5J	3.64	3	1.22	1	6	28	DIARRHEA
Q6A	3.66	4	1.40	1	6	29	ILLNESS TOLERANCE
Q6B	3.52	2	1.55	1	6	29	UNCONTROLL ILLNES
Q6C	5.23	5	.73	4	6	30	SUPERNAT. CAUSES
Q6D	3.83	4	1.12	1	6	30	NOT FOLLOW INSTRU
Q6E	3.90	4	1.18	2	6	29	NEGLECTING HEALTH
Q6F	4.60	4	.97	3	6	30	PERSONAL HYGEINE
Q6G	3.79	4	.96	2	6	28	EATING HABITS
Q6H	5.21	5	.73	3	6	29	SUPERSTIT BEHAV
Q6I	3.67	2	1.37	2	6	30	TRUST IN DOCTORS
Q7A	4.43	4	1.14	1	6	30	ROBBERY
Q7B	3.47	3	1.28	1	6	30	BURGLARY
Q7C	3.13	3	1.04	1	6	30	MURDER
Q7D	3.57	4	1.53	1	6	28	ZOMBIFICATION
Q7E	4.00	4	1.07	2	6	29	TRAFFIC ACCIDENTS
Q7F	4.30	4	1.15	2	6	30	UNPAID DEBTS
Q7G	4.41	5	1.08	3	6	27	SORCERY
Q7H	4.53	4	1.07	3	6	30	EVIL WITCHCRAFTS

CLERGYMEN QUESTIONNAIRE (CONT.)

Var.	Mean	Mode	SD	Min.	Max.	N	Label
Q7I	4.30	4	.95	3	6	30	PROSTITUTION
Q7J	3.32	3	1.19	1	6	28	PORNOGRAPHY
Q7K	3.69	3	1.20	1	6	29	PROMISCUITY
Q7L	3.52	3	1.09	1	6	29	ABORTION
Q7M	4.13	3	1.01	3	6	30	CHILD ABUSE
Q7N	3.03	3	.94	2	6	29	RAPE
Q8A	3.73	3	1.05	2	5	30	WORTHLESSNESS
Q8B	4.21	5	1.01	2	6	29	PESSIMISM
Q8C	4.69	5	1.00	3	6	29	FEAR OF DEMONS
Q8D	4.31	4	1.07	2	6	29	DEATH OBSESSION
Q8E	4.07	5	1.00	1	5	29	ANGER CONTROL
Q8F	3.61	3	1.13	2	6	28	OBSESSIONS
Q8G	4.03	4	.87	2	5	29	MARITA COMMUNICAT
Q8H	3.68	4	1.09	1	6	28	SEX DISSATISFACT
Q8I	4.24	4	.91	2	6	29	INFIDELITY
Q8J	4.04	3	.92	3	6	28	MARITAL ROLES
Q8K	3.82	3	1.12	2	6	28	FAMILY PLANNING
Q8L	3.04	3	.84	2	5	28	STERILITY
Q8M	4.31	5	1.04	3	6	29	CHILD REARING
Q8N	4.54	4	1.00	3	6	28	JEALOUSY
Q8O	4.13	4	.82	3	6	30	IN-LAWS
Q8P	4.70	5	1.07	2	6	27	CONSTANT WORRY
Q8Q	2.81	3	.96	1	5	27	SUICIDAL IDEATION
Q8R	4.00	4	.94	2	6	28	SLEEP DISORDERS
Q8S	4.44	5	1.12	3	6	27	INFERIOR COMPLEX
Q8T	3.73	4	1.04	2	6	26	FALSE GUILTS
Q8U	4.63	5	1.00	3	6	30	DEMON PERSECUTION
Q8V	4.18	4	1.06	2	6	28	INTROVERSION
Q8W	4.50	5	1.32	1	6	28	RESIGNATION
Q8X	4.14	4	.99	2	6	29	MAINTAIN RELATION
Q8Y	4.80	4	.92	3	6	30	TRUST ISSUES
Q8Z	5.07	6	.92	3	6	29	GOSSIPS
Q9A	5.20	6	.92	3	6	30	CROWDED QUARTERS
Q9B	5.20	6	.89	3	6	30	OVERPOPULATION
Q9C	5.48	6	.83	3	6	29	CHILD MALNUTRIT
Q9D	5.55	6	.69	4	6	29	CHRONIC UNDERNOUR
Q9E	5.62	6	.56	4	6	29	INADEQUAT SANITAT
Q9F	4.90	5	1.06	2	6	30	LACK OF VACCINATI
Q9G	5.25	6	.93	3	6	28	ILLITERACY
Q10A	5.63	6	.67	4	6	30	MORE TRAINING
Q10B	5.40	6	.67	4	6	30	CHURCH INVOLVEMEN
Q10C	5.67	6	.61	4	6	30	NEED FOR SERVICES
Q10D	2.53	1	1.53	1	6	30	SIN CAUSE MH PROB