

Depressive Symptoms Reported by Haitian Men from Armed Groups who participated in Rehabilitation Programs

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ABSTRACT

Disarmament, demobilization, and reintegration (DDR) programs combine individual and group-level interventions with change at the state-level to create the conditions for peace after civil war and other forms of violent armed conflict. At the individual level, interventions typically include disarmament of insurgents in the context of a rehabilitation program which will demobilize the armed groups and reintegrate their members into society. This study examined quantitative data from a longitudinal data set on 741 Haitian men from who participated in or qualified to participate in DDR programs after the 2004 coup. Each of the three interventions had a different focus (education with leadership training, faith-based change with job training or education, and job placement with limited training). The three interventions were compared to determine the impact that intervention type and content had on depressive symptoms of program participants. Education (both classical and vocational), as well as engagement in sports and recreation, was associated with a decrease in depressive symptoms as measured by the Beck Depression Inventory. Depression symptoms increased among men who participated in a short-term low-status job placement focused intervention. This highlights the need for interventions which empower participants through education, leadership skills, or informally (through group sports), and which provide opportunities for meaningful future careers.

Key words: Conflict, crime, depression, education, program evaluation

INTRODUCTION

In 2004 a group of heavily armed and well-funded insurgents, backed by foreign powers and the domestic elite, overthrew the elected government of Haiti. Members of the disbanded Haitian army led the insurgency, along with armed militias loyal to the country's political elite; they were assisted by members of criminal gangs and private security squads hired by some of Haiti's wealthiest families.^[1]

The armed conflict began in 2002, culminated in the 2004 ouster of President Jean Bertrand Aristide, and continued to simmer through 2007 under the violently repressive interim

government of Gerard Latitue, an American of Haitian descent from Boca Raton, Florida who was installed as the new prime minister.^[2] Democratic elections were held in 2007, at which point both state-sponsored violence and crime, in general, began to decline.^[3] Beginning in June 2004, the United Nations mission in Haiti began disarmament, demobilization, and reintegration (DDR) campaign modeled on traditional DDR programs such as those operated in Northern Uganda, Liberia, and Sierra Leone.^[4]

Men who were members of armed insurgent groups were eligible to participate in the DDR program with the condition that they agree to disarm and participate in rehabilitation programs. A number of different intervention programs were

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funded as part of the DDR effort in Haiti. This study examines three distinct programs, each with its own theory of change and resulting intervention focuses, and compares participants in each with those who were eligible but were not selected to participate in an intervention (the control group).

Intervention A: Treatment as usual (TAU)

The TAU intervention was a traditional, individually focused DDR intervention. Participants aged 18 and older had a non-residential intake period in which they completed paperwork, were assessed by a nurse or other medical professional, took an educational and vocational assessment examination, and met with project staff members. Men in this intervention were expected to attend group classes 4–7 h per day, 5 days a week, for a minimum of 60 days, and a maximum of 180 days.

The primary focus of the intervention was on providing vocational education and training in work skills so that program completers could obtain gainful employment. The theory of change supported by the program was grounded in strain theory. According to this theory, strain occurs when people are exposed to cultural values and goals which they are unable to achieve through culturally-appropriate methods.^[5] In this case, program leaders argued that combatants had embraced values which emphasized the importance of material possessions as a tangible demonstration of economic security in a turbulent social and economically changing society. As one coordinator said, “they see wealth on TV, and among those who work for the government, business owners, the elite, and they want to look rich with fancy shoes and a car because those outward trappings of wealth communicate something to the community.”

During armed conflict members of gangs and other armed groups were able to improve their social position by taking items of value from businesses and community members. These stolen goods gave combatants a sense of economic stability. Program leaders argued that lack of employment in the post-conflict era left former combatants with no option but crime to support themselves. They hoped that by providing vocational education and work skills courses, the men would obtain lawful work and have no need to turn to crime to support themselves.

Intervention B: Faith-based program

Intervention B was conducted by a faith-based nongovernmental organization (NGO) based in Port-au-Prince which was based on beliefs about individual change which has emerged from social control theory. Social control theory focuses on the durability or strength of the commitments or bonds an individual has to other individuals, his or her family or group, and society in general.^[6] This theory focuses on the human need to belong as a key motivation influencing the individual’s emotions, thinking, beliefs, and behavior.^[7]

In the field of criminology, one foundational application of this theory is in answering the question: Why do some people commit crimes while others abstain? Social control theorists answer this question by explaining that when social bonds are strong, and the individual feels connected to society, and deviant behaviors are limited.^[8] The probability of deviance is, however, increased the moment that the bonds are weak. Broken or weak bonds are not causes of delinquency per se, but they do allow delinquency to occur.^[9] The bonds which connect a person to society or a group include: (1) Attachments (e.g., an expression of concern that motivates the person to avoid or decrease crime to avoid frustrating a respected person or the group as a whole); (2) commitments (e.g., the investment of time, energy, or oneself which could be placed at risk by deviant behavior); (3) involvements (e.g., becoming so consumed by other activities that there is less time or energy for delinquent pastimes); and (4) beliefs (e.g., being socialized into and internalizing the value system of a group or society).

Services offered within Intervention B included six core components: Spiritual growth, personal development, life skills, education foundations, professional exploration, training, and development, and community integration. Each of these components focus on aspects of introducing, promoting, teaching, internalizing, and strengthening beliefs and behaviors tied to social bonds, which ultimately creates a situation in which the program participant responds to social controls and refrains from criminal behaviors.

Sports and organized recreation were emphasized as a key part of facilitating community integration (through organized football play in neighborhood leagues as well as free play in participant’s own neighborhood). Sports and organized recreation activities were used to teach life skills. In one activity participants went horseback riding and were coached on how to interact with the horse in a way that was respectful, calming, and which met the horse’s needs to food, water, rest, and affection. Participants had to delay meeting their own needs until after caring for the horse and had to control their voices and actions to avoid startling the animal or causing it anxiety. Sports were used daily or every other day afternoon break during classes and meetings. They were frequently used in metaphors and analogies. Sports were even integrated into bible study lessons and math tutoring.

Intervention C: Education focused intervention

Intervention C was a sustained effort by four NGOs to promote professional and classical education opportunities to violence-involved youth and young adults throughout Haiti. Services provided as part of Intervention C can be roughly categorized into seven service areas: (1) Educational assessment, case management, and support including workshops and disability services; (2) education provision including individual and small group tutoring, classical school, high school completion, vocational school, Philo

(postgraduate year of study) and post-secondary academic learning; (3) direct services and coordination of services related to housing, medical/dental care, mental health care, obtaining documents, substance abuse treatment, accessing food aid, low-cost and free childcare options, and transportation; (4) life skills training; (5) pro-social political involvement opportunities and coaching including public advocacy, and service learning and community service; (6) vocational skills and practical experience including workshops, internship placement and supervision, and vocational mentorship; and (7) sports and recreation.

Intervention C's theory of change emerged from the founding NGO's focus on social ecology and reduction of social disorganization.^[10] Social ecology emphasizes the importance of place.^[11] Crime is linked to deficits in the participant's neighborhood, and it was these deficits that made participants more vulnerable to engaging in crime and joining armed groups. Recognizing that members of armed groups have been socialized into the adoption of values that embrace crime,^[12] Intervention C's leadership theories that group members can, through a process of education and resocialization, transform their values and adopt the values of those who participate in education (who are a distinct group within Haitian society). Participants thus move from being insurgents to being scholars.

Intervention C's theory of change took this one step farther. Participants changed their views and values through the process of resocialization into a new (educationally focused) community while at school. This was facilitated by being housed in school dormitories during the week, an element of place-changing which was intentionally included in the intervention. The process of resocialization continued when participants were home in their community. When participants went home on the weekends they were expected to engage in pro-social political organizing to change and challenge the marginalization experienced by their communities. In this way, participants could disrupt the normative structure of the own community to argue for and promote other values while also advocating for changes in social structures that belittle, marginalize, and oppress residents of poor zones.

At the micro-level, staff emphasized how this works because, they argue, an individual's self-perceptions and identity can have a significant impact on their potential for success post-demobilization. Job readiness training increases the tenacity of participants or builds on tenacity that participants possess before the program, in spite of challenges. Furthermore, it can improve an individuals' ability to cope with difficult life situations. Ultimately, these factors empower individuals and enable them to approach post-intervention life with more confidence. This is grounded in the literature which argues that though stigma and limitations on agency exist, empowerment through education or job skills training reduces a propensity

toward recidivism.^[13] Ellison offers support to this perspective of the role of education in the peacebuilding process.^[14] He offers five strong theoretical viewpoints. First, skills training provide opportunities for employment and make violence a less attractive option. Second, education protects participants by promoting disaster survival and preparedness skills. Third, education helps re-establish "normality" for young people. Fourth, education helps make up lost ground and helps deter future violence. By raising the opportunity cost of going to war for a now-educated individual, people are less likely to take risks with violence. Finally, education contributes to social transformation by infusing various social sectors with more human capital. Each of these aspects of education is touched on in the programmatic content of Intervention C's activities.

METHODOLOGY

The dataset included information on 741 men (aged 18–31 at baseline) in three treatment groups and two non-treatment groups. The treatment groups included: Intervention A, a traditional, "TAU" approach, which included 50 men (6.7% of the study participants); Intervention B, a faith-based intervention, which included 150 men (20.2 of the study participants); and Intervention C, an education-focused program, which included 252 (34% of the study participants). The two non-treatment groups were comprised of men who were eligible and were offered the opportunity to participate but refused to do so ($n = 45$; 6.1% of the study participants) and men who were eligible to participate but were not selected to do so ($n = 244$; 32.9% of the study participants).

Study participants were interviewed in Haitian Creole by trained research assistants at baseline (when they started the intervention), 6 months later, 12 months post-baseline, and then annually for 5 more years. In addition to obtaining qualitative data and completing a medical and occupational assessment, each participant also completed a series of clinical measures during the research interview. One of these measures was the Beck II, otherwise known as the Beck Depression Inventory (BDI).

The BDI was developed in 1961 as a 21-item, administer-assisted questionnaire aimed at assessing the presence and intensity of depression-related symptoms.^[15] The development of the BDI was remarkable in that its focus on symptoms represented a dramatic shift away from the dominant psychodynamic conception of depression of the time.^[16] The BDI has undergone several revisions to reflect the DSM's changing diagnostic criteria for depression, with the most recent revision being the Beck Depression Inventory, version 2 (BDI-II).^[17] Today the BDI-II is one of the most frequently-employed depression assessment tools in research and clinical settings. The BDI-II contains the same number of items as the original BDI but differs somewhat

in item content.^[18] Furthermore, the BDI-II is completely self-administered.^[19] Norms were established based on a standardization sample comprised 317 female outpatients and 183 male outpatients from urban and rural settings.^[20] Ages ranged from 13 to 86. 91% of the outpatients in the sample were Caucasian. 4% were African-American, and 1% were Asian.

Research indicates that BDI-II scores correlate with those of other depression-assessment measures, such as the Hamilton Psychiatric Rating for Depression and the Scale for Suicidal Ideation.^[21] Reliability is high, with research yielding an alpha level of 0.92 for outpatients and 0.93 for college students. A study of 26 of 26 outpatients referred for depression revealed a 1-week test-retest correlation of 0.96.^[20] A 2005 study demonstrated the validity of the BDI as a depression assessment measure among African-Americans in a clinical setting.^[22] A study of Caucasian and Mexican American students found no difference in reliability between the groups.^[20] The BDI-II contains 21 items. Each item has four possible responses. Each response corresponds with a number ranging from 0 to 3. Respondents are to circle the number associated with their chosen response. Scores are obtained by summing the numbers circled. Scores range between 0 and 63.^[23] Interpretation is as follows: 14–19 = mild, 20–28 = moderate, and 29–63 = severe.^[24]

To examine the association between categorical variables (e.g., program type) and quantitative ones (e.g., locus of control scores), I compared the means of the quantitative variable distributions in the different groups. In cases where the categorical variable had three or more categories, I did a comparison of means through analysis of variance (ANOVA). The requirements for an ANOVA are: (1) Each group must have a normal distribution or have >30 cases and (2) variances must be homogeneous in all of the groups. In cases where the variable does not have a normal distribution a non-parametric test was used; I used a Kruskal–Wallis test in these cases as I had more than two groups and thus, could not use a Mann–Whitney U-test.

Findings

The difference in focus among the interventions was most obvious when it came to the amount and type of education the participants received. None of the intervention participants reported receiving vocational education in the 6 months before baseline. Among those who were eligible to participate in DDR but were not selected, three individuals indicated that they had attended vocational training programs. The mean number of hours of vocational training at baseline was 3.20 h (standard deviation [SD]: 29.109). At T2, T3, and T4, Intervention B had the highest mean number of hours of formal vocational education with a mean of 246.65 h (SD: 91.176), 329.74 h (SD: 492.88), and 285.54 h (409.376), respectively. The relationship between group and hours of

formal vocational training was statistically significant at each data collection point after baseline.

A depression measure was included in the study, as depression has been tied to the locus of control, traumatic and stressful experiences, self-efficacy, academic achievement, vocational performance, learning ability, poor emotional regulation, and involvement in criminal activity. Depression was common with 60–70% of the study population exceeding the symptomatic threshold for depression at any given time.

It was hypothesized that receiving services and participating in a rehabilitation program of any type would be positive and would have a protective effect on depression, either reducing scores or preventing moderate scores from increasing, as the participants worked to improve their lives and their future prospects looked brighter. However, this was not the case.

The focus of the intervention itself appears to have a strong relationship with depression scores. For participants in Intervention A (TAU), which used short training courses and prepared men for jobs associated with low social status (e.g., making charcoal or working construction) without addressing other elements of rehabilitation, depression increased during the 1st year [Figure 1]. There was a statistically significant relationship between intervention/control group and depression; a higher percentage of Intervention A's participants were depressed at all points after T1 when compared to the other two intervention groups. Depression among Intervention B and Intervention C participants decreased over 6 years.

Education (both classical and vocational), as well as engagement in sports and recreation, was associated with a decrease in depressive symptoms as measured by the BDI-II. When comparing the control group of men who were eligible but not selected to participate in a program with those in Intervention A, by T8, the men in the control group had a slightly lower average score on the BDI-II, indicating that they were less likely to be depressed than those who participated in Intervention A. This relationship was statistically significant.

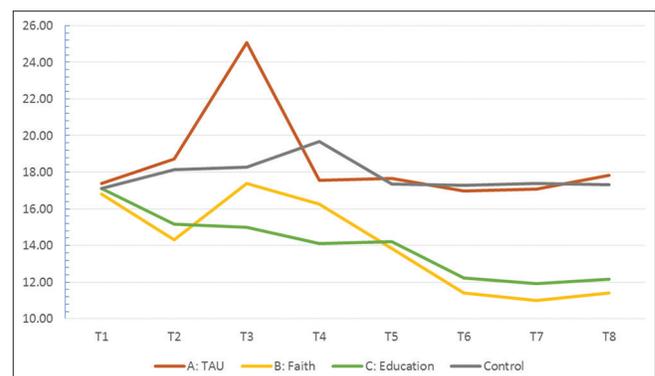


Figure 1: Mean scores on the Beck Depression Inventory by group over time

CONCLUSION

Haitian men who were involved in armed conflict and were members of insurgent groups during the coup period were particularly vulnerable to depression with more than half of all men exceeding the symptomatic threshold for depression as measured by the BDI-II when they were first interviewed. Men who participated in a rehabilitation program which used traditional methods to prepare them for a low-status job were prone to more severe depression and an increase in depressive symptoms during the 1st year of their rehabilitation. However, depressive symptomology decreased for men who participated in interventions which focused on educational transformation, spirituality, integration of sports and recreation, and training or vocational education for a higher status career. As men became more successful in their classes and internships, they became more confident and less depressed. It is clear that the focus of the intervention matters. Future work with insurgent and crime-involved men should consider how the program focus empowers men and gives them hope for a long-term career.

AUTHOR'S DECLARATIONS

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