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Perceived discrimination, humiliation, and mental health: a mixed-methods study among Haitian migrants in the Dominican Republic

Percepción de discriminación, humillación, y la salud mental: estudio de métodos mixtos entre migrantes haitianos en la República Dominicana

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Objective. Many Haitian migrants live and work as undocumented laborers in the Dominican Republic. This study examines the legacy of anti-Haitian discrimination in the Dominican Republic and association of discrimination with mental health among Haitian migrants.

Design. This study used mixed methods to generate hypotheses for associations between discrimination and mental health of Haitian migrants in the Dominican Republic. In-depth interviews were conducted with 21 Haitian and 18 Dominican community members and clinicians. One hundred and twenty-seven Haitian migrants participated in a pilot cross-sectional community survey. Instruments included culturally adapted Kreyòl versions of the Beck Depression Inventory (BDI) and Beck Anxiety Inventory (BAI) and a locally developed function impairment scale.

Results. Haitian migrants described humiliation (*imilyasyon*) as a reason for mental distress and barrier to health care. Dominicans reported that discrimination (*discriminación*) was not a current social problem and attributed negative social interactions to sociocultural, behavioral, and biological differences between Dominicans and Haitians. These qualitative findings were supported in the quantitative analyses. Perceived discrimination was significantly associated with depression severity and functional impairment. Perceived mistreatment by Dominicans was associated with a 6.6-point increase in BDI score (90% confidence interval [CI]: 3.29, 9.9). Knowing someone who was interrogated or deported was associated with a 3.4-point increase in BAI score (90% CI: 0.22, 6.64).

Conclusions. Both qualitative and quantitative methods suggest that perceived discrimination and the experience of humiliation contribute to Haitian migrant mental ill-health and limit access to health care. Future research should evaluate these

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associations and identify intervention pathways for both improved treatment access and reduction of discrimination-related health risk factors.

Keywords: migration; mental health; discrimination; Dominican Republic; Haiti; undocumented

Objetivo: Muchos inmigrantes haitianos viven y trabajan sin documentos en la República Dominicana. Este estudio examina la discriminación haitiana en la República Dominicana, y su asociación con la salud mental de los migrantes haitianos.
Diseño: Se realizaron métodos mixtos para generar hipótesis sobre las asociaciones entre la discriminación y la salud mental de migrantes haitianos en la República Dominicana. Entrevistas de profundidad fueron conducidas con 21 haitianos y 18 dominicanos en la comunidad y en varias clínicas. Una muestra probabilística de 127 haitianos participaron en una encuesta de corte transversal, que incluyó un Inventario de Depresión de Beck (BDI) y un Inventario de Ansiedad de Beck (BAI) adaptados a la cultura haitiana y una escala de evaluación de función.
Resultados: Los haitianos describieron la humillación (imilyasyon) como una razón de la angustia mental y una barrera a la búsqueda de atención médica. Los dominicanos contestaron que la discriminación no era un problema corriente social, citando diferencias socioculturales, tanto como diferencias en comportamiento, y en lo biológico entre dominicanos y haitianos como obstáculos a la interacción positiva social. El análisis cuantitativo apoyó estos resultados cualitativos. La discriminación percibida fue asociada con la severidad de depresión y la dificultad funcional. La percepción de maltrato percibido de haitianos por dominicanos fue asociado con un aumento de 6.6 puntos en el promedio del BDI (IC 95%: 3.29, 9.9). Conocer a alguien interrogado o deportado fue asociado con un aumento de 3.4 puntos en el promedio del BAI (90% IC: 0.22, 6.64).
Conclusión: Ambos métodos cualitativos y cuantitativos sugieren que la discriminación percibida y la experiencia de humillación contribuyen significativamente a la angustia mental de los migrantes haitianos y son barreras al acceso a la asistencia médica. En el futuro, las investigaciones deberían evaluar estas asociaciones e identificar modos de intervención para mejorar el acceso a la asistencia médica y reducir el efecto de discriminación.

Palabras clave: migración; salud mental; discriminación; República Dominicana; Haití; indocumentado

Introduction

The links among globalization, migration, and mental health have drawn increased scrutiny (Lindert et al. 2009; Bhugra et al. 2011). Every year, an estimated 214 million people migrate across national borders (IOM 2013), often triggered by political, socioeconomic, or environmental pressures. An estimated 10–15% of international migrants are classified as 'illegal,' undocumented, unauthorized, or irregular.

'Migration on the periphery' refers to the movement of generally uneducated, rural residents of impoverished regions on the periphery of development to areas of marginally improved living standards, often making periodic return trips to their poorer sending communities (Martinez 1995). Labor migrants often find themselves simultaneously needed but unwanted, indispensable to growing economies, yet deemed a threat to cultural and national identities. This bears important consequences for their health.

When host societies construct concepts of legitimacy and deservingness, those failing to meet such criteria are excluded from political and moral spheres, where their 'lives, bodies, illnesses, and injuries' are considered less worthy (Willen 2012, 806). They undergo a stigmatizing process of being 'othered,' based on supposedly intrinsic differences between

the dominant 'us' and nondominant 'them' (Grove and Zwi 2006), the citizen and noncitizen (Bail et al. 2012), and the deserving and undeserving (Sargent 2012). Newly arrived migrants must navigate these hierarchical categories, coming to recognize their own marginalized social status. For example, in contrast to their first-generation peers, second-generation Mexican immigrant women in the USA more readily reference their Mexican identity as a reason that stigmatizing practices are directed toward them, contributing to their psychosocial distress (Viruell-Fuentes 2007; Viruell-Fuentes, Miranda, and Abdulrahim 2012).

Perceived discrimination and mental health

Perceived discrimination only exacerbates existing consequences of migration arising from diminished social support, exhaustion, exposure to trauma, and acculturative stress (Bhugra et al. 2011; Bhugra, Wojcik, and Gupta 2011). The harmful impact of perceived discrimination on migrant mental health has been documented (Lin et al. 2011; Llácer et al. 2009). Chronic, everyday discrimination predicts poor mental health after controlling for other sources of distress and socioeconomic status (Williams, Yan Yu, Jackson 1997). There are three major pathways whereby perceived discrimination can affect mental health (Jones 2000). The first is through institutional practices that restrict socioeconomic mobility. The second is through interpersonal experiences of discrimination. The third occurs when members of the minority group internalize stigmatizing attitudes and beliefs about themselves (Williams and Williams-Morris 2000). The last pathway is especially useful in understanding *public regard*, or the manner in which one racial or ethnic group perceives the attitudes of another group toward them (Sellers et al. 1998).

Haiti, the Dominican Republic, and anti-Haitianismo

Haiti and the Dominican Republic share the Caribbean island of Hispaniola, yet there are stark economic and human development disparities between the two (World Bank 2012a, 2012b). Indeed, poverty is a leading determinant of migration from Haiti to the Dominican Republic (Ministerio de Trabajo 2011).

Today, there are an estimated 500,000 to 1.5 million Haitians and Haitian descendants in the Dominican Republic, the majority undocumented, and many having lived in the country for two or more generations (Canales, Vargas Becerra, and Montiel Armas 2009). The imprecise population estimate of Haitian migrants in the Dominican Republic reflects the more fundamental – and political – nature of migrant Haitian–Dominican relations: although migrant workers have established themselves within Dominican society, they remain a largely marginalized and unrecognized population.

With roots in European colonialism, anti-Haitianism (*anti-haitianismo*) is a view of Haitians as more African, less civilized, superstitious practitioners of Vodou (Howard 2007). Officially promulgated during the Trujillo dictatorship (1930–1961), *anti-haitianismo* is an ultra-nationalistic, overtly racist ideology; those appearing 'more Haitian' occupy the lower strata in a racial–moral hierarchy (Bartlett, Jayaram, and Bonhomme 2011). Nonetheless, race in Dominican culture is a complex construct, as the majority of Dominicans share some degree of African ancestry (Sagas and Inoa 2003).

The purpose of our exploratory study was to formally investigate the relationship between perceived anti-Haitian discrimination and migrant mental health in the Dominican Republic.

Methods

Setting

Data were collected during March–April 2011 in the Duarte Province, Dominican Republic (Figure 1). In 2008, Duarte Province had a population of 310,357 (SESPAS 2008), mostly concentrated in urban and peri-urban areas. Lying two hours from the capitol Santo Domingo, San Francisco de Macorís is the province's largest city. Smaller communities lie on the outskirts of San Francisco and throughout the province, where production of rice and cacao is common and where many Haitian migrants live and work.

Research was facilitated through a longstanding research partnership between US University, Dominican University, and the regional public hospital Blinded. The partnership comprises community-based participatory research, engaging community members, community health workers (CHWs), and in-hospital staff to seek improved quality of care (Foster, Burgos et al. 2010; Foster, Chiang et al. 2010).

The study team comprised four multilingual (English-Spanish or Kreyòl-Spanish-French), locally hired research assistants (RAs), including one Dominican and three Haitians. The lead author, proficient in Kreyòl, French, and Spanish, coordinated the study. RAs were trained in obtaining verbal informed consent, confidentiality, and all data collection procedures.

Data collection sites included the public hospital, regional clinics, and six predominantly migrant Haitian communities in and around San Francisco de Macorís. We purposively selected Haitian migrant communities through discussions with professional partners in the Ministry of Health, Haitian community members, and Dominican clinical

Figure 1. Map of Dominican Republic and Haiti with study site circled (source: image from Google Earth).

staff. One community was located within the urban core of the city, and the remaining five were located in rural settings.

The study was approved by the Emory University Institutional Review Board and the Ethics Committee of the regional hospital. All participants gave verbal informed consent.

Data collection: conceptual overview

We integrated qualitative and quantitative methods throughout the research process to explore migrant experiences and their mental health (Johnson, Onwuegbuzie, and Turner 2007; Figure 2). Mixed-methods approaches have been used for studies of mental health and discrimination in both high-income and low-income country settings (Shariff-Marco et al. 2009; Kohrt 2009; Kohrt et al. 2009). After identifying Haitian migrant communities, we used qualitative and quantitative methods to gather preliminary data and build rapport. Haitian RAs visited the communities to explain the project's purpose, conduct a household-level census, perform free-listing activities regarding daily tasks, and pilot a survey. After these activities, the team met to discuss results and overall impressions, challenges, and reactions in the community. During these debriefing sessions, we became aware of the centrality of perceived discrimination. Following this, the team met on an ongoing basis with research partners and community members to reevaluate the project's focus and methodology. Steps taken during this iterative process included development of two survey questions to target public regard among Haitian migrants and questions and probes for in-depth interviews with community members and clinicians.

Qualitative data collection and analysis

For in-depth interviews, purposive sampling was used, with the aim of identifying individuals with a unique insight into the lived experience of Haitian migrants, perceptions and experiences of discrimination, and mental health (Table 1). These interviews explored perceptions, attitudes, and beliefs regarding migration from Haiti, perceptions and experiences of racism and discrimination, clinical experiences, treatment-seeking behavior, and causes and symptoms of mental distress. In-depth interviews lasted 30–60 minutes and were

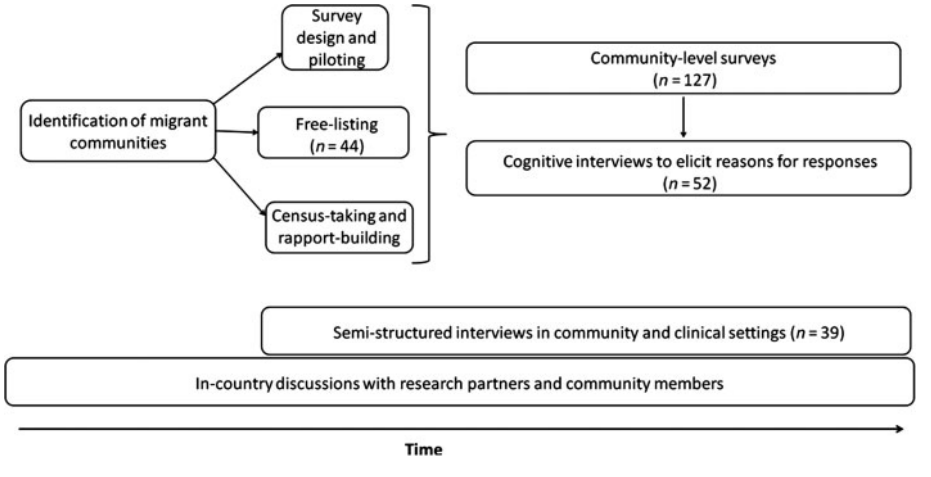

Figure 2. Chronological outline of mixed-methods data collection.

Table 1. In-depth interview participants (n = 39).

Social group	ID	Occupation	Gender	Age range
Migrant Haitian	MH01	Construction worker	Male	20s
	MH02	Construction worker	Male	Ω
	MH03	Market vendor	Female	20s
	MH04	Market vendor	Female	20s
	MH05	Market vendor	Female	Ω
	MH06	Market vendor	Female	30s
	MH07	Rice farm laborer	Male	40s
	MH08	Rice farm laborer	Male	30s
	MH09	Rice farm laborer	Male	20s
	MH10	Rice farm laborer	Male	20s
	MH11	Rice farm laborer	Male	30s
	MH12	Rice farm laborer	Male	20s
	MH13	Rice farm laborer	Male	40s
	MH14	Rice farm laborer	Male	20s
	MH15	Rice farm laborer	Male	20s
	MH16	Ice cream salesman	Male	20s
	MH17	Student, market vendor	Female	20s
	MH18	Mason	Male	30s
	MH19	Unemployed	Female	30s
	MH20	Ω	Male	30s
	MH21	Ω	Male	20s
Dominican	DM01	Medical doctor	Female	40s
	DM02	Medical doctor	Male	20s
	DM03	Medical doctor	Female	20s
	DM04	Medical doctor	Male	Ω
	DM05	Medical doctor	Male	Ω
	DM06	Nurse	Female	30s
	DM07	Nurse	Female	40s
	DM08	Nurse	Female	50s
	DM09	Nurse	Female	20s
	DM10	Nurse	Female	Ω
	DM11	Nurse	Female	30s
	DM12	Nurse	Female	Ω
	DM13	Nurse	Female	40s
	DM14	Psychologist	Female	40s
	DM15	Employer of migrants	Male	50s
	DM16	Employer of migrants	Male	50s
	DM17	Charity worker	Female	50s
	DM18	Shop owner	Female	40s

Note: Ω = Missing information

conducted by the lead author with a bilingual RA or by the RAs alone. To reduce bias and ensure comprehension and comfort among interview participants, a Dominican RA interviewed Dominican participants and Haitian RAs interviewed Haitian participants. All interviews were audio-recorded, transcribed in Kreyòl or Spanish by native-speaking RAs, and then translated into English by bilingual speakers.

A free-listing activity was utilized to develop a function impairment instrument for use in community surveys. Haitian RAs purposively sampled 21 men and 23 women in rural and urban communities. Participants listed important tasks in daily life. The 10 most frequently cited tasks by sex were included in the function impairment instrument (Bolton

and Tang 2002). During the community-level survey, participants rated their degree of difficulty in completing those tasks. Among 99 of 127 survey participants, reasons for functional difficulty were elicited and coded as perceived anti-Haitianism, economic difficulties, or other.

Brief (10–15 minutes) cognitive interviews were conducted among 52 of the 127 survey participants to better determine reasons for providing answers to survey items on the culturally adapted Kreyòl versions of the Beck Depression Inventory (BDI) and Beck Anxiety Inventory (BAI). Participants were purposively selected based on severity of responses to certain survey items (e.g., feeling worthless, sadness, pessimism). Five cognitive interviews were audio-recorded, transcribed, and translated into English; the remaining were recorded in field notes taken by RAs, who wrote key words and phrases used by respondents.

An important challenge regarding these interviews was the inherent power imbalance between the research team and participants, particularly in migrant communities. Haitian migrants in the Dominican Republic are little recognized, and many live in fear and suspicion of outsiders. Given this context, the particularly sensitive topics of mental health and perceived discrimination, and the close proximity that qualitative methods bring to bear between researchers and participants, we strove to adhere to ethical principles requiring us to articulate the project's beneficence, ensure it minimized harm and maintained confidentiality, and strike a balance between our goals as researchers with the interests and potential repercussions felt among participants (Hennink, Hutter, and Bailey 2011).

At times, informal meetings were held with multiple gatekeepers within the communities. These contacts were facilitated by the locally hired Haitian RAs, themselves familiar with the communities. To build rapport with Dominican participants, we relied on well-established relationships at the administrative level in the public hospital and regional office of the Ministry of Health.

We pursued an exploratory-descriptive level of qualitative analysis (Figure 3; Sandelowski and Barroso 2003). The lead author first reviewed all transcripts and field notes. Based on these initial readings, parent codes were created. All codes were compiled into a codebook with definitions, inclusion and exclusion criteria, and examples. The codebook was reviewed by the first and second authors for agreement. Codes were clustered to become parent codes around broadly prevalent themes, such as the migrant experience, sources and barriers to health care, perceptions of Haitians among Dominicans and vice versa, and causes of mental distress. Parent codes were applied to all texts, and additional subcodes were created in a sequential manner through indexing of *in vivo* terms or memos about subjects that continually resurfaced under each parent code. MaxQDA10 software was used to manage the coding and analysis (VERBI 1989–2010).

Quantitative instruments and analysis

Across the six communities, we conducted a pilot survey of migration and mental health experiences with 127 adult Haitian migrants. Each survey participant self-identified as Haitian and reported having migrated from Haiti to the Dominican Republic. Survey participants were identified through systematic random sampling. In each of the six migrant communities, we conducted a census of all Haitian households. We then used probability proportional to size to draw samples from each community so that each participant belonged to a different family.

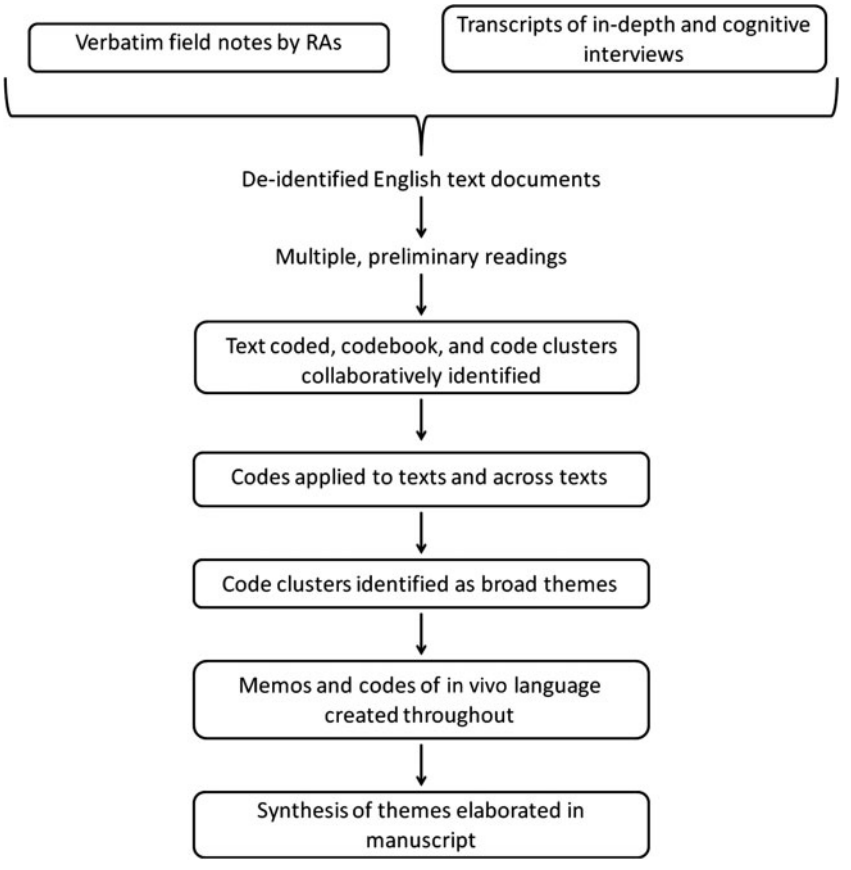

Figure 3. Conceptual outline of qualitative data analysis pathway.

Each participant completed a migration history questionnaire, culturally adapted BDI and BAI, and the function impairment instrument for men or women. The BDI and BAI comprise 21 items and are based on experiences over the previous two weeks. Total score can range from 0 to 63; higher scores indicate greater severity (Beck, Ward, and Mendelsohn 1961). For the BAI, item 20 (facial flushing) was found not to be applicable and was removed, so the highest possible score is 60 (Kaiser et al. 2013). The migration history questionnaire captured basic demographics, place of origin in Haiti, reason for leaving, length of time in the Dominican Republic, perceived discrimination, and public regard, all of which were developed and refined while in country after piloting and discussions with RAs.

The BDI and BAI have been culturally adapted for use with Haitian populations (Wagenaar 2012; Kaiser et al. 2013). The instruments underwent a transcultural translation and adaption process for psychiatric instruments (van Ommeren et al. 1999; Kohrt et al. 2011). The process involves several stages of translation and discussion involving bilingual lay individuals, bilingual professionals, general community members, and independent bilingual experts. This assures each item in the adapted instrument demonstrates semantic, technical, content, criterion, and conceptual equivalence (Flaherty et al. 1988). In the instrument development study, BDI mean (*M*) was 22.9, standard deviation (SD) was 12.2,

and Cronbach's alpha (α) was 0.89; BAI M = 23.1, SD = 18.3, and α = 0.94 (Kaiser et al. 2013).

All survey data were entered into Excel 2007, checked for data entry errors and implausible values, and analyzed using SAS 9.3 (SAS Institute Inc. 2011). Because this represents the first study of its kind among this population, quantitative analysis was exploratory. To account for small sample size, we calculated 90% confidence intervals ($p < 0.10$), as analysis was hypothesis generating rather than aiming to carry strong inferential weight. Multivariable linear regression models were constructed, with continuous depression total score, anxiety total score, and functional impairment total score as outcomes for separate models. Continuous outcomes were deemed more appropriate than categorical to optimize the variance of the small sample size and due to lack of validated categorical cut-offs for the instruments. BDI, BAI, and functional impairment scores were normally distributed. For individuals with missing or no response to instrument items, we imputed values by taking the individual's mean score for answered items and then multiplying by total items on the screener. Seventy-nine percent of observations were complete for the BDI, with 15% missing only one item (either item 10 or 11). Seventy-six percent were complete for the BAI, with 18% missing only one item and 5.5% missing two or more items. Ninety-two percent were complete for the function impairment instrument.

Exploratory analysis began with all likely predictive and confounding variables. Variables considered for inclusion in the models were age, sex, marital status, migrated alone, knew someone in the Dominican Republic prior to migrating, engages in periodic round-trips between Haiti and the Dominican Republic, number of household members, feels that Dominicans mistreat Haitians, feels that there are problems between Haitians and Dominicans, ever been interrogated or deported, and knew someone who had been interrogated or deported.

Backward selection procedures ($\alpha < 0.10$) were used to obtain final models. To establish significance of predictor variables, t-tests were used. Clustering effects were accounted for by creating dummy variables for each community. Cook's D, leverage values, jackknife residuals, and partial residual plots were examined in the final model to assess for effects on the values of regression coefficients, extremeness of observations in relation to independent predictors, outliers, and violations of the linearity assumption. Significant differences in functional impairment scores between men and women were computed through t-tests.

Results

Quantitative findings

The community survey sample was young (M = 33 years, range 18–58 years), largely uneducated (men's education M = 4.5 years, range 0–14 years; women's education M = 3.9 years, range 0–9 years), and mostly male (59%) (Table 2). Most individuals had migrated within the last 10 years (mean length of time 7.3 years, range 0.5–30 years), had known someone in the Dominican Republic before migrating (54%), and engaged in periodic round-trips between the two countries (79%). 'Problems between Haitians and Dominicans' or that 'Dominicans mistreat Haitians in this community' were reported by 26% and 29% of the sample, respectively. Twenty-nine percent reported a personal experience of having been interrogated or deported or of knowing someone who was.

Table 2. Demographics and migration characteristics of Haitian migrants (n = 127).

Characteristic	*N* (%)
Female	53 (41.7)
Persons per household	4.42 (range 1–16)
Persons married	23 (18.4)
Persons with children	102 (80.9)
Primary reason for migration	
Economic insecurity	98 (81)
Family	6 (5.0)
Hunger/sickness	6 (5.0)
Security/government	2 (1.7)
Other	9 (7.4)
Migrated with family	38 (30.4)
Migrated alone	46 (36.8)
First time in Dominican Republic at the time of survey	26 (20.8)
Knew someone in Dominican Republic before migrating	67 (54.0)
Had job arranged in advance	16 (12.8)
Engage in periodic round-trips	100 (78.7)
Send remittances back to Haiti	100 (79.4)
Suffer >3 months of inadequate money to buy enough food for self or family	61 (48)
Access to a toilet or latrine	93 (76.9)
Obtain drinking water through purchase	71 (57.3)
Report that 'there are problems between Dominicans and Haitians in my community'	33 (26.2)
Report that 'Dominicans mistreat Haitians in my community'	36 (28.8)
Cite being Haitian or 'not being in my country' as a reason for difficulty in completing daily tasks	31 (31.3)
Past experience of interrogation or deportation – self	13 (10.4)
Past experience of interrogation or deportation – knowing another	31 (25)
Report past experience of being attacked or robbed	17 (13.9)

BDI and perceived discrimination

Mean imputed BDI score for the sample was 27.11 (90% confidence interval [CI]: 25.23, 28.98; median 27; $\alpha = 0.85$). The final linear model for depression had an r^2 of 0.41 and revealed no significant multicollinearity (variance inflation factor [VIF] < 10). Significant covariates of BDI score were being married (protective effect; $a\beta = -5.08$; CI −9.26, −0.9), migrating to the Dominican Republic alone ($a\beta = 5.45$; CI 2.28, 8.62), feeling that Dominicans mistreat Haitians ($a\beta = 6.59$; CI 3.29, 9.9), and having ever been personally interrogated or deported ($a\beta = 5.22$; CI 0.14, 10.29; Table 3).

Table 3. Multivariable linear regression of Kreyòl Beck Depression Inventory (BDI) total score for Haitian migrants in the Dominican Republic, March–April 2011 (n = 119).

Covariate	$a\beta$ (90% confidence interval)
Married	−5.08 (−9.26, −0.90)
Came alone	5.45 (2.28, 8.62)
Reports that Dominicans mistreat Haitians in community	6.59 (3.29, 9.90)
Ever interrogated or deported	5.22 (0.14, 10.29)

BAI and others' experiences of discrimination

Mean imputed BAI score was 16.17 (CI: 14.92, 17.42; median 16.33; $\alpha = 0.85$). The final linear model for anxiety had an r^2 of 0.33 and revealed no significant multicollinearity (VIF < 10). Being married and having migrated to the Dominican Republic alone were associated with worse mental health ($a\beta = 4.43$, CI: 0.63, 8.24 and $a\beta = 3.37$, CI: 0.24, 6.51, respectively). Having an acquaintance who had experienced interrogation or deportation was associated with higher anxiety score ($a\beta = 3.46$, CI: 0.39, 6.53; Table 4). Additionally, participants living in communities that are remote or with more reports of violent retaliation by Dominicans against Haitians tended to have higher anxiety scores on average.

Table 4. Multivariable linear regression of Kreyòl Beck Anxiety Inventory (BAI) total score for Haitian migrants in the Dominican Republic, March–April 2011 ($n = 119$).

Covariate	$a\beta$ (90% confidence interval)
Married	4.43 (0.63, 8.24)
Came alone	3.37 (0.24, 6.51)
Knows someone who was interrogated or deported	3.43 (0.22, 6.64)
Community[a]	
A	9.89 (4.67, 15.11)
B	12.51 (7.71, 17.32)
C	6.38 (−0.12, 12.88)
D	4.84 (−0.04, 9.71)
E	3.98 (−0.29, 8.26)

[a]Communities are anonymized in this table. To note, A was urban and B–E were rural.

Functional impairment and perceived discrimination

Mean imputed functional impairment score for men was 17.44 (CI: 15.99, 18.9; median: 18; $\alpha = 0.75$), and for women it was 19.84 (CI: 18.26, 21.41; median: 20; $\alpha = 0.71$). Scores were significantly different ($p = 0.03$). Of 99 observations for which a reason was cited for functional difficulty, 31 (31.3%) cited perceived anti-Haitianism as the main reason for difficulty.

The functional impairment regression model achieved good fit ($r^2 = 0.19$) and had no significant multicollinearity (VIF < 10). Significant covariates of functional impairment were female sex ($a\beta = 2.09$; CI 0.13, 3.87) and feeling that Dominicans mistreat Haitians in the community ($a\beta = 2.72$; CI 0.65, 4.79; Table 5).

Table 5. Multivariable linear regression of functional impairment for Haitian migrants in the Dominican Republic, March–April 2011 ($n = 124$).

Covariate	$a\beta$ (90% confidence interval)
Female	2.09 (0.13, 3.87)
Reports that Dominicans mistreat Haitians in community	2.72 (0.65, 4.79)

Qualitative findings

'*Us little miserable ones*': *reasons for migration and daily obstacles*

When asked to explain why Haitians come to their country, Dominicans explained that Haiti's poverty, punctuated by the January 2010 earthquake, forces Haitians to look

toward their neighbor. Haiti's instability, they explained, works synergistically with a Dominican economy dependent on cheap labor, such that migrants find a better life outside Haiti while fulfilling essential economic roles in the Dominican Republic. An employer suggested that Haitians even depend on the Dominican Republic to survive: 'They cross the border at any cost and come to work because they will die in their country […] Where else can they go? Without us, they almost couldn't exist' (DM15, male).

Employers of migrants referenced how the Dominican economy has changed in a way that favors the influx of an undocumented workforce. Two employers in the agriculture sector described how Haitians come to do work that Dominicans no longer prefer because more Dominicans attend school. Both employers described that the nature of the work itself – typically 'stoop labor' under the sun – was disagreeable. Another employer explained that rural Dominican farmers and small landowners face their own financial constraints and have little choice but to hire migrants willing to work for less. A different employer explained, 'The government doesn't give priority to the rural farmer. The smaller farmer is buying more expensive products, the gasoline is more expensive, everything is more expensive, and then when [Haitians] go to harvest the rice, it's cheaper' (DM16, male).

Both migrants and Dominican farm employers–or the *gran neg* (big men) as the migrants called them – agreed that they had a good working relationship with each other. Contentious relationships were instead described between migrants and poor Dominicans. Whereas Dominican employers reported that Dominicans were uninterested in low-paying jobs, Haitian migrants reported that poor Dominicans were resentful of their presence, presumably because of competition for work: 'The big men, we help them in their work. The Dominicans who don't have opportunities, who don't have money like the big men, they don't want to see us around' (MH07, male rice farm laborer).

Lack of legal documentation was cited as a major challenge in daily life. For most interviewed migrants, purchasing a passport and an accompanying *cédula*, or identity card granting authorized status, was unaffordable. Instead, many described passing *anba fil*, or 'below the wire,' a phrase for those who cross the border without paperwork, a process rife with corruption and theft.

Even for those with a passport or *cédula*, life was not always easier. One woman described arbitrary stops and exploitation:

> You must show [immigration officials] your passport. Sometimes they will treat a Haitian like a little toy (*yon ti jwèt*), and they will make you spend what you have […] They will take your passport and visa from you and sell it to another Haitian who might look like you. And then it's the same immigration person that will give you problems for not having your passport later. (MH04, market vendor)

For undocumented Haitians, legal paperwork represented the possibility for upward mobility while leaving some vulnerable to further exploitation.

The challenges to acquiring documents were perceived by some as an intentional arrangement to keep Haitians in low-paying jobs: 'It's a way for them not to give a job to you, asking about the *cédula*,' said one woman (MH03, market vendor). In a rural community, one man exclaimed:

> Where do you put a day's work for 400 gourdes [approximately $10 USD]? You can't send your kids to school. They all have to bend down right there in the dirt. They do the same

> thing that the father is doing; once the child is grown, that's what the child will end up doing too. (MH08, rice farm laborer)

While Dominican informants referenced economic drivers of migration, their accounts diverged from migrants when asked whether migrants succeeded in finding a better life. Employers felt that migrants benefited from an economic niche outside their home country, finding an opportunity for self-improvement. A migrant, on the other hand, summed up his experience this way: 'If our country was good, we would not come here to be humiliated by the Dominicans' (MH08, rice farm laborer). Migrants described proximate, daily obstacles: lack of legal documentation, inability to find a sustainable income, and *imilyasyon* (humiliation). Haitians reported feeling powerless and belittled, sometimes referring to themselves as *ti malere*, 'little miserable ones,' and *ti jwèt* (little toys) stuck in a game whose main actors are the 'big men' for whom they work or immigration officials, whose decisions seem arbitrary and exploitive.

'*They humiliate us*'

At the time of our fieldwork, cholera, which emerged in Haiti in October 2010, had been reported in the Dominican Republic (Tappero and Tauxe 2011). One woman described the blame incurred by Haitians following the epidemic's spread: '[The Dominicans] say this is a problem only for Haitians to have […] If a Dominican has cholera, they blame it on us Haitians' (MH04, market vendor). In these accounts, the epidemic appeared to further stigmatize migrants. She elaborated:

> They say it's we who have brought this illness, but I say, Who are we? We are not God who can create these things. And now they think the illness can be transported in the clothes that we sell, so now people are afraid to buy clothing from us.

The fear and stigma of cholera exacerbated an already marginalized social space. Increased psychosocial stress and internalized stigma resulted from these 'street-level' interactions where Dominicans passed over Haitians in the market or resorted to name-calling. A female Haitian market vendor said, 'Because you're a Haitian, to [a Dominican] you are just like a dog, and you don't have much *vale* [value]. It's like you're more animal than person. These words can make you reflect [and] you can become discouraged' (MH03).

Vale (value or worth) was a predominant theme in accounts by Haitian participants. *Vale* can represent both financial means and self-worth as a human being: 'In life, when you have nothing, you're worth nothing (*ou pa vo anyen*). You're poor,' stated one unemployed Haitian female (MH19). Being poor *and* Haitian in the Dominican Republic convinced some that as a collective body, Haitians *pa gen vale*, or 'have no worth.' BDI item 14 captured worthlessness, expressed as *pa vo anyen* – 'not worth anything.' Sixty-nine percent (n = 88) of the survey sample endorsed this item:

> When I live in the Dominican Republic, they humiliate us (*yo imilye nou*) because we're not in our country. (MH18, male mason)

> I don't see a way out of this misery because of how Dominicans say bad things to us. (MH21, male community member)

> Dominicans humiliate me; they treat me like garbage […] In the eyes of the Dominicans, I am worth nothing. (MH05, female market vendor)

In their use of *vale*, migrants connected the concrete and symbolic meanings of worth, represented by both a lack of money and being Haitians in another country.

The clinical experience: views of Haitian patients

Pierre[1] (MH01, male construction worker) had been living in the Dominican Republic with members of his family for three years. At the time of our interview outside the public hospital, he was waiting for his sister, who was receiving treatment for postpartum hemorrhage. When asked how he and his sister were treated inside the hospital, he first commented on the time it took Dominican providers to attend to them:

> In the hospital, they almost treat you the same as a Dominican, but it can be worse. I'll take the example of my sister. She's been sick, bleeding, and if I hadn't been diligent, the people in the hospital wouldn't have cared for her, they wouldn't have asked what was wrong with her. They take too much time to take up your case, so you're obligated to wait.

Even when that care arrived, it was apparently disjointed and poorly communicated, leaving Pierre resigned to accept whatever decision was made. Pierre said he avoids going to the public hospital because 'it takes too long for them to care for a Haitian.' He described how the hospital staff seemed to respond more quickly to the needs of nearby Dominican patients and concluded saying, 'it's as if they take me for a little toy (*yon ti jwèt*).'

Pierre's sense of resignation at the public hospital was echoed by other migrants. In general, private clinics were said to be of better quality but too costly for most. However, alongside financial constraints in accessing care, Haitian participants implicated their nationality: 'If you are Dominican, you can go [to the private clinic], but if you're Haitian, you can't go because you don't have money' (MH04, female market vendor). Much like Pierre's experience, this woman explained how Haitians are largely ignored at the hospital, since 'they see you are a person without money, [and] they won't be eager to help you. Because we're Haitian, and we don't have value, we don't have money, [so] you sit there.' Overcoming the language barrier did not always facilitate the matter: 'Even if you speak Spanish, if they see you are Haitian, you call for them, but they won't take up your case because you're Haitian' (MH03, female market vendor). Thus, Haitian participants widely shared the perception that Dominicans not only could access better quality care but also received preferential treatment in the same clinical space as Haitians.

The clinical experience: views of Dominican health care professionals

Working in a large, publicly subsidized hospital and its outlying clinics granted Dominican interview participants a unique perspective on caring for Haitian patients. Clinicians attributed many of their patients' afflictions to circumstances not found among their Dominican patients.

Most interviewed clinicians reported that unsanitary, crowded living conditions in which many Haitians live were conducive to spreading disease. Some Dominicans in the community presumed that Haitians chose to live that way out of social or cultural custom:

'That is the biggest difficulty they have – their way of life – so many of them live all together […] Me, I like privacy' (DM18, Dominican female shop owner). Additionally, some Dominicans emphasized an ignorance of hygiene: 'They don't take care of themselves so much, they don't know how to take care of themselves (*no se saben cuidar*)' (DM11, Dominican nurse). In this way, social and health disparities among Haitians could be explained away through ignorance, supposed preferences, or social practices, which could predispose them to disease:

> They are people with less privacy than the Dominican[s], they have more sexual relations with consecutive people than the Dominicans […] A Dominican woman is proud of having a husband, the Haitian no, she has many relationships. (DM11, Dominican nurse)

Building on the premise 'the Haitian patient has another culture, other beliefs, other ideologies, and even another language' (DM11, Dominican nurse), one Dominican physician went even further to say Haitians had a different physical and mental constitution, which grants them unusual strength to cope with the difficulties they experience:

> The Haitian is a human being who tolerates more than any other human being, because they are, let's just say, accustomed (*acostumbrado*) to living with anemia; they endure levels of hemoglobin that the books don't accept […] The books tell you that with a hemoglobin of 5 one [should] die, [but] the Haitian goes [around] perfectly with a hemoglobin of 5, he goes around in the street, and then he is going around working, but how it doesn't give him motion sickness, or anything, that's just how they are. (DM01)

Another doctor in an outlying clinic agreed: 'Haitian patients are, in a certain way, stronger with regards to health' (DM05). Thus, being *acostumbrado* to malnutrition, poverty, and hard work further differentiates Haitians from Dominicans: 'They have strong minds and can resist the problems that they really have' (DM09, Dominican nurse). In this way, while Dominican clinicians may have intended to admirably characterize Haitians, their references to social, cultural, or even biological differences provided a means to overlook more complex structural factors at root, which seemed painfully obvious to their patients:

> You have to carry a large sack of rice on your head […] You have to get up early, which sometimes bring sickness that you never thought you would find in this life […] You're poor, and when it gives you this illness, if you don't have means to go to the hospital, you may find yourself just having to deal with it. (MH08, male rice farm laborer)

Yet while multiple reasons were provided for the different ways Haitians acquire, experience, and seek care for disease, Dominican clinicians were adamant that all patients, regardless of nationality, were treated the same. Maintaining that they provide impartial care to everyone, clinicians said many Haitian patients incorrectly presume they are being discriminated against: 'They believe even though you treat them well, they feel that you are maltreating them, they believe you are going to hurt them' (DM01, Dominican doctor). This misconception was said to reflect a historical misunderstanding between the two countries. The same doctor continued: 'They have a resentment against the Dominican Republic, one that grows from Haiti; they feel that this part of the island is also theirs, because of the history of wars and the independence and all that (DM01).'

Another doctor further explained that while this 'resentment' against the Dominicans 'makes them feel like however you deal with them is bad, […] that's not to say that's really how it is' (DM02). He went on:

> Just because their country has its problems, they shouldn't feel ashamed […] They should feel proud, because their problem isn't because of them but because of their politics.

According to him, Haitian patients, who unjustifiably feel 'ashamed,' are responsible for any misunderstanding with their Dominican clinicians. For this doctor, rather than feeling ashamed, worthless, or humiliated, Haitians should 'feel proud.' He concluded, 'I don't see what the problem is, but that's getting into culture […] That's a question of how they see it from their perspective, their point of view' (DM02).

Thus, competing pictures emerged from the clinical setting. From one perspective, Haitians cited the structural difficulties they endure in daily life – including their working conditions, lack of documentation, and financial constraints – and the perception that they were unimportant and relegated to a lower rung in the ordering of clinical priorities. Dominican clinicians differentiated their Haitian patients on the basis of cultural, social, or 'bodily predispositions' (Holmes 2012, 879) not found among Dominican patients. Those 'predispositions' were considered responsible for their poor health and inability to grasp the good intentions of care providers.

Discussion

Perceived discrimination is central in the self-reported experience of Haitian migrants in the Dominican Republic, is underrepresented in accounts by Dominicans, and is significantly associated with mental distress measured through both depressive and anxiety symptoms. While migrants and Dominicans cited similar drivers of migration, their accounts diverged when asked to describe the lived experience of migrants and root causes of their ill-health. Compared to Dominican informants, migrants grounded their explanations of distress within more proximate determinants, including the stress of migrating, trying to find work without legal documents, and feeling humiliated. This *imilyasyon* was explained to occur through interactions with some Dominican clinicians and poor community members. Humiliation and feelings of worthlessness were connected to perceived mistreatment by Dominicans.

In our exploratory analysis of depression, anxiety, and functional impairment, we found that self-reports of mistreatment by Dominicans associated with a 6.6-point increase in BDI score. Ever having been interrogated or deported associated with a 5.2-point increase in BDI score, while knowing someone who had been interrogated or deported was associated with a 3.4-point increase in BAI score. Considering approximately 30% of our sample reported perceptions of mistreatment by Dominicans and one-quarter knew someone who was interrogated or deported, these exposures represent a substantial burden on the mental health of Haitian migrants. Perceived discrimination is associated not only with higher depressive symptoms but decreased ability to complete daily tasks, a particularly detrimental effect for migrants who are typically far removed from their family and natal community and who are relied upon for financial remittances.

'Othering' notions of difference originally promulgated under *anti-haitianismo* resurfaced in the clinical setting. Dominican clinicians employed essentialist as well as contextual approaches in framing the ailments of migrants. First, some complaints were reduced to biological or behavioral differences. Haitians were sometimes characterized

as preferring to live in crowded conditions or as having cultural or social customs predisposing them to disease. In some instances, Dominican clinicians assigned a different physiology altogether to Haitian patients, contending that their collective suffering as a poor and marginalized group has, over time, habituated them to pain and suffering, a perspective that reduces the social to the biological (Fassin 2001). While this 'clinical gaze' (Foucault 1975) seemed to prevent some clinicians from scrutinizing broader determinants of ill-health, other care providers cited the precarious conditions in which migrants live. Both of these approaches – one essentialist, the other contextual – were rooted in a 'biopolitics of otherness' (Fassin 2011, 214).

Attributing feelings of worthlessness, humiliation, and powerlessness to interactions with Dominicans reflects low public regard and high internalized stigma. Haitian participants connected feelings of worthlessness to their own perception of how Dominicans consider Haitians *as a whole*. As a collective body, many Haitians perceive themselves to lack *vale*, a perception reinforced through structural practices such as unpredictable round-ups and deportations, paying lower wages, passing over them in clinical settings, or blaming them for the cholera epidemic. In this way, discrimination influences how migrants perceive themselves, their deservingness, and their own place in the racial–moral hierarchy of Dominican society. Future research should explore how internalized stigma and humiliation within this population relate to macro-level ideologies, practices, and institutional policies that construct and perpetuate hierarchies of deservingness (Viruell-Fuentes, Miranda, and Abdulrahim 2012).

As well, these experiences were illustrative of 'humiliation' rather than 'discrimination.' *Imilyasyon*, an emotionally charged and locally salient word among migrants, contrasts with the more legalistic concept of *discriminación*. Different meanings of negative social experiences can be reflected in the linguistic constructs used by majority and minority groups (Beck, Mijeski, and Stark 2011). In the Dominican Republic, *discriminación* may convey a more abstract concept, one more closely associated with the criticism of international human rights organizations and foreign diplomats, whose critiques are sometimes broadcast on the front pages of national newspapers (Noticias

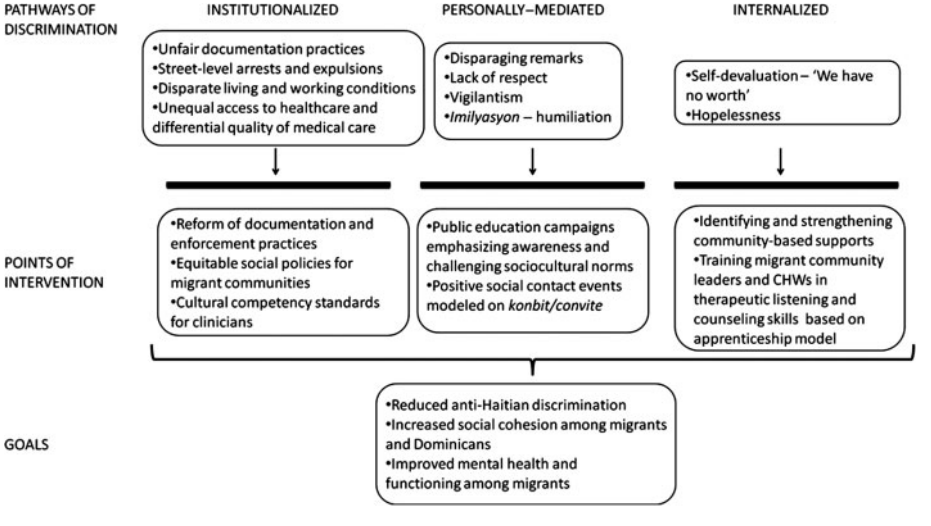

Figure 4. Conceptual outline of anti-Haitian discriminatory pathways and points of intervention.

Aliadas 2011). In this study, Dominican participants seemed to know what discrimination was but felt strongly that it no longer operates to the degree that it once did. For Haitians, humiliation rather than discrimination appeared to more accurately encompass the personal experience of living and working in the Dominican Republic. Humiliation seems to more closely mirror the experience of stigmatized groups – those who are first differentiated from the dominant group, labeled, and stereotyped consequently suffer status loss and discrimination and have limited access to economic, social, or political power (Link and Phelan 2001). Tracking the language of those who bear the brunt of structural violence can help 'expose assumptions and political practices that hold structural violence in place' (Briggs 2005, 283).

To reduce negative effects of perceived discrimination and humiliation, interventions must break the institutional, personally mediated, and internalized pathways through which discrimination causes harm (Jones 2000; Figure 4). First, to dismantle anti-Haitian institutional policies, major steps are needed toward reforming unfair documentation practices, which systematically deny valid work permits and perpetuate street-level arrests and deportations. Equitable health and social policies must address longstanding service gaps in marginalized communities, particularly in rural areas where disparities are greatest. In the health sector, cultural competency standards should be integral to clinical training and practice, with attention to the unique health needs and expectations of Haitian migrants. Finally, nationwide public education campaigns can challenge anti-Haitian norms by articulating the contribution Haitian migrants have long made to Dominican society, contextualizing their health within broader social determinants, and emphasizing the two countries' shared values.

To reduce personally mediated and internalized discrimination, community interventions can build on shared cultural practices among Haitians and Dominicans. The identical social structures represented by the *convite/konbit* form of collaboration among farmers is an example of how the two countries share certain customs and values (Domínguez, Castillo, and Tejeda 1978; Métraux 1951). The shared linguistic root of *convite/konbit* and its spirit of solidarity and cooperation point to how both groups have much in common. The *convite/konbit* can thus provide a model for community-level interventions that bring Haitians and Dominicans together, with the aim of identifying common goals and fostering community empowerment. Such 'positive contact events' can be successful at reducing prejudicial beliefs (Pettigrew and Tropp 2006). Grounding such events in a shared historical heritage can help foster their acceptance by the community.

Additionally, strengthening existing forms of community support in migrant communities and following principles of the apprenticeship model to train CHWs and lay providers can help reduce harmful effects of discrimination and stigma (Murray et al. 2011). Based on findings in Haiti (Wagenaar et al. 2013; Khoury et al. 2012), community-based support in Haitian migrant communities likely includes nonbiomedical care providers, such as Christian pastors and traditional healers, including Vodou priests and herbalists. Support networks in migrant communities are underexplored and deserve more inquiry. Dominican CHWs can help educate fellow Dominican community members about the harmful effects of discrimination, correct unfounded fears and misinformation, and promote social events to facilitate trust and integration. Haitian migrant community leaders can be trained in basic therapeutic listening and counseling skills in order to help fellow migrants with feelings of low self-worth and humiliation.

Essentially, this model encourages social cohesion and mobilization by incorporating existing resources and empowering community members with new knowledge and skills.

Limitations

While this study sheds new light on a poorly understood population, there are several important limitations. First, while native-speaking Spanish and Kreyòl RAs collected all data, analysis was conducted in English. Important nuances and subtleties communicated in the original languages may have been lost. Our survey results are limited by the small sample size and limited inference to the six purposively enrolled communities. Cross-sectional surveys cannot distinguish multifactorial pathways. The current quantitative analyses are intended to be hypothesis generating, and larger studies are required for hypothesis testing of the relationship between discrimination, humiliation, and mental health among Haitians in the Dominican Republic.

Conclusion

This analysis helps advance an understanding of the mental health of 'peripheral migrants' in developing countries, particularly in contexts where the historical, social, and cultural identities of sending and receiving populations are deeply intertwined. In the Dominican Republic, Haitian migrants have long constituted an important part of the country's economic and social fabric, yet remain marginalized from legal, health, and social spheres. That vulnerability becomes evident when assessing their mental health, which is associated with perceptions of humiliation and discrimination.

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Note

1. Pseudonym.

Key messages

(1) Many Haitian migrants live in the Dominican Republic. This study suggests perceived discrimination is common in self-reported experiences of Haitian migrants. Haitians describe experiencing *imilyasyon* (humiliation) resulting from interactions with Dominicans.
(2) Dominican informants deny discrimination against Haitians and attribute negative social interactions to sociocultural, behavioral, or biological differences.

(3) Exploratory quantitative analyses suggest perceived mistreatment by Dominicans associates with increased depression, anxiety, and functional impairment among migrants. Migrating alone, being single, and experiencing interrogation or deportation also associate with depression. Knowing someone who was interrogated or deported associates with higher levels of anxiety.

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