THE CLIFFORD BEERS FOUNDATION

THE INTERNATIONAL JOURNAL OF

Mental Health PROMOTION

Promoting Mental Health
Preventing Mental Disorders

VOLUME NINE
ISSUE ONE
FEBRUARY 2007

THE INTERNATIONAL JOURNAL OF
Mental Health
PROMOTION

THE EDITOR

Michael Murray is Chief Executive of The Clifford Beers Foundation and Head of The Centre for Mental Health Promotion and Research at the University of Central England in Birmingham.

He has acted as a member of the Experts Committee of the European Commission, was chair of the Organising Committee for the second World Conference on the Promotion of Mental Health and the Prevention of Mental Disorders, and has sat on national and international advisory bodies.

EDITORIAL STATEMENT

The aim of the Journal is to nurture and encourage understanding and collaboration in the field of mental health promotion (and the prevention of mental disorders) within a truly multi-disciplinary forum.

In this forum, researchers and practitioners from different disciplines, cultures and countries can fruitfully collaborate to make significant progress towards the achievement of conceptual clarity and in turn advance the development, evaluation, dissemination and implementation of new concepts and effective programmes.

Topics of interest for the Journal include theoretical studies, empirical and applied original research, evaluative studies of innovative programmes, analysis of issues fundamental to mental health promotion (and the prevention of mental disorders) and policy making.

The editorial board aims to be eclectic and academically catholic, with no allegiance to any specific dogma or conceptual framework or ideology.

As the definition and concept of mental health promotion continue to stimulate extensive debate, often including discussion relating to the difference and overlap between health promotion in general, mental health promotion, and the prevention of mental health disorders, this lack of conceptual clarity leads to confusion, invalid assumptions and unproductive, even futile, debate. The sources of the controversy are diverse and stem from the different underlying perspectives, professional roles and philosophies and beliefs of individuals and sectional interests.

Among scientists, clinicians, practitioners, academics, policy makers and consumer groups this discussion will continue, as much controversy exists as to the way mental health promotion should be defined – if defined at all.

It is intended that the Journal will address these issues to promote progress in achieving conceptual clarity as a crucial prerequisite for fruitful collaboration in the development, dissemination and implementation of effective programmes.

Published by
The Clifford Beers
Foundation
Mariazell
5 Castle Way
STAFFORD
ST16 1BS

Telephone
0044 (0) 1785 246668

Fax
0044 (0) 1785 246668

Email
journal@charity.demon.co.uk

Website
www.cliffordbeersfoundation.co.uk

Editor
Michael Murray
The Clifford Beers
Foundation
5 Castle Way
STAFFORD
ST16 1BS

Telephone
0044 (0) 1785 246668

Fax
0044 (0) 1785 246668

Email
editor@ijmhp.co.uk

Journal Website
www.ijmhp.co.uk

ISSN 1462-3730

The views and opinions expressed by authors are their own. They do not necessarily reflect the views of their employers, the Journal, the Editorial Board or The Clifford Beers Foundation.

GRAPHICS/TYPESETTING
Colin Reed, C. A. Reed IMC
colin@careedweb.com

PRINTING
John Leigh, Stafford

THE INTERNATIONAL JOURNAL OF
Mental Health PROMOTION

VOLUME NINE ● ISSUE 1 ● FEBRUARY 2007

Editorial 2

FEATURE Melancholy, the Muse and Mental Health Promotion: An Analysis of the Complex Relationship between Mood Disorder and Creativity: Developing a Specific Model of Mental Health Promotion: Six Key Themes
Judith Lee 4

FEATURE Recognition of Children of Preschool Age at Risk for Internalising Disorders in Mainstream and Islamic Primary Care
Frits Boer, Hedy Stegge and Hayriye Akyuz 17

FEATURE Prevalence of Depression in Various Ethnic Groups of Immigrants and Refugees: Suggestions for Prevention and Intervention
Willem H.J. Martens 25

FEATURE Domestic Violence and Chemical Dependency Co-Morbidity: Promoting Eclectic Responses to Concomitant Mental Health Concerns
Paula T. McWhirter 34

Copyright for all published material in this journal is held by The Clifford Beers Foundation unless specifically stated otherwise. Authors and illustrators may use their own material elsewhere after publication without permission but The Clifford Beers Foundation asks that this note be included in any such use: 'First published in The International Journal of Mental Health Promotion, VOLUME 9 ISSUE 1' Subscribers may photocopy pages within this journal for their own use without prior permission subject to both of the following conditions: that the page is reproduced in its entirety including the copyright acknowledgements: that the copies are used solely within the organisation that purchased the original journal. Permission is required and a reasonable fee may be charged for commercial use of articles by a third party. Please apply to The Clifford Beers Foundation for permission.

Michael Murray
The Clifford Beers Foundation

A sound mind in a sound body is the most useful instrument wherewith to serve God.

St Ignatius of Loyola (1491-1556)

I was recently asked to review a book devoted to the subject of mental health promotion. There is much to commend in the book, and I am sure that it will be used for both my teaching and future research. However, one thing that caught my attention was the proposition that mental health promotion is a fairly new arrival on the scene. True, there is much debate, confusion and controversy as to what we might mean by mental health promotion, but my contention is that the subject has been around throughout history.

Since the beginning of time the health of one's relationships with self and others (mental health) and with a higher being (spiritual health) have been interdependent. No understanding of mental health is complete if it ignores spiritual health. No conception of spiritual health is complete if it ignores mental health, and positive mental health is synonymous with the term 'wholeness'. Both point to the fulfilment of the human potential for living a constructive life. Spiritual practices foster an awareness that serves to identify and promote such values as creativity, patience, perseverance, truth, kindness, compassion, wisdom, hope and aspiration, all of which support good mental health promotion practice.

Although, more recently, awareness has been growing of the importance of mental health as a vital component of well-being and health in general, we must not forget that even the more 'professional' practice of mental health promotion also has a long history with roots in the 19th century. It was in the climate of the reform movement, for example the fostering of women's rights and actions against child labour, that a social movement striving for better conditions for the populace as a whole evolved. Early pioneers such as Clifford Beers also led the way to the development of the mental hygiene movement during the 1920s and '30s, when there was substantial activity to stimulate the integration of mental health principles into the practice of social work, nursing, public health administration, education, industry and government.

Throughout the 1960s and '70s a number of themes began to emerge in mental health promotion, including promotion of self-esteem, self-help groups and mental health in the workplace. At around the same time it became more and more apparent that there needed to be a new approach to the demands placed on society by mental and emotional disorders. Spurred on by the work of George Albee and William Ryan, and the Carter Commission of 1977, realisation grew that mental health problems are not limited to those individuals with a disabling mental disorder, but include those people who suffer with a variety of social ills that directly and adversely affect their everyday lives.

The 1980s and '90s witnessed a trend towards a more scientific approach to mental health promotion. Today, a multi-disciplinary contribution is evident, with community and clinical psychology, social psychology, epidemiology, social marketing and health education among the various fields of science contributing to the endeavour. After many years of a somewhat humble approach to mental health promotion and prevention of mental disorders, the field is gaining momentum on the social, political, economic, and health and welfare agendas, and taking a rightful place in government strategic planning.

In addition, in recent years a new range of topics have been added to existing themes: war traumas, mental health of migrants and refugees, sexual and physical abuse and, of course, the detection of child problems in primary care, to name just a few. With some confidence, we can now assert the beginning of a revitalised movement to develop new initiatives in the field.

But if mental health promotion has always been an important feature in our quest to achieve and maintain the mental strengths we need to deal with life's problems, we must also remember that new approaches and tactics will be necessary,

 © The Clifford Beers Foundation

including new policies, procedures and programmes, if we are to meet new and changing demands. Our society is faced with a series of impending and crucial tasks, but right now society as a whole is not doing much about it. Futurists tell us that we face a world of ever more rapid and complex changes, and predict that the mentally healthy individual of tomorrow must be flexible and open-minded. (S)he must be capable of constant adaptation to changing conditions.

It would be both inappropriate and foolish to minimise the extent of the task ahead. There is much work to be done but, on a positive note, much has been achieved, especially in recent years. There is a real opportunity to build on the growing momentum. If the opportunity is not grasped, we will have much to regret in future years. Thankfully, there is growing awareness in the field of mental health promotion of the need to co-operate and work together to make the best possible use of very limited resource and to learn from each other.

In the Journal we hope to play at least a small part in this process, and I am pleased to say that in this issue we have four papers that address this point. In *Melancholy, the Muse and Mental Health Promotion: An Analysis of the Complex Relationship between Mood Disorder and Creativity: Developing a Specific Model of Mental Health Promotion: Six Key Themes*, Judith Lee provides a very interesting submission on the subject of the complex relationship between mood disorder and creativity. She describes key themes identified in her extensive research on the subject. The emphasis of the research was to explore ways in which creative individuals with mood disorder can harness difficult experiences and feelings and make use of them productively in their work and everyday life. Consequently, the main aim of the research was to extrapolate from these findings any aspects that would be of benefit to other sufferers of mood disorder, whether creative or not. The six key themes outlined comprise a synthesis of both the findings of empirical work and the literature review. For each of the six themes, a table summarises the main issues, cross-referencing them with the following: the literature review, library-based biographical data, art therapy case studies and one-to-one interviews. The themes form a part of the overall research findings, and highlight dimensions which could lead to further research. One practical outcome of the research described is the design of a model for managing mood disorder.

Our second paper, *Recognition of Children of Preschool Age at Risk for Internalising Disorders in Mainstream and Islamic Primary Care* by Frits Boer, Hedy Stegge and Hayriye Akyuz from The Netherlands, investigates the extent to which professionals in primary care are aware that precursors of internalising problems, anxiety and depression, appear as early as the preschool years, and how such issues may or not be addressed. The paper re-emphasises that, as we are to be able to conduct preventive programmes in early childhood, it is essential that professionals recognise children showing these precursors when they are brought to their attention by parents during regular check-ups.

In the study prototypical descriptions of children at risk for internalising problems were presented to professionals, after which recognition and services provided were investigated in a structured interview. As well as professionals in mainstream health services, the study included Islamic counsellors (imams) to increase sensitivity to cultural differences in the use of services. The study provides preliminary evidence for the contribution professionals in primary care can make to early identification of children at risk for internalising disorders, and discusses how professionals differ in their recognition of risk factor subtypes and the advice they give parents.

A topical and relevant issue in world affairs at the moment is the mental health of refugees and immigrants. A very detailed piece of research, *Prevalence of Depression in Various Ethnic Groups of Immigrants and Refugees: Suggestions for Prevention and Intervention*, is presented by Willem H.J. Martens. From an assessment of the article and study of the detailed data presented, we can see that there are remarkable differences in the prevalence and vulnerability to depression between ethnic groups, immigrants and refugees. Correlates of depression in various ethnic groups are examined, and the paper discusses prevention and intervention. The analysis of the research data also confirms that there is sufficient evidence to conclude that intervention and prevention programmes should be designed and implemented in a way that ensures that they meet the special needs of specific categories of immigrants and refugees.

In our final paper, *Domestic Violence and Chemical Dependency Co-Morbidity: Promoting Eclectic Responses to Concomitant Mental Health Concerns*, Paula McWhirter from the University of Okalahoma suggests that, although chemical dependency and a history of physical or sexual violence are problems commonly experienced concomitantly by women, barriers still persist to implementing programmes that deal with them together. The article describes an eclectic, cross-problem group intervention designed to acknowledge the specific needs of those women who have experienced both chemical dependency and domestic violence problems. The evaluation data suggest a positive effect for the proposed intervention, providing support for creating and maintaining policies among mental health provider organisations that recognise and address common co-morbidity.

Judith Lee
Director of Education, Northern Ireland Association for Mental Health

Melancholy, the Muse and Mental Health Promotion – an Analysis of the Complex Relationship between Mood Disorder and Creativity, Developing a Specific Model of Mental Health Promotion: Six Key Themes

Key words: melancholy; depression; creativity; mental health promotion

A B S T R A C T

This article describes some key themes arising from a doctoral thesis (DPhil degree awarded in April 2006) on the complex relationship between mood disorder and creativity. A particular emphasis of the research was to explore how creative individuals with mood disorder are able to harness difficult experiences and feelings and make use of them productively in their work and every-day life. The main aim was to extrapolate from these findings any aspects that would be of benefit to other sufferers of mood disorder, whether creative or not. The six key themes outlined comprise a synthesis of the findings of both the literature review and empirical work.

Introduction

The notion that creativity and genius often feed off mental turmoil is not new. The ancient Greeks, including Aristotle, believed that there was a direct correlation between brilliance and madness. In the Renaissance, melancholy almost had a fashionable cachet, as denoting sensibility. This idea was revived in the Romantic Movement of the 19th century, when poets such as Bryon spoke of the:

> *apostle of affliction, he who threw enchantment over passion and from woe wrung overwhelming eloquence* (1986 p105).

I acknowledged, however, from the start of my research work that the popular image of the 'mad artist', whose suffering is an inevitable and necessary prerequisite for creative success, was too simple. Documentary evidence has shown that, while there is strong evidence to demonstrate a link between creativity and mood disorder, particularly bipolar disorder, the relationship is a complex one.

The poet Robert Burns acknowledged the link when he wrote:

> *The fates and character of the rhyming tribe often employ my thoughts when I am disposed to be melancholy. There is not, amongst all the martyrlogues that ever have penned, so rueful a narrative as the lives of poets* (cited in Bett, 1952 p147).

Chapter 4 of the literature review explored the range of existing studies on the topic such as Jamison (1994), Ludwig (1995), Andreason (1987) and Karlsson (1981). Jamison (1994 p5) said that her aim was to:

 © The Clifford Beers Foundation

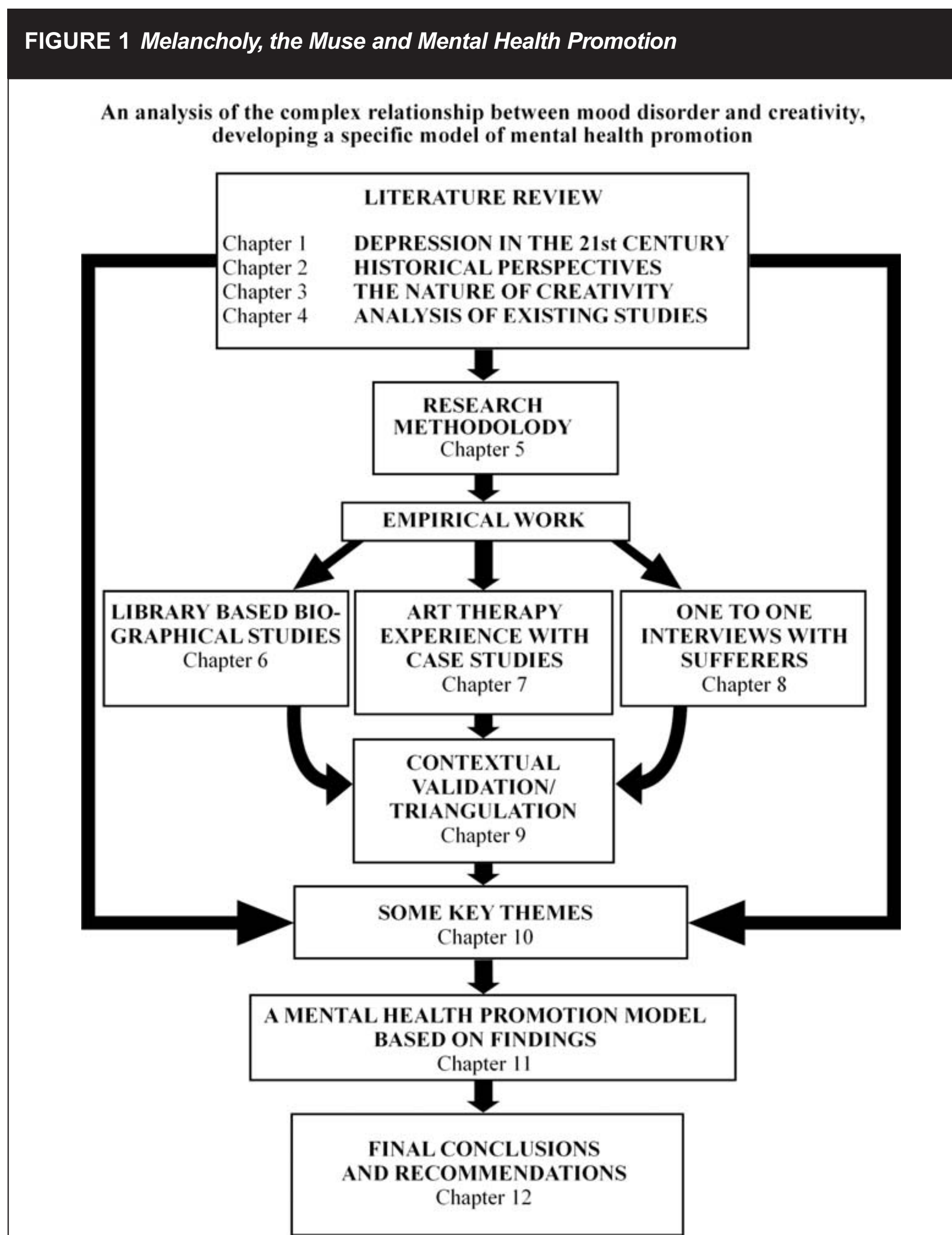
> *… make a literary, biographical and scientific argument for a compelling association, not to say actual overlap, between the two temperaments – the artistic and the manic depressive – and the relationship to the rhythms and cycles or temperament of the natural world.*

Analysis of Jamison's and other studies revealed certain patterns. For example, writers and poets had consistently the highest rates of mood disorder compared to other artists and to scientists; evidence for a genetic link was identified by most. The benefits conferred by mood disorder included some brought by the depression cycle, although hypomania was viewed as particularly beneficial to creativity. Intriguingly, these findings were often reinforced by aspects of the empirical work, especially one-to-one interviews with sufferers of mood disorder.

Methodology

Figure 1, below, presents a diagrammatic representation of the structure of the thesis. The research approach chosen was qualitative and multi-method in practice. This multi-faceted method seemed particularly in keeping with the

FIGURE 1 ***Melancholy, the Muse and Mental Health Promotion***



complexity of the topic being researched, allowing for humanistic, holistic exploration. The one-to-one interviews with sufferers were of particular importance, as sufferers can be viewed as experts in their own right.

Four substantial chapters were devoted to the literature review. They explored in turn depression in the 21st century, historical perspectives, the nature of creativity and, finally, an analysis of existing studies that examine the links between mood disorder and creativity. This provided a sound foundation for the empirical work. That was important, given the unique interface of the different phenomena under examination. Developed from the literature review, a tentative hypothesis was outlined, which was that:

> *Mood disorder, particularly bipolar disorder, despite its negative aspects, can nevertheless confer benefits. These may lead to positive outcomes in the long term, such as that of a fuller integration of the personality as a whole.*

The plan was to 'test' this hypothesis through the data emerging from the empirical work. Biographical studies of six famous creative individuals formed the first part of this task. Chapter 7 of the thesis was based on the art therapy personal practitioner experience, including case studies. Together these two chapters provided a rich range and breadth of data. Chapter 8 comprised analysis of data collected from one-to-one interviews with sufferers of mood disorders. Thus, as well as historical/biographical documentary data, the user's voice became an essential component of the empirical research.

A sample of ten individuals was identified. The sample was purposive, aiming primarily to identify sufferers who were experienced in living with, and managing, their mood disorder. The criteria reflected this. A rich seam was uncovered. The data collected and analysed in this dimension of the empirical work was qualitatively significant, and greatly influenced the shape of the design of a mental health promotion model described in Chapter 11 of the thesis entitled *The Heroic Heart – A Model for Managing Mood Disorder.* This model became the most original aspect of the research, and reflects many of the themes outlined below.

Findings: six key themes

These six themes are not mutually exclusive; indeed there is an element of overlap. They are:

- the co-existence of mood disorder and creativity
- modern depression vs. historical melancholy
- the paradoxical benefits of mood disorder
- the need for psychological uncertainty
- creative adaptive potential
- the sufferer, like the artist, as a seeker of truth.

For each of the six themes, one of the tables below summarises the main issues, cross-referencing them with, in turn, the literature review, library-based biographical data, art therapy case studies and one-to-one interviews. Additional explanatory text follows.

Elucidation of the key themes

The Co-Existence of Mood Disorder and Creativity

The main issues of this theme are summarised in ***Table 1***, opposite.

An important aspect of this research was to try to establish the nature of the link between mood disorder and creativity. It became clear, on investigation, that the link was frequently very real. Numerous creative individuals throughout the centuries have suffered from a form of mood disorder. Yet it also soon became apparent that the nature of the relationship is not simple. All the evidence, from the analysis of the studies on the subject to the biographical and autobiographical material in this thesis, reflects the complexity of the phenomenon.

There has long been a perceived association between madness and creativity. Aristotle, for example, believed all successful men to be touched by the same instability, particularly disorder of the 'black bile' which caused melancholic spirits (1957). Shakespeare, writing of a range of types of melancholy in his plays such as *As You Like It*, *Hamlet* and *King Lear*, reflected the Renaissance views of the time, that melancholy was inextricably linked with the human condition.

In the 19th century melancholy came to be seen as synonymous with the artistic genius. A number of 20th century studies have demonstrated a high correlation between creativity and mood disorder, particularly bipolar disorder (or manic depression), among them Jamison (1994), Ludwig (1995), Richards (1988) and Andreason (1987). Writers and poets consistently show a higher rate of mood disorder than other artists. Jamison, in her study, found that a larger percentage of writers had been treated for mood disorder (38%); playwrights had the highest treatment rates for depression at 68%; but nearly all (89%) the creative artists and writers said they had experienced an intense, highly creative and productive episode – the other side of the coin.

Other data arising from this research supports this finding. Those studied in the biographical chapter all suffered

TABLE 1 ***Co-existence of Mood Disorder and Creativity***

KEY THEME: CO-EXISTENCE OF MOOD DISORDER AND CREATIVITY	Evidence to support key themes			
	Literature Review	**Biographical Data**	**Art Therapy Case Studies**	**Interviews/ Sufferers/Co-Researchers**
Historical perspectives	■ Links with brilliance - Aristotle - The Renaissance sensibility - Ficino/Shakespeare - Romantic era - Rich pictorial and literacy tradition of depression	■ Transformation of suffering into art, eg Montaigne, Nietzsche, Conrad, Byron, Miró, Woolf	■ Experience of difficult feelings through imagery, leading to greater understanding	■ Creative learning through living with illness ■ The illness acting as a catalyst for change
Evidence from the analysis of existing studies	■ Unusually large percentage of creative individuals with mood disorder (Ludwig, Jamison)	■ Art work and other documentation reflecting overlap		
Biographical and auto-biographical evidence	■ Complex relationship, eg work as a defence against depression (Churchill, Newton), or depression as improving insight/depth of understanding and acuity (Woolf, Schumann)	■ Individual testimony in documentation such as letters and journals (eg Woolf, Lowell, Poe)	■ Use of imagery such as painting, collage, poetry, to express emotion, wishes and fears	■ The need to tell their 'story' – the process of re-invention of the self ■ Invention as a creative process
Creativity in 'non-eminent' sufferers	■ Roger's belief in need to increase society's creativity ■ Jung's individuation as aspirational goal		■ Finding a powerful personal language ■ Creative 'traits', eg flexibility	■ Unexpectedly high levels of creativity in sample – illness as a trigger for creativity
Parallels between mood disorder and the creative process	■ Individual testimony in letters, journals, etc	■ Heightened creativity at certain times of the cycle of an illness such as hypomania	■ Images reflect 'highs' and 'lows' in style and content	■ The cyclical nature of both the creative process and mood disorder

from mood disorder. Yet in different ways they were often able to use the effects of the illness, especially the hypomanic episodes, to enhance their creativity. Schumann's *Year of Song* is one famous example. Woolf and Miró also drew on their experience of both depression and hypomania, and used it in their work.

The experience of suffering mood disorder often seems to act as a catalyst for creative activity. An unexpected finding of the interviews with the sample was the level of creativity of the participants. Of those interviewed with mood disorder, half found various types of creative activity, such as art, writing and even inventing, helpful.

One other dimension became apparent, particularly in listening to the stories of those interviewed. It seemed reasonable to draw parallels between the cycles of mood disorder (particularly bipolar disorder) and the stages of the creative process. The four stages of the creative process – preparation, incubation, illumination and verification – have echoes of the cyclical downs and highs of mood disorder, with all the attendant emotions. The artist, just like the sufferers of depression, often feels 'stuck' or lost in a chaos of ideas and feelings, before insight dawns, leading to increased confidence and awareness. Just as the creative process does not always follow a sequential pattern, but may flow backwards and forwards between the four stages, so also the cycles of mood disorder can be erratic.

Another aspect of the link between the creative process and mood disorder is that many of the temperamental qualities required for creativity often seem either to develop as a result of the illness, or to be strengthened by it. They include aspects such as perseverance through difficulties, coping with ambiguity and trying to make sense out of difficult, complex experiences. This particular finding seems very important, and may often be an under-estimated 'spin-off' of the experience of the illness.

Modern depression vs. historical melancholy

The main issues of this theme are summarised in ***Table 2***, opposite.

For most of recorded history since ancient Greece, melancholy and melancholia have been the terms used to describe a wide range of mood disorders, from transient sadness to full-blown manic bipolar illness.

It is clear from the literature that depression as we now know it, in its variegated forms, has been in existence since time began. How societies in different eras viewed depression reflects the cultural mores of the time. What is not clear, however, is whether the prevalence of depression has varied to any great degree from century to century.

Melancholy, reflecting societies' levels of interest in the subject, has a rich literary and pictorial tradition. Writers from the 16th century onwards, such as Montaigne (2003) and Nietzsche (1974), used it as subject matter. Montaigne, for example, normalised the difficult range of emotional and intellectual experience.

> *We must learn to suffer what we cannot avoid. Our life is composed, like the harmony of the world, of discords, as well as different tones, sweet and harsh, sharp and blunt, soft and hard.* (tr. Screech, 2003 p1237)

Melancholy became inextricably linked with philosophy. The experience of melancholy was described as part of understanding what it is to be human. Several of those interviewed in the sample understood their depression as an extension of the human condition – a kind of exaggerated form of normal feeling and behaviour, with more extreme highs and lows.

This way of understanding the experience of depression appears to have been largely lost over time, yet what emerges very strongly from the biographical and autobiographical findings is the existential need to make sense of a seemingly senseless confusing experience and find meaning.

There is a sense that something of the richness of melancholy in all its variety has become reduced to checklists of symptoms. By contrast, in some centuries, melancholy's complex nature was in fact almost celebrated. Burton (1621) spent a lifetime trying to pin down the 'chameleon' of melancholy, puzzling over the 'plethora' of its manifestations. Burton identified melancholy with intelligence and scholarship, mid-life crises, love and jealousy, and religion. His lifelong devotion to the subject was partly therapy for his own depression, yet his is not the only attempt to define and portray the nebulous quality of melancholy. There is a rich cultural tradition in which melancholy has been considered an interesting enough phenomenon to deserve reflection in a variety of ways.

A major exhibition, *Melancholie genie et folie en Occident*, devoted to the topic of melancholy and its portrayal in the arts throughout Western history, was held at the Grand Palais in Paris in November–December 2005. Interest in the event appeared high; queues waited in the cold to buy tickets. Could this be a small manifestation of some broader trend in society, a kind of revival of interest in melancholy?

TABLE 2 *Modern Depression vs. Historical Melancholy*

KEY THEME: MODERN DEPRESSION vs. HISTORICAL MELANCHOLY	Evidence to support key themes			
	Literature Review	Biographical Data	Art Therapy Case Studies	Interviews/ Sufferers/Co-Researchers
Terminology/definitions	■ Melancholy/melancholia until the 20th century used to describe spectrum from transient sadness to psychotic mood disorder ■ Modern 'depression' – clinically limiting	■ The experience is richly articulated especially by poets and writers over the years both in their work and in journals, letters etc.	■ Experience expressed vividly – denoting dimensions relating to 'whole self' ■ Ability to break away from narrow definitions through engaging in the creative process	■ Sense of stigma attached to 'label' of modern clinical depression ■ Negative sense of being identified by a set of symptoms
The increase in prevalence of depression	■ WHO's prediction ■ Danger of 'medicalisation of misery' or ordinary unhappiness?			■ Query over society's values – sense of societal malaise/ anomie?
Melancholy as an integral part of the human condition	■ Robert Burton's 'Anatomy' ■ Richness of description of experience through ages in pictorial and literary tradition ■ Shakespeare's plays	■ The reluctance to be treated (e.g. Munch) ■ Artists' view of it as an important part of their creativity despite pain	■ Learning to manage this part of life – accepting it as part of themselves	■ Viewed by many as an exaggerated form of normal feeling and behaviour
The diversity of historical melancholy compared to day	■ Burton's 'chameleon' ■ Melancholy or suffering as a necessary part of life (Nietzsche) ■ Positive views of melancholy through the ages	■ Unique, varying ways of dealing with mood disorder ■ Modern 1950s psychotropic drugs help stabilise the illness	■ Sense of feeling constrained or defined by the illness – frustration and anger	■ Stigma

The paradoxical benefits of mood disorder

Although it may seem paradoxical, even counter-intuitive, the co-existence of bipolar disorder and creativity appears to confer benefits, not only for the highly talented, but for 'ordinary' sufferers of the illness – see ***Table 3***, opposite.

It became clear in the interviews and other aspects of the empirical research, such as the biographical studies, that the benefits could be categorised broadly as those which arise immediately from the stages of the mood disorder, such as the hypomanic phase, and may be transient, and other, perhaps less obvious, benefits which develop over time and lead to lasting changes.

The benefits of hypomania are well documented in the literature and reflect personal experiences. Those interviewed attested to the benefits of hypomania in particular, while regretting the often damaging and embarrassing effects of full-blown mania (loss of inhibition, inappropriate sexual behaviour, overspending, etc). However, hypomania allowed for increased energy, confidence, enthusiasm and fluency of ideas. One individual interviewed described the intensity of these periods as 'vivid 3D thought'. Those with bipolar disorder all found they could achieve much during these periods, due to the increase in energy and confidence, but admitted in calmer moments that some of the work produced might not always have been of as high a standard as they had thought at the time.

Jamison (1994) has written of mood cognition and behavioural changes reported in writers and artists during intense creative periods. Enthusiasm, energy, self-confidence, speed of mental association, flowing of thoughts, increased mood or euphoria, ability to concentrate, emotional intensity, sense of well-being, rapid thinking, expansiveness, sensory awareness and restlessness were listed as the main dimensions of those in her sample.

While the benefits of hypomania are understandable – it is as if sufferers at this time live much more vividly and intensely than the rest of us – the benefits of depression are less obvious. However, depressed mood can lead to a period of calmer reflection, when the individual can reflect and stock take. For the creative individual, it may be a time for review of work done in a hypomanic period. The benefit can be that this mood acts as a censor, helping to modify and edit work which might in places be brilliant, and in others erratic.

Research by Taylor and Brown (1988) has in fact indicated that those who are mildly depressed generally have a more realistic perception of life than those in 'normal' mood states. Lederach (2005) uses a similar concept, 'constructive pessimism', and comments on the value of facing difficult realities, of seeing things, as far as possible, as they really are.

Depression or melancholic states bring with them sensitivity and compassion that can be meaningful in themselves and act as a balance to the often hectic enthusiasms of hypomania. Everyone in the sample interviewed reported a sense of increased insight and awareness as a result of the experience of the illness. One person even felt that the very uncertainty of their health and the future seemed to 'sharpen the sword' (of the mind).

Interestingly, these new levels of insight and awareness forced on the individual by circumstance of the illness are not transient. In those interviewed, all without exception spoke of the longer-term impact of newly acquired insight and awareness. Comments included:

> *'I've grown up a lot since 1990; I'm still learning a lot about myself, about life and about people',*

and

> *'I'm more in tune with other people's problems; almost intuitively I can read people'.*

The need for psychological uncertainty

Sufferers of mood disorder are invariably thrown into a state of confusion in the early stages of the illness. Those interviewed in the sample spoke of the fearfulness and uncertainty at this time. Significantly, over time, they almost all learned to cope, or to live with periods of uncertainty (***Table 4***, page 12).

Rogers (1995) refers to the ability to tolerate ambiguity and uncertainty as an important component of extensionality, or openness to experience, which he cites as one of his conditions of constructive creativity. Keats described this ability as 'negative capability':

> *when a man is capable of being in uncertainties, mysteries, doubts, without any irritable reaching after fact and reason* (cited in Motion, 1997 p165).

Artists tend to have this capacity for coping with ambiguity and uncertainty. The creative process often includes new ideas arising out of chaos. Ludwig (1995), in his study of eminent individuals, refers to this tension as 'psychological unease'. He argues that psychological unease can serve as a source of creative tension, which can be relieved when the individuals are at work or in the midst of solving problems.

Churchill alluded to the tension inherent in the creative process of painting by comparing working on a painting with going into battle. This insight is important, as artists

TABLE 3 *The Paradoxical Benefits of Mood Disorder*

KEY THEME: THE PARADOXICAL BENEFITS OF MOOD DISORDER	Evidence to support key themes: Literature Review	Biographical Data	Art Therapy Case Studies	Interviews/ Sufferers/Co-Researchers
Benefits of hypomania	■ Analysis of studies all reveal increased fluency, energy, flow of ideas, enthusiasm, confidence at this time	■ Increased productivity e.g. 'Year of Song'. Increased energy, confidence, flow of ideas, enthusiasm (e.g. Newton and Churchill's prodigious output)	■ John – sense of speed, acceleration and energy euphoria	■ 'Vivid 3D Thought' ■ Individuals spoke of the 'edge' this period gave – increased alertness and problem-solving ability
Benefits of depression	■ Time of calmer reflection, stock taking, censoring or editing of work carried out in hypomanic state (e.g. Newton) ■ 'Constructive pessimism'	■ Woolf's 'plunge into truth' ■ Correction of mistakes, etc. (e.g. Newton)	■ Insight, time of reflection ■ Awareness of 'darker' side of self	■ Facing the abyss – a life-changing experience
Enhanced psychological acuity/ insight over time	■ Artists' belief in the necessity of the experience for their work (Miró, Woolf)	■ Pascal's 'Pensées' ■ Montaigne's autobiographical work ■ Woolf's 'psychoanalysing' self through writing	■ John 'No Magic Sunrise' painting at end of treatment ■ Fresh perspective on life/personal values	■ Deepened understanding of self and others (not transient)
Opportunity for personal development	■ Existential view of making sense of one's own life (Kafka, Sartre, Schopenhauer)	■ Churchill's writing and painting	■ Process of re-integration of aspects of self over time (John) ■ Self-acceptance	■ Increased compassion ■ Change ■ Sense of being more 'whole' as a person

TABLE 4 *The Need for Psychological Uncertainty*

KEY THEME: THE NEED FOR PSYCHOLOGICAL UNCERTAINTY	Evidence to support key themes			
	Literature Review	Biographical Data	Art Therapy Case Studies	Interviews/ Sufferers/Co-Researchers
Coping with uncertainty as a creative aptitude	■ Keats' 'Negative Capability' ■ Roger's view of the need for openness to experience as essential to creativity ■ Ludwig's 'Psychological Unease'	■ The Romantic Era of painting and literature denoting man's insignificance in the face of mighty nature (Friedrich, Byron, Coleridge)	■ The search for a solution often changes to an inner search for meaning and understanding – an inner, even spiritual, journey	■ Learning to accept the fluctuations of mood disorder, its unpredictability and take some control over it
Strength through adversity	■ Danger of avoidance of painful feelings (e.g. Patmore's risk-free society)	■ The need for discipline in the arts – Churchill's analogy with 'going into battle' ■ The importance of a 'meaningful confrontation with reality'	■ Strength through increased inner knowledge and self-determination	■ The 'illness' as a 'strength-building exercise' – if you can weather it ■ Increased resilience through adversity

TABLE 5 *Creative Adaptive Potential*

KEY THEME: CREATIVE ADAPTIVE POTENTIAL	Evidence to support key themes			
	Literature Review	Biographical Data	Art Therapy Case Studies	Interviews/ Sufferers/Co-Researchers
Acceptance of the cycles of illness	■ Adaptive reactions ■ Evolutionary psychiatry (Stevens & Price) – argues depression and mania are adaptive reactions and useful	■ Individual variances e.g. inability to do this – Schumann found depression incapacitating, Woolf used 'deeper' truths in his writing	■ Painting of the seasons – different moods for different times of the year	■ Sense of 'embracing the illness' ■ 'Go with the flow' ■ Adaptation
Self-efficacy/agency	■ Using the experience of illness therapeutically by writing about the phenomena e.g. Burton, Montaigne, Pascal, Nietzche, Kafka	■ Pre-1950s psychotropic medications more difficult to manage illness – suicidal ideation more prevalent (Woolf, Hancock & Schumann)	■ A sense of increased self responsibility and insight through the process of therapy and other treatment – taking charge of one's own life	■ Adaptation process over time ■ Learning to manage the illness ■ Sense of control
The benefit of mood disorder to society	■ Helping to make sense of what it is to be human, philosophers, writers and artists in particular articulating this ■ The need for a degree of psychosis for divergent thinking – leading to innovation, coping	■ The richness of the pictorial and literary tradition – mood disorder as a catalyst for serious creative endeavour ■ Contributions of eminent talented individuals to society	■ Enhanced insight on an individual level leading to increased personal responsibility and self-determination	■ The ability to cope with melancholy independently in the community, with support ■ The opportunity to 'give back' to society by helping others

 © The Clifford Beers Foundation

need to be disciplined in their work and to have a strong capacity to organise warring elements. They dive into the 'primordial soup' of an alternative reality, but can surface again and use the experience in their work. Miró and Woolf both worked like this. Woolf spoke of the 'assault of truth' which cannot be avoided (Lee, 1997).

The dive into this 'primordial soup' of the unconscious, or willingness to delay the need for certainty of outcome, is part of the creative process – the 'incubation' period, before the 'eureka' moment.

A positive strong finding among the sample was that strength or resilience developed through adversity. One viewed the illness as:

> *'a strength-building exercise – if you can weather it',*

and:

> *'you go through so much; you can go through anything life throws at you when you are well. Being able to cope with things because you've had to already in your illness, it does help. It makes you a stronger person'.*

In this respect, most of the sufferers of mood disorder interviewed shared many characteristics with the highly creative individuals.

Creative adaptive potential

Creative adaptive potential (***Table 5***, opposite) can be looked at from the perspective of the individual as well as that of the broader society.

The individuals interviewed all spoke of the importance of accepting the reality of the illness, with its highs and lows. One even recommended that the best thing was to 'embrace' it. Over time, it seemed, they became increasingly adept at 'going with the flow' of the illness. They learned how to 'use the illness', 'when to go for it' and when it was better to 'lie low and not expect too much of oneself'.

There is increasing interest in the literature on the potential adaptive way of viewing depression, based on Darwinian ideas of evolution. Stevens and Price (2000) in their book *Evolutionary Psychiatry* discuss both depression and mania as adaptive reactions.

Individuals' ability to adapt to the effects of their mood disorder often goes beyond simply coping or managing the illness. Those interviewed after having lived with the illness for some years seemed to have become experts in managing their illness. An adaptation or sense of integration often seemed to occur, triggered by the illness. There is thus evidence that individuals can do much to take control of their own illness and manage it creatively. For those who are seriously ill, this needs to be in the context of appropriate treatment and support. There is evidence, then, that in the right circumstances, individuals can learn to work with the 'highs' and 'lows' of the illness in an adaptive way.

Those who lived with the illness before the 1950s, the decade when the major psychiatric drugs were introduced, fared less well, partly because they lacked appropriate medication, and partly because the mood disorder was less well understood. Woolf suffered five serious depressive breakdowns, and ultimately dreaded another journey into despair so much that she took her own life. Schumann could not be consoled by his depressions, and found them simply incapacitating.

On a broader societal level, there is much current interest in research on the adaptive function of mood disorder and the reason for its evolutionary survival. Nettle (2001), for example, discusses the possibility that some genetic variants predispose to psychosis. If they often have terrible outcomes for individuals, why have these genes persisted in the human species? Why has natural selection not 'ejected them' from the gene pool? He argues that there are advantages for society in a degree of psychosis, either depressive psychosis or schizophrenia, which can aid divergent thinking and enhance mood, energy and flow of ideas and thinking, leading to originality and innovation. In other words, the common factor in both madness and creativity is strong imagination – good for society, but not always advantageous for the individual.

The debate about the adaptive function of mood disorder continues. The arguments, although not conclusive, are quite compelling in making the case that mood disorder has an adaptive function of potential benefit to society.

The sufferer, like the artist, as a seeker of truth

Artists try to express some fundamental truth in ways that help increase understanding of aspects of human experience (***Table 6***, page 14).

Koestler (1969) discusses the central importance to the creative act of the 'night journey', during which the artist-hero suffers overwhelming experiences on a spiritual journey from which he emerges 'powerfully enriched' by new insight, regenerated on a higher level of integration. Sufferers similarly seek a truth for themselves. There is often a desire, a drive, for authenticity and meaning.

The experiences of those interviewed, often related in 'life story' format, show the progress or journey through the early initial stages of the illness, and the many adjust-

TABLE 6 *The Sufferer, Like the Artist, as a Seeker of Truth*

KEY THEME: THE SUFFERER, LIKE THE ARTIST, AS A SEEKER OF TRUTH	Evidence to support key themes			
	Literature Review	**Biographical Data**	**Art Therapy Case Studies**	**Interviews/ Sufferers/Co-Researchers**
Suffering as a creative journey	■ Lessons from literature - Job's suffering - Dante's Divine Comedy - Shakespeare – the search for meaning through suffering (e.g. King Lear'	■ Use of experience of suf-feringin artwork - Woolf's highly psychological novels - Miró's drawing on his suffering in his work	■ With time acceptance of no easy answers ■ Growing sense of self-determination	■ An inner voyage or journey ■ A spiritual dimension – greater understanding of life
The 'Assault of Truth'	■ Artist's ability to dip in and out of the 'primordal soup' (Koestler) ■ Existential making sense of seeming nothingness	■ The need to face reality e.g. Woolf's plunge into a deeper 'reality' Roethke: 'In a dark time, the eye begins to see'	■ Often initially resisted, but over time insight develops ■ Confronting difficult realities – no one absolute truth	■ 'Facing the Abyss' - an experience for artists and non-artists alike
The self as a 'work in progress'	■ Lifelong learning as an aspira-tion ■ Socratean Educative Ideology – the self as the 'product'	■ Constant reinvention of the self over time – meaningful, cre-ative activity as necessary to this development	■ For both art therapy case stud-ies there was a 'sense of work in progress'.	■ The role of suffering leading to greater understanding ■ Process of integration of the self ■ The recovery process

ments to life goals that have to be made. This stage was followed by a final coming to terms with the reality of the illness, and a review of values and priorities. Sufferers of mood disorder have to face the raw chaotic messy material of life and try to make sense of it and find a certain truth and meaning.

Although spirituality *per se* was not discussed overtly by the individuals interviewed, their description of the journey towards recovery reflects a spiritual dimension. One of those interviewed put it this way.

> *'Maybe you do in life have to suffer to understand… I'm still learning a lot about myself, about life and about people… I'm more in tune with other people's problems, almost intuitively.'*

All felt the need for a meaningful activity, often with the hope of helping others. Rogers (1995) speaks of the 'realisation of the self' as a process and of the need to accept oneself as a stream of becoming, not a finished product.

> *It means that the person is a fluid process, not a fixed and static entity; a flowing river of change, not a block of solid material; a continually changing constellation of potentialities, not a fixed quantity of traits.*

This more 'organic' description of the process of self-realisation, or integration, seems to reflect the reality of mood disorder and of sufferers' actual lived experience. The empirical work has demonstrated clearly that individuals can and do 're-invent' themselves constantly over time, often feeling that they have become better people as a result of the experience of illness.

Rank (1989) reminds us that in ancient Greece the state of being a pupil did not mean simply acquisition of a certain skill or knowledge; it referred to the forming of a personality which is then perfected and developed over time. Socrates' educational ideology is an example of this process, where the concrete art product might be considered almost a by-product of the central artistic process – that of the individual as a creative entity or product in his own right.

Paradoxically, the illness process is not always a barrier to development of the whole personality, but may in fact act as a catalyst for a fuller, more integrated personality. Naturally, it is not certain that all those with serious mood disorder, bipolar or unipolar, are capable of this development; the sample interviewed were characterised by very high levels of insight and awareness.

Summary

The above themes reflect the qualitative, humanistic research approach. Although quite broad in themselves, they reflect the findings of the empirical work and the literature review, and in turn feed into the concluding findings of Chapter 12 of the research work. They also helped inform the design of the model for managing mood disorder described in Chapter 11 of the thesis.

Address for correspondence

Judith Lee, Director of Education, Northern Ireland Association for Mental Health, Beacon House, 80 University Street, Belfast, BT7 1HE. Phone: +44 (0)28 90328474, Fax: +44 (0)28 90234940, e-mail: Judith.Lee@niamh.co.uk

References

Andreason, N.C. (1987) Creativity and mental illness: prevalence rates in writers and their first degree relatives. *American Journal of Psychology* **144** 1288–92.

Aristotle (1957) *Problems* II*, Book XXX* (trans. W.S. Hett) London and Cambridge, Mass, USA: Heinemann with Harvard University Press.

Bell, O. & McNeillie, A. (Eds) (1977–84) *The Diary of Virginia Woolf* (5 vols). London: Hogarth Press.

Bett, W.R. (1952) *The Infirmities of Genius.* New York: Philosophical Library.

Byron, George Gordon (1986) *Lord Byron, The Complete Poetical Works, 'Childe Harold's Pilgrimage', vol. 2, canto III, stanza 77, lines 726-732* Jerome J. McGaun (Ed), Oxford: Oxford University Press.

Burton, R. (1621) *The Anatomy of Melancholy* (2001 edition). New York: The New York Review of Books.

Harrison, G.B. (1934) *The Life and Writings of William Shakespeare*. London: Clowes and Sons Ltd.

Jamison, K.R. (1994) *Touched with Fire: Manic-Depressive Illness and the Artistic Temperament*. New York: Simon & Schuster Inc.

Karlsson, J.L. (1981) Genetic basis of intellectual variation in Iceland. *Hereditas* **95** 283–8.

Koestler, A. (1969) *The Act of Creation*. London: Picador.

Lederach, J.P. (2005) *The Moral Imagination. The Art and Soul of Peacebuilding*. New York: Oxford University Press.

Lee, H. (1997) *Virginia Woolf*. London: Vintage.

Ludwig, A.M. (1995) *The Price of Greatness – Resolving the Creativity and Madness Controversy*. New York, London: The Guilford Press.

Montaigne, Michel de (2003, orig. 1572) *The Complete Essays* (trans. M.A. Screech). London: Penguin Classics.

Motion, A. (1997) Letters to his brother. *Keats*. London: Faber and Faber.

Nettle, D. (2001) *Strong Imagination, Madness and Creativity in Human Nature*. Oxford, New York: Oxford University Press.

Nietzsche, Friedrich (1979) *Ecce Homo* (trans. R.J. Hollingdale). Harmondsworth: Penguin.

Rank, O. (1989, first published 1932) *Art and Artist: Creative Urge and Personality Development.* New York, London: WW Norton & Co.

Richards, R.L., Kinney, D.K., Lunde, I. & Benet, M. (1988) Creativity in manic depressives, cyclothymes and their normal first degree relatives: a preliminary report. *Journal of Abnormal Psychology* **97** 281–8.

Rogers, C.R. (1995, first published 1961) *On Becoming a Person – A Therapist's View of Psychotherapy*. New York: Houghton Miffin Company.

Screech, M.A. (trans. 2003) *Michel de Montaigne, The Complete Essays*. London: Penguin.

Stevens, A. & Price, J. (2000, first published 1996) *Evolutionary Psychiatry – A New Beginning.* London and Philadelphia: Routledge.

Taylor, S.E. & Brown, J.D. (1988) Illusion and well being: a social psychological perspective on mental health. *Psychological Bulletin* **103** 193–210.

Frits Boer

Amsterdam Medical Centre, Department of Child and Adolescent Psychiatry, and de Bascule, Academic Centre for Child and Adolescent Psychiatry, Amsterdam

Hedy Stegge

Free University, Department of Developmental Psychology, Amsterdam

Hayriye Akyuz

Mentrum Mental Health Organisation, Amsterdam

Recognition of Children of Preschool Age at Risk for Internalising Disorders in Mainstream and Islamic Primary Care

ABSTRACT

Precursors of internalising problems, anxiety and depression, appear as early as the preschool years. To be able to conduct preventive programmes in early childhood, it is essential that children showing these precursors be recognised. This study investigates to what extent professionals in primary care are aware of these precursors, when brought to their attention by parents during regular check-ups. Prototypical descriptions of children at risk for internalising problems were presented to professionals, after which recognition and services provided were investigated in a structured interview. As well as professionals in mainstream health services, the study included Islamic counsellors (imams), to increase sensitivity to cultural differences in the use of services. The study provides preliminary evidence of the contribution professionals in primary care can make to early identification of children at risk for internalising disorders. Professionals prove to differ in their recognition of risk factor subtypes and the advice they give parents. These differences are most evident between professionals in mainstream care and professionals in Islamic care.

Key words: prevention; early childhood; primary health care; anxiety; depression; transcultural mental health

Introduction

Anxiety and depression, the internalising disorders of childhood and adolescence, are responsible for much suffering, due to their high prevalence and the impairment that accompanies them. Epidemiological studies show that in the 4–20 age range, 8–12% of children are afflicted by at least one anxiety disorder, and 2–5% suffer from depression (Bernstein & Borchardt, 1991; Birmaher *et al*, 1996). Anxiety disorders commonly commence during the school years, whereas depressive episodes usually begin after puberty. Early signs, however, can appear as early as the preschool years (Keenan *et al*, 1997; Kashani *et al*, 1997). Although episodes of anxiety and depression can be transitory, there is often a relapse, leading to a chronic condition that persists into adulthood (Heijmens Visser *et al*, 1999).

Given the prevalence and continuity of internalising disorders, it is important to identify children at risk for internalising disorders as early in development as possible, to allow timely preventive interventions. Surprisingly, few preventive programmes exist for childhood internalising disorders, in contrast to the large number of programmes developed for externalising disorders (Bayer & Sanson,

2003; Greenberg *et al*, 2001). The programmes that exist have been developed for school-age children (Beardslee *et al*, 1997; Dadds *et al*, 1997, 1999) or adolescents (Clarke *et al*, 1995). To our knowledge there is only one programme designed for children of pre-school age (Rapee *et al*, 2005).

To be able to develop preventive programmes for children of preschool age, it is essential to know which criteria to use for selecting at-risk children. Although our knowledge of risk factors for internalising disorders is far from conclusive, research has yielded a number of child characteristics and environmental influences that contribute to the development of internalising problems (Greenberg *et al*, 2001; Bayer & Sanson, 2003). Of these two, the child characteristics may be especially important, given the finding that early adverse family circumstances and parenting characteristics do not contribute to later psychopathology once child characteristics are accounted for (Mesman & Koot, 2001). In preschool age there are two groups of child characteristics that have been identified as important risk factors:

- temperamental characteristics (Biederman *et al*, 1995; Kovacs & Devlin, 1998)
- earlier forms of similar psychopathology (Mesman & Koot, 2001).

The temperamental characteristics that have been identified are **behavioural inhibition** (Biederman *et al*, 1995; Rapee *et al*, 2005) and **negative affectivity** (Kovacs & Devlin, 1998). Early (preschool age) forms of anxiety disorder are either a **separation anxiety disorder** or a **specific phobia** (Öst & Treffers, 2001). **Major depressive disorder** can be found in children of preschool age as well, when developmentally modified criteria are used (Luby *et al*, 2002).

While it is theoretically possible to identify risk factors for internalising disorders in children of preschool age, the next step is to find out how children at risk can be recognised. Rapee and colleagues (2005) used a screening method in which questionnaires assessing temperamental characteristics were distributed to parents of children attending 95 Australian preschools. As is common with such an impersonal approach, the number of non-responding families exceeded 70%. In countries such as The Netherlands where parents of young children are seen routinely for regular check-ups by professionals following their development (the general practitioner or the public health child care department), it is possible to use a more personal approach that may yield better compliance. The same is true for those professionals in primary care to whom parents turn for parenting problems with their preschool child: psychologists in public centres for parent education and support. In areas with a substantial Muslim population, such as the city of Amsterdam (14%; City of Amsterdam, Department of Research and Statistics, 2006; www.os.Amsterdam.nl/english/), a fourth type of professional, the imam, should be added, because many citizens with an Islamic background prefer to address mental health and parenting questions to the Islamic clergy (imam) rather than to professionals in mainstream health services (Ali *et al*, 2005).

To be able to use the contacts parents of preschool children have with professionals in primary care in identification of children at risk for internalising disorders, it is essential that these professionals recognise these children when they are described by their parents, even when the parents do not explicitly express worries or concerns.

This study therefore addresses the following questions.

- Do professionals in primary mental health care recognise prototypical descriptions of risk factors for internalising disorders as problems that are brought to their attention by parents?
- Are there differences in recognition according to prototype?
- Are there differences in recognition according to the type of professional in mainstream and Islamic primary care?
- What kind of advice do parents receive when they describe risk factors for the development of internalising disorders?

Method

Sample

This exploratory study was carried out in the city of Amsterdam and neighbouring municipalities. The aim was to include those professionals who provide universally available services for parents of young children:

- general practitioners (further referred to as **GPs**)
- nurses in public health child care departments (further referred to as **nurses**)
- psychologists in public centres for parent education and support (further referred to as **psychologists**)
- **imams**.

All parents of preschool children in The Netherlands have contact with either GPs or nurses for regular check-ups regarding their physical and psychological development, whereas those parents with minor or major parenting

concerns will address one or more of all four types of professional.

Seventy professionals from these four groups were approached, of whom forty-five were willing to participate (sixty-four per cent response rate): eleven GPs, nine nurses, thirteen psychologists and twelve imams.

The third author (Hayriye Akyuz) interviewed the professionals. In a semi-structured interview, prototypical descriptions (described in more detail below) were offered, and questions were asked about recognition, prevalence and the services provided.

Prototypical descriptions

An experienced child and adolescent psychiatrist and an experienced developmental psychologist wrote portraits of children which showed one of five types of child characteristic considered to be risk factors for development of internalising problems:

- temperamental characteristics of **behavioural inhibition** (Biederman *et al*, 1995)
- temperamental characteristics of **negative affectivity** (Kovacs & Devlin, 1998)
- preschool age types of anxiety disorder, **separation anxiety disorder**
- **specific phobia** (Öst & Treffers, 2001)
- preschool age type of **major depressive disorder** (Luby *et al*, 2002).

The descriptions were based on the literature and clinical experience. Care was taken not to mention explicitly the temperament or disorder, but to stick to a behavioural description (see the **Appendix** for the complete text of the prototypes). It was indicated that these descriptions applied to children between 0 and 6 years of age.

Data analysis

The chi-square test was used to test the significance of differences in distribution. The limit of statistical significance was $p < 0.05$.

Results

Professionals

In the three groups of professionals in mainstream care there was a predominance of women; in the group of imams the reverse is true (***Table 1***, below). The professionals did not differ much in age. The imams on average had somewhat less professional experience than the other three groups.

TABLE 1 ***Professional Experience of Professionals***

Profession	Total (females)	Mean age (SD)	Experience* mean (SD)
GP	11 (7)	46.7 (9.5)	17.8 (9.4)
Nurse	9 (8)	40.6 (7.6)	12.8 (8.6)
Imam	12 (4)	40.4 (8.4)	9.5 (7.0)
Psychologist	13 (10)	41.0 (10.7)	13.2 (8.7)

** in years*

Recognition of prototypical descriptions

When professionals were asked whether the description provided in the prototype is ever brought to their attention by parents they meet in practice, Negative affectivity proved to be recognised most (***Table 2***, below). When the professionals who recognise this prototype are asked to estimate the prevalence of this characteristic, Negative affectivity is estimated to be the most frequent (***Table 2***).

TABLE 2 ***Estimate of Prevalence per Prototype***

Prototype	Reported recognition	Estimate of prevalence when recognised
Negative affectivity	91%	19%
Behavioural inhibition	74%	8%
Depression	63%	5%
Separation anxiety	78%	7%
Specific phobia	76%	4%

Table 3, below, shows the extent to which different types of professional recognised prototypes. It shows that the imams differed from the other professionals in their recognition of early forms of behavioural inhibition and separation anxiety. These differences proved to

TABLE 3 ***Recognition of Prototype According to Profession***

Prototype	GPs	Nurses	Psychologists	Imams
Negative affectivity	82%	89%	100%	100%
Behavioural inhibition	82%	100%	92%	33%
Depression	64%	89%	62%	50%
Separation anxiety	91%	89%	92%	50%
Specific phobia	82%	89%	62%	83%

be significant when tested (χ^2= 18.97, df=3, p= .002), respectively (χ^2= 9.24, df=3, p= .026).

Additional problems

After presentation of the prototypical description, professionals who recognised the type of child described were asked whether parents who had given these descriptions typically bring forward other types of associated problem. The additional problems that were mentioned could be categorised as either externalising or somatic. Professionals reported that parents of children characterised by negative affectivity tend to report externalising problems as well, in contrast to the other prototypes. Somatic problems are reported alongside all prototypes, especially in association with depression (***Table 4***, below).

TABLE 4 ***Additional Problems Reported Alongside Prototype***

Prototype	Externalising problems	Somatic complaints
Negative affectivity	21%	41%
Behavioural inhibition	9%	56%
Depression	0%	62%
Separation anxiety	3%	39%
Specific phobia	0%	14%

Parental requests for advice

When professionals recognised a prototypical description, they were asked whether parents who describe their child in this way experience these characteristics as something to worry about and tend to ask for professional advice. ***Table 5***, below, shows that this is usually the case, although with differences according to prototype and profession. Statistical testing showed significance with regard only to separation anxiety (χ^2= 10.44, df=3, p= .015). Most professionals reported that parents describing negative affectivity in their child also ask for advice. The same holds true for specific phobic reactions. But describing a child of preschool age with depressive characteristics does not always occur in the context of help seeking, according to nurses and, especially, imams.

TABLE 5 ***Parents ask Advice about these Characteristics****

Prototype	GPs	Nurses	Psychologists	Imams
Negative affectivity	100%	88%	100%	67%
Behavioural inhibition	56%	78%	75%	75%
Depression	72%	50%	88%	33%
Separation anxiety	70%	75%	92%	50%
Specific phobia	67%	88%	88%	80%

**Only professionals who recognised the prototype were included.*

Interventions offered

What do professionals do when parents describe characteristics that show that their child is at risk of developing an internalising disorder? According to their report, they sometimes abstain from specific interventions (***Table 6***, below). This is especially the case when the characteristics

TABLE 6 ***Intervention Offered to Parents According to Prototype and Profession***

Prototype and intervention	GPs	Nurses	Psychologists	Imams
Negative affectivity				
Abstain from intervention				17%
Parenting advice	100%	88%	54%	42%
Referral to mental health		13%	8%	
Referral to other service			38%	
Faith healing				42%
Behavioural inhibition				
Abstain from intervention	11%		8%	
Parenting advice	78%	100%	58%	100%
Referral to mental health				
Referral to other service	11%		33%	
Faith healing				
Depression				
Abstain from intervention	29%	14%		17%
Parenting advice	71%	86%	29%	67%
Referral to mental health				
Referral to other service			71%	
Faith healing				17%
Separation anxiety				
Abstain from intervention	40%	13%		
Parenting advice	60%	75%	58%	100%
Referral to mental health		13%		
Referral to other service			42%	
Faith healing				
Specific phobia				
Abstain from intervention	11%	13%		10%
Parenting advice	89%	87%	50%	10%
Referral to mental health				
Referral to other service			50%	
Faith healing				80%

** Only professionals who recognise the prototype are included.*

are those of a depressed child or a child with separation anxiety. In most cases professionals provide parenting advice. They do not often refer children to agencies for mental health. Psychologists do refer children with precursors of internalising problems to other agencies, especially (as we gathered during the interviews) to child physical therapists. Imams also offer faith healing (asking parents to repeat extra Koran verses) as a form of treatment, especially when parents describe negative affectivity or specific phobia (the conditions recognised best by imams).

Discussion

When descriptions of risk factors for internalising disorders in preschool-age children are presented to Dutch professionals in primary care, a large majority recognise these prototypes as problems brought forward by parents who consult them. The temperamental characteristic **negative affectivity** is recognised by more than 90%, the temperamental characteristic **behavioural inhibition** and early expressions of anxiety disorders (**separation anxiety disorder, specific phobia**) are recognised by approximately 75%, and early expressions of **depression** by approximately 60%. This provides preliminary evidence of the contribution professionals can make to early identification of children at risk of developing internalising disorders, at least in those countries with a public health system such as that in The Netherlands, where these professionals are consulted routinely by all parents of preschool children.

However, when we look at differences between types of professional, some interesting differences appear. GPs, nurses, psychologists and imams all endorse the recognition of **negative affectivity** and **specific phobia**. But imams differ from the other three groups of professionals in their less frequent recognition of **behavioural inhibition**, **separation anxiety disorder** and **depression**. When professionals are asked which of the child characteristics described are a source of concern for parents and have led them to ask for advice, there are differences according to prototype and profession. This raises the question of whether professionals meet different types of parent, or whether professionals differ in their sensitivity to these precursors – a question to be discussed below.

What advice do professionals give when parents bring these problems to their attention? Before discussing this, we need to note that at present professionals have no specific preventive interventions to offer, which, as was often remarked during the interviews, they regret. In general professionals in primary care have four options:

- abstain from intervening
- parenting advice along general principles
- referral to an institute for mental health
- referral to another service (for instance a child physical therapist).

For imams there is an extra option, faith healing (usually by advising parents to repeat extra verses of the Koran).

When investigating the advice currently offered by professionals in primary care, there is again a distinction according to the type of problem described, and according to the type of professional. Most professionals offer general parenting advice, although in some cases they refrain from intervention. Interestingly, the latter proved to be the case especially with regard to the prototypical description of a depressed child. Note that the professionals were not informed explicitly about the depression. It may be that they regarded the description of a child who does not seem to take pleasure in activities and who is easily tired and irritable (see **Appendix** for the full description) as that of a child going through a phase. It is more understandable that some professionals prefer to abstain in the case of separation anxiety, as this form of anxiety is very common in early childhood, and an expectant attitude is defensible when it is combined with provision of information to the parents. The same can be said about the specific phobia.

The tendency identified in this study for psychologists to refer children to child physical therapists could be idiosyncratic, and attributable to close co-operation between public centres for parent education and support in the Amsterdam region and child physical therapists who offer sensory integration therapy (Ayres, 1972). The faith healing offered by imams is obviously non-specific for the problems under consideration. Although it can provide support for parents, and therefore indirectly bring some benefit to the child, it also shows the need for the development of more specific interventions that can be used within Islamic care.

There are limitations to this study that have to be discussed. The sample was relatively small, and although we trust that the relatively good response rate (64%) has yielded a representative sample, we were not able to compare the characteristics of non-responders with those of responders. Although great care was given to the construction of the prototypical descriptions, their validity was not assessed formally. However, some support for their validity can be derived from this study. Professionals were asked to mention additional problems brought to their attention alongside the prototypes. Externalising problems were mentioned in association with negative affectivity, which is in accordance with the fact that this precursor, in contrast

to the others, is also associated with higher risk for development of externalising problems. The high frequency of somatic complaints as additional to depressive symptoms also testifies to the validity of this prototype, considering the often somatic expression of depressive problems in childhood.

What further research is needed? The aim of this study was to explore the possibility of identifying children of preschool age at risk for internalising disorders, through contact between professionals in primary care and the parents of young children. This seems possible, but restrictions have to be made. Not all prototypes of risk factors are recognised equally, and some professionals seem to meet a wider range of risk factors than others do. Relying solely on professional report does not enable us to discover whether parents are less inclined to report certain problems to certain professionals than to others, or whether certain professionals lack sensitivity to these problems. It is therefore important to extend this study to include parental report, to show how far professionals need to become more aware of problems that parents bring forward but that remain unrecognised. By including parents, it is also possible to identify patterns of preference in addressing concerns to specific professionals, such as the GP or the imam.

We recommend including imams, and possibly other professionals with a distinct cultural and/or religious background, in further studies, considering that some citizens with a non-European background prefer to address their mental health and parenting concerns to counsellors in their cultural community. This is especially important with regard to the development of preventive interventions for internalising disorders. There is a dearth of such interventions in general, but they may be needed even more for children in Europe with a non-European background, bearing in mind the extent of internalising problems among them and the tendency in many European societies to focus exclusively on the externalising problems of immigrant youth (Bengi-Arslan *et al*, 1997; Bengi-Arslan *et al*, 2002).

This study is about the feasibility of preventive efforts through primary care for parents of young children, and not about the content of preventive programmes. Obviously the development of such programmes has high priority. In carrying out this study we met an urgent need among professionals in primary care for specific interventions for children with precursors or mild forms of internalising disorders. We recommend that these programmes be developed in close collaboration with primary care officials, from both mainstream and specific culture-bound services.

Acknowledgement

This study was supported financially by the Frijling Prins Fonds.

Address for correspondence

Frits Boer, Amsterdam Medical Centre/de Bascule, PO Box 12474, 1100 AL Amsterdam, The Netherlands. Tel.: + 31-20/5663383. Email: f.boer@amc.uva.nl.

References

Ali, O.M., Milstein, G. & Marzuk, P.M. (2005) The imam's role in meeting the counselling needs of Muslim communities in the United States. *Psychiatric Services* **56** 202–5.

Ayres, A.J. (1972) *Sensory Integration and Learning Disorders*. Los Angeles: Western Psychological Services.

Bayer, J.K. & Sanson, A.V. (2003) Preventing the development of emotional mental health problems from early childhood: recent advances in the field. *International Journal of Mental Health Promotion* **5** 4–16.

Beardslee, W.R., Wright, E.J., Salt, P., Drezner, K., Gladstone, T.R.G., Versage, E.M. & Rothberg, P.C. (1997) Examination of children's responses to two preventive intervention strategies over time. *Journal of the American Academy of Child and Adolescent Psychiatry* **36** 196–204.

Bengi-Arslan L., Verhulst F.C. & Crijnen, A.M. (2002) Prevalence and determinants of minor psychiatric disorder in Turkish immigrants living in the Netherlands. *Social Psychiatry and Psychiatric Epidemiology* **37** 118–24.

Bengi-Arslan L., Verhulst F.C., van der Ende, J. & Erol, N. (1997) Understanding childhood (problem) behaviors from a cultural perspective: comparison of problem behaviors and competencies in Turkish immigrant, Turkish and Dutch children. *Social Psychiatry and Psychiatric Epidemiology* **32** 477–84.

Bernstein, G.A. & Borchardt, C.M. (1991) Anxiety disorders of childhood and adolescence: a critical overview. *Journal of the American Academy of Child and Adolescent Psychiatry* **30** 519–32.

Biederman, J., Rosenbaum, J.F., Chaloff, J. & Kagan, J. (1995) Behavioral inhibition as a risk factor for anxiety disorders. In: J.S. March (Ed) *Anxiety Disorders in Children and Adolescents*. New York: The Guilford Press.

Birmaher, B., Ryan, N.D., Williamson, D.E. *et al* (1996) Childhood and adolescent depression: a review of the past 10 years. Part I. *Journal of the American Academy of Child and Adolescent Psychiatry* **35** 1427–39.

Clarke, G.N., Hawkins, W., Murphy, M., Sheeber, L.B., Lewinsohn, P.M. & Seeley, J.R. (1995) Targeted prevention of unipolar depressive disorder in an at-risk sample of high school adolescents: a randomized trial of a group cognitive intervention. *Journal of the American Academy of Child and Adolescent Psychiatry* **34** 312–21.

Dadds, M.R., Holland, D.E., Laurens, K.R., Mullins, M., Barrett, P.M. & Spence, S.H. (1999) Early intervention and prevention of anxiety disorders: results at two-year follow-up. *Journal of Consulting and Clinical Psychology* **67** 145–50.

Dadds, M.R., Spence, S.H., Holland, D.E., Barrett, P.M. & Laurens, K.R. (1997) Prevention and early intervention for anxiety disorders: a controlled trial. *Journal of Consulting and Clinical Psychology* **65** 627–35.

Greenberg, M.T., Domitrovich, C. & Bumbarger, B. (2001) The prevention of mental disorders in school-aged children: current state of the field. *Prevention & Treatment* **4** 1–62.

Heijmens Visser, J., van der Ende, J., Koot, H.M. & Verhulst, F.C. (1999) Continuity of psychopathology in youths referred to mental health services. *Journal of the American Academy of Child and Adolescent Psychiatry* **38** 1560–8.

Kashani, J.H., Allan, W.D., Beck, N.C., Bledsoe, Y. & Reid, J. (1997) Dysthymic disorder in clinically referred preschool children. *Journal of the American Academy of Child and Adolescent Psychiatry* **36** 1426–33.

Keenan, K., Shaw, D.S., Walsh, B., Delliquadri, E. & Giovannelli, J. (1997) DSM-III-R disorders in preschool children from low-income families. *Journal of the American Academy of Child and Adolescent Psychiatry* **36** 620–7.

Kovacs, M. & Devlin, B. (1998) Internalising disorders in childhood. *Journal of Child Psychology and Psychiatry* **39** 47–63.

Luby J.L., Heffelfinger A.K., Mrakotsky, C., Hessler, M.J., Brown, K.M. & Hildebrand, T. (2002) Preschool major depressive disorder: preliminary validation for developmentally modified DSM-IV criteria. *Journal of the American Academy of Child and Adolescent Psychiatry* **41** 928–37.

Mesman, J. & Koot, H.M. (2001) Early preschool predictors of preadolescent internalizing and externalizing DSM-IV diagnoses. *Journal of the American Academy of Child and Adolescent Psychiatry* **40** 1029–36.

Öst, L.-G. & Treffers, Ph.D.A. (2001) Onset, course, and outcome for anxiety disorders in children. In: W.K. Silverman & P..D.A. Treffers (Eds) *Anxiety Disorders in Children and Adolescents: Research, Assessment and Intervention*. Cambridge: Cambridge University Press.

Rapee, R.M., Kennedy, S., Ingram, M., Edwards, S. & Sweeney, L. (2005) Prevention and early intervention of anxiety disorders in inhibited preschool children. *Journal of Consulting and Clinical Psychology* **73** 488–97.

Appendix: Prototypical descriptions used in this study

Negative affectivity

(this label is not read to the professional)

- Parents report that these children often experience and show negative emotions. They get angry easily, and can become very distressed, for instance when they are not allowed something they would like. These children are also very upset when they are hurt, or after the occurrence of something unpleasant.
- Parents report that these children react with negative emotions in other situations as well. They are very sad when they lose something they like (for instance a favourite toy), and react strongly to unexpected events.
- Parents report that they realise that other children of this age are sometimes angry, sad or distressed, but they emphasise the extreme nature of these reactions in their child, and their difficulty in calming down.

Behavioural inhibition

(this label is not read to the professional)

- Parents report that these children are often reticent in social contacts. They would rather watch other children play than participate actively. They are shy towards strangers and often don't feel at ease in company. They do not assert themselves, and are easily dominated by others.
- When compared with others, these children are rather reserved, unspontaneous, timid and constrained. Parents also report that these children do not like wild play or enervating activities. They do not approach new situations easily.
- Parents report that these children are very sensitive to criticism (including that from the parents themselves). They react to it by crying, having a temper tantrum, or by being over-compliant.
- Parents report that they realise that other children of this age are sometimes reserved, shy or over-sensitive, but they emphasise the extreme nature of these traits in their child.

Depression

(this label is not read to the professional)

- Parents report that these children don't seem to derive any pleasure from activities. In particular, they don't seem to get pleasure from playing. In contrast to other children, they don't very often react enthusiastically.
- Sometimes parents report that their child makes a sad impression as well. But it is also possible that they don't mention this, but rather emphasise how often their child is irritable.
- In contacts with peers, these children are inclined to hold back. They often give the impression of being tired.

Separation anxiety disorder

(this label is not read to the professional)

- Parents report that these children always try to stay close to them. When they have to separate from their parents, for instance because they have to go to school or have to spend the night somewhere else, they try to resist at all costs. Sometimes their resistance looks like anger, in other cases like panic.
- When these children are not close to their parents, they can be very concerned about bad things that might happen to their parents.
- Parents report that they realise that other children of this age sometimes have problems with separation from their parents, but they emphasise the extreme nature of these problems in their child.

Specific phobia

(this label is not read to the professional)

- Parents report that something specific makes these children very anxious. It could be a certain animal, such as a dog or a spider. It could also be a certain weather condition, such as storm or thunder, or the dark. These children will do anything not to be confronted with the object of their fear. When this happens nevertheless, there is a strong reaction, sometimes a panic attack, sometimes rage, sometimes freezing.
- Parents report that they realise that other children of this age are afraid of certain things, but they emphasise the extreme nature of the anxiety in their child, for instance by pointing out the preoccupation of their child with the feared object, even when there is no direct threat.

F E A T U R E

Willem H.J. Martens

Director, W. Kahn Institute of Theoretical Psychiatry and Neuroscience, The Netherlands

Prevalence of Depression in Various Ethnic Groups of Immigrants and Refugees: Suggestions for Prevention and Intervention

Key words: depression; immigrants; refugees; ethnic differences; prevention; intervention

Introduction

About 13 million people in the world are classified as refugees, and many more former refugees have been granted citizenship in their new countries. The prevalence of post-traumatic stress disorder, major depression or psychotic illnesses in these individuals is not known (Fazel *et al*, 2005). Migrants migrate for a number of reasons and for varying durations. The rates of depressive neurosis vary according to migrant status. Migrants in some groups are less likely to report symptoms of depression. The impact of migration on depression is not as clear and straightforward as for other psychiatric conditions (Bhugra, 2003). This article examines the prevalence of depression in refugees (or asylum seekers) and immigrants and its correlates, and presents suggestions for prevention and interventions.

A B S T R A C T

There are remarkable differences in the prevalence of and vulnerability to depression between ethnic groups of immigrants and refugees. Correlates of depression in various ethnic groups are examined in this article, and issues for prevention and intervention are discussed. Analysis of the research data indicates that there is sufficient evidence to conclude that intervention and prevention programmes should be constructed in such a manner that they meet the special needs of specific categories of immigrants and refugees.

Depression in immigrants and asylum seekers

This section presents the evidence on the prevalence of depression in a number of immigrant and asylum-seeking categories.

Children of asylum seekers

All the ten children aged between six and seventeen years taken from a remote Australian Immigration Reception and Processing Centre to a child and adolescent mental health service (CAMHS) met DSM-IV criteria (American Psychiatric Association, 1994) for both post-traumatic stress disorder (PTSD) and major depression with suicidal

ideation. Eight children, including three pre-adolescents, had made significant attempts at self-harm. Seven also had symptoms of anxiety disorder, and half reported persistent severe somatic symptoms. The majority (n=8) of children of preschool-age (n=10; younger than six years) were identified with developmental delay or emotional disturbance (Mares & Jureindini, 2004).

Immigrant children

School children who were recent immigrants (n=1004; aged 8–15 years) in Los Angeles were surveyed by Jaycox and colleagues (2002) in relation to their previous exposure to violence, and for DSM-IV symptoms of post-traumatic stress disorder (PTSD) and depression. The participants included children whose native language was Spanish, Korean, Russian or Western Armenian. Participants reported high levels of exposure to violence, both personal victimisation and witnessing of violence, in the previous year and in their lifetimes. Thirty-two per cent of children reported PTSD symptoms in the clinical range, and sixteen per cent reported co-morbid depressive symptoms in the clinical range. Depressive symptoms were predicted by recent victimisation only ($p < .001$) (Jaycox *et al*, 2002).

Chinese immigrants

Stokes and colleagues (2001) investigated depression in Chinese immigrants in the USA, using an updated Chinese translation of the original 30-item Geriatric Depression Scale (GDS; Yesavage *et al*, 1983). A convenience sample of 102 Mandarin-speaking, elderly Chinese participants (aged 60 yrs+) in two centres for old people in Santa Clara County, California was recruited. A total of 29.4% (n=30%) of participants showed symptoms of depression, higher than the range found in the older adult American population (13–20%). Those most likely to be depressed were in the 60 to 69 year age group (32%), lived with their children (37%), rated their financial and health status as below average, had less than secondary school education and had lived in the USA for less than five years (Stokes *et al*, 2001).

Depression in elderly Chinese immigrants (n=1537) in Canada was studied by means of a Chinese version of the 15-item Geriatric Depression Scale. A structured questionnaire was used to conduct face-to-face interviews. Nearly a quarter (25%) of the elderly Chinese immigrants reported having at least a mild level of depressive symptoms. Having more cultural barriers and a stronger identification with Chinese cultural values resulted in a higher probability of being depressive (Lai, 2004a).

The depressive symptoms of elderly immigrants (n=444) who had migrated from mainland China to Canada were measured by a Chinese version of the Geriatric Depression Scale. The findings indicated that 23.2% (n=103) of the elderly immigrants had some depressive symptoms. When other predicting variables were adjusted, elderly immigrants with more chronic illnesses, a less positive attitude to ageing, worse physical health, a worse financial situation, a lower level of ethnic identification as Chinese, more service barriers, a lower level of life satisfaction and shorter length of residency in Canada, and those who lived alone, tended to have more depressive symptoms (Lai, 2004b).

Koreans

The Center for Epidemiologic Studies Depression Scale was used to measure depression, by applying DSM-III criteria (American Psychiatric Association, 1980) to a community sample of 860 adult Korean immigrants residing in Toronto, Canada. A total of 2.6% of men and 6.7% of women manifested depressive syndrome, rates not substantially different from those reported in North American community populations (Noh *et al*, 1992b). Gender, marital status, intention to re-migrate and social support were the most powerful correlates of depressive syndrome. In summary, Korean immigrants in Toronto are not exceptionally vulnerable to depression, and social support from informal ethnic networks at the time of arrival has long-lasting effects on their mental health (Noh *et al*, 1992a).

Cambodians

To assess the prevalence of depression in USA Cambodian refugees, a cross-sectional, face-to-face interview was conducted in the Khmer language on a random sample of households from the Cambodian community in Long Beach, California. Adults (n=586; aged 35 to 75 years) who had lived in Cambodia during the Khmer Rouge reign and migrated to the United States before 1993 were randomly selected. Exposure to trauma and violence before and after immigration was measured using the Harvard Trauma Questionnaire and Survey of Exposure to Community Violence, and weighted past-year prevalence of post-traumatic stress disorder (PTSD) and major depression was measured by the Composite International Diagnostic Interview version 2.1. All participants had been exposed to trauma before immigration; 99% (n=483) had come close to death from starvation, 90% (n=437) had had a family member or friend murdered and 70% (n=338)

reported exposure to violence after settlement in the United States. High rates of major depression (51%, weighted) were found. In bivariate analyses, older age, having poor English-speaking proficiency, unemployment, being retired or disabled, and living in poverty were also associated with higher rates of major depression. Following multivariate analyses, pre-migration and post-migration trauma remained associated with major depression (Marshall *et al*, 2005).

Latino immigrants

One study screened 5122 Latina immigrants (n=5122; low-income families) who lived in the USA for DSM-IV major depression. Overall, 11.7% of the sample suffered from major depression. The rates of depression were 11.4% for women who lived with their children, 10.9% for those who had no children and 18.1% for those who were not living with their children. The odds of depression for immigrant Latinas who were separated from their children were 1.52 times as great as the odds for those whose children were currently living with them (p=.02). The odds of depression were similar among women who lived with their children and those who did not have children (Miranda *et al*, 2005b).

Black and colleagues (1997) investigated the prevalence of depressive symptoms and associated risk factors among older Mexican-Americans (n=2823; aged 65+ yrs), using data from the Hispanic Established Populations for Epidemiologic Studies of the Elderly. Multivariate logistic regression was used to examine the association between depressive symptoms and sociodemographics, chronic health conditions, disability and cultural factors. Just over a quarter (25.6%) of respondents reported high symptom levels. Rates among women (31.9%) and, particularly, men (17.3%) were higher than has been typically reported for older Mexican Americans and older adults in general. Female immigrants were at significantly higher risk for depressive symptoms than those born in the USA, whereas male immigrants were at lower risk. Gender, lack of insurance, financial strain, chronic health conditions and disability were associated with depressive symptoms. Several cultural factors were also associated with increased risk, including immigrant status, levels of acculturation and assimilation, health locus of control and recent immigration (Black *et al*, 1998).

A systematic sample of Latino immigrant adults (n=638; migrated to the United States from Central America, South America and Mexico) in three community-based primary care clinics in Los Angeles was studied by Eisenman and colleagues (2003). The study reports:

- exposure to political violence in the home country before immigrating to the United States
- communication with clinicians about political violence
- self-reported measures of health-related quality of life using the Medical Outcomes Study Short Form 36 (MOS SF-36)
- symptoms of depression.

In weighted analyses, 54% of the participants reported experiences of political violence in their home country, including 8% who reported torture. Of those exposed to political violence, 36% had symptoms of depression, compared with 8% among those not exposed to political violence. Controlling for age, sex, country, years lived in the United States, acculturation, income, health insurance status and recruitment site in a sub-sample of 512 participants (56%), those who reported exposure to political violence were more likely to meet symptom criteria for depression than were participants not reporting political violence (Eisenman *et al*, 2003).

Gonzalez and colleagues (2001) studied depression in Latino immigrants (n=1781; mean age of 70.6; 58.2% women; 85% Mexican Americans) who lived in the USA. Depressive symptoms were assessed by use of the Center for Epidemiologic Studies Depression scale (CES-D). Acculturation was measured by the Acculturation Rating Scale for Mexican Americans—II. Psychosocial, behavioural and medical histories were also obtained. The prevalence of depression (CES-D > or = 16) was 25.4%. Women were at greater risk (32.0%) than men (16.3%). Prevalence was higher among immigrants (30.4%), bicultural participants (24.2%) and less acculturated participants (36.1%) than US-born people (20.5%) and more acculturated groups (16.1%). When adjustments for education, income and psychosocial, behavioural and health problem factors were made, the least acculturated participants were at significantly higher risk of depression than highly acculturated Mexican Americans (Gonzalez *et al*, 2001). The high prevalence of depression among the least acculturated group may be related to cultural barriers encountered by immigrants and less acculturated older Mexican Americans, and to poorer health status.

Africans and Caribbeans

Miranda and colleagues (2005a) interviewed 9151 black women, 7965 born in the USA, 913 born in Africa and 273 born in the Caribbean. Controlling for other predictors, USA-born black women had odds of probable depression

that were 2.94 times as great as those of the African-born women and 2.49 times as great as for Caribbean-born women. The findings suggest that living in the USA might increase depression among poor black women receiving services in county entitlement clinics.

Ethiopians

The Composite International Diagnostic Interview questionnaire was used by Fenta and colleagues (2004) to measure depression among Ethiopian immigrants and refugees (n=342) who lived in Canada. The results suggested a lifetime prevalence of depression of 9.8%, which was slightly higher than the lifetime prevalence rate in the Ontario population as a whole (7.3%). However, the rate among Ethiopian immigrants and refugees was approximately three times as high as the rate estimated for Southern Ethiopia (3.2%). The data confirmed the significance of known risk factors for depression in immigrants, including younger age, experiences of pre-migration trauma, refugee camp internment and post-migration stressful events.

Somalis

The prevalence of depression was 25% in Somalis, and 25% in whites, both groups living in London. Physical health status and SAD (Symptoms of Anxiety and Depression Scale) scores were associated in Somalis and whites. Physical health problems were also linked with lower LSI scores in Somalis and whites. Social factors (for example poor housing conditions) were strongly associated with SAD scores among Somalis and to a lesser extent among Bengalis. Ethnicity became a statistically non-significant risk factor for high SAD scores after adjusting for age, weekly income, physical health and social problems (Silveira & Ebrahim, 1998).

From the Maghreb

Western societies host an increasing number of elderly labour migrants from Turkey and Morocco. Van der Wurff and colleagues used the Center for Epidemiologic Depression Scale (CES-D) to interview 330 Turkish, 299 Moroccan and 304 Dutch elderly people (55–74 years). The prevalence of self-reported depressive symptoms (CES-D> or=16) was very high in elderly migrants: 33.6% for Moroccan and 61.5% for Turkish elderly. The prevalence of depressive symptoms in the native Dutch sample was similar to that found in earlier studies in the Netherlands and abroad: 14.5%. In all three samples, depressive symptoms were associated with sex, chronic physical illness and physical limitations. In multivariate analysis, ethnic origin was uniquely associated with the presence of clinically significant depressive symptoms. Only a small number of remigration and acculturation items were associated with depressive symptoms in bivariate analysis (van der Wurff *et al*, 2004).

Pertinez Mena and colleagues (2002) showed that DSM-1v depression tended to be more frequent in immigrant patients (n=41) from the Maghreb Region (15.2%) who live in Spain than in autochthonous Spanish patients (13.4%).

Former Soviet Union

Arorian & Norris (2003) investigated, in their longitudinal study, 253 ever-depressed former Soviet immigrants living in the USA who had remained or become depressed during a two-year period. The survey found that 43% of the sample remained depressed, 26% became depressed and 30% had their depression lift over the course of two years. The three groups did not differ with regard to demographic characteristics, loss of employment or a negative change in marital status in the two-year study period. They did differ with respect to the presence of local family and immigration demands (P <.05). Those who remained depressed were less likely to have family in the area, and had the highest immigration demand score at both points in time (Arorian & Norris, 2003).

Consecutive patients (n=57; Russian-Jewish emigrants who live in Israel) at the primary care clinic were assessed on the Hamilton Depression Scale (Ham-D). The subjects completed self-rating scales, including the Beck Depression Inventory (BDI), Life Orientation Test, Beck Hopelessness Scale, Attributional Style Questionnaire and Snaith-Hamilton Pleasure Scale. Data on demographics and physical complaints were collected and analysed. Of the patients studied, 82.5% showed psychological distress (BDI > or=10), and 43.9% had clinically significant depressive symptoms (Ham-D > or=17). BDI and Ham-D scores were significantly correlated with number of psychosomatic complaints, hopelessness and lack of optimism, anhedonia and dysfunctional attributional style (Gutkovich *et al*, 1999).

Bosnians

Mollica and colleagues (2001) re-interviewed 376 adult Bosnian refugees who had originally lived in a refugee camp in Croatia and were still living in the region (77.7% of the original participants) three years later. DSM-IV, the

Hopkins Symptom Checklist-25 and the Harvard Trauma Questionnaire were used. Of the original respondents who met the DSM-IV criteria for depression, PTSD or both, 45% continued to have these disorders and 16% of respondents who were asymptomatic three years earlier had developed one or both disorders. Depression was not associated with emigration status.

Hindus

Pertinez Mena and colleagues (2002) studied variables related to mental disorders in a random sample of 112 immigrant Hindu patients (n=26; mean age 39 years; 52.7% men) who lived in Spain. DSM-IV depression tended to be slightly more frequent in patients belonging to ethnic minority groups (15.2%) than in autochthonous patients (13.4%).

Bengalis

In a study population of 75 Bengalis and 127 whites aged 60+ yrs (measures included the SAD), the prevalence of depression was 77% in Bengalis and 25% in whites. Social factors (such as poor housing conditions) were associated with SAD scores among Bengalis. Ethnicity became a statistically non-significant risk factor for high SAD scores after adjustment for age, weekly income, physical health and social problems (Silveira & Ebrahim, 1998).

Pakistanis

General practice patients were screened with the Personal Health Questionnaire to detect depressive illness in people of Pakistani origin (75% of the sample were Pakistan-born), which was confirmed using the Psychiatric Assessment Schedule (Dean *et al*, 1983); the estimated prevalence of major depression was 42%. Forty-four people with depression and thirty-three non-depressed comparison subjects were interviewed successfully using the Life Event and Difficulty Schedule (Brown & Harris, 1978), in either Urdu or English. Seventy-five per cent of the cases and thirty-six per cent of the non-cases had experienced an independent severe event and/or a major difficulty. Difficulties associated with depression were most commonly in the marital, health and housing categories; overt racial harassment and discrimination were rare (Husain *et al*, 1997). The somatic presentation of depression in this population is clear (Husain *et al*, 1997).

Table 1, overleaf, summarises the findings of the research discussed above.

Depression related to the asylum procedure

Asylum seekers arriving in the USA and Europe are likely to be held in detention for months or years pending adjudication of their asylum claims. Keller and colleagues (2003) interviewed 70 asylum seekers detained in New York, New Jersey and Pennsylvania. They used self-report questionnaires to assess symptoms of anxiety, depression and post-traumatic stress disorder. At baseline, 60 (86%) participants had clinically significant symptoms of depression, 54 (77%) of anxiety and 35 (50%) of post-traumatic stress disorder; all symptoms were significantly correlated with length of detention. At follow-up, participants who had been released had marked reductions in all psychological symptoms, but those still detained were more distressed than at baseline (Keller *et al*, 2003).

Suggestions for prevention and intervention measures

Analysis of the research data presented in this article indicates that there is sufficient evidence to conclude that intervention and prevention programmes should be constructed in such a way that they meet the special needs of specific categories of immigrants and refugees. For example, many refugee and immigrant children demonstrate mental problems and vulnerability. They need a safe environment and protection from victimisation in their host land, and adequate treatment (psychotherapy, social guidance/support, neurobiological treatment, family replacement programmes) for severe trauma and associated depression PTSD, self-harm and suicide.

For Chinese immigrants, more adequate social support should be organised in order to avoid loneliness and homesickness, in the form of self-help groups and shared activity groups made up of people with the same ethnic background. Financial assistance, health guidance and cultural adjustment programmes for the elderly are required (especially for those who have lived for less than five years in the host country). For Korean elderly people, financial assistance, English lessons and treatment of pre-migration and post-migration trauma could contribute to reduction of their depressive symptoms and increase in their well-being (again, for those who have lived for less than five years in the host land).

Intervention and prevention programmes for South American immigrants should be focused mainly on reunion of parents with their children, treatment of chronic health conditions, financial assistance, cultural adjustment and treatment of trauma (as a consequence of political violence).

TABLE 1 ***Prevalence of Depression in Different Ethnic Groups of Immigrants and Refugees (cont. on next page)***

Ethnic Origin	Prevalence *(csp=complete study population)*	Correlates of Depression
China and Taiwan	Older persons (csp n=107) in USA 29.4% compared with 13–20% in older native Americans (Stokes *et al*, 2001); elderly in Canada (csp n=1537) 25% (Lai, 2004a); in Canada (csp n=444) 32.2% (Lai, 2004b). Taiwanese (csp n=70) in USA 21.5% (Lai, 2005)	Age 60–69 yrs (32%); living with their children (37%); low socio-economic status (SES); poor health; less than high school education; less than five years in the USA (Stokes *et al*, 2001). More cultural barriers and a higher level of identification with Chinese cultural values (Lai, 2004a); elderly immigrants with more chronic illnesses, less positive attitude to ageing, poorer physical health, less adequate financial situation, lower level of ethnic identification as Chinese, more service barriers, lower level of life satisfaction, shorter length of residency in Canada and those who lived alone (Lai, 2004b). Predictive factors for depressive symptoms were a negative attitude to ageing, poor general physical health, single marital status, barriers to access to health care, poor financial status, lower level of identification with Chinese health beliefs and low income (Lai, 2005)
Cambodians	Cambodian victims of Khmer Rouge in USA (csp n=586 adults) 51% (Marshall *et al*, 2005)	Older age, having poor English-speaking proficiency, unemployment, being retired or disabled and living in poverty were associated with higher rates of PTSD and major depression. Pre-migration trauma remained associated with PTSD and major depression (Marshall *et al*, 2005)
Koreans	In Canada (csp n=860 adults) 2.6% men (1.1%–4.1%), 6.7% women (4.3%–9.1%) (Noh *et al*, 1992b) and 4.5% (Noh *et al*, 1992a) – not different from the native Canadian population	Both the role demand (or double burden) and power explanations of gender differences might be supported (Noh *et al*, 1992b); social support from informal ethnic networks at the time of arrival has long-lasting effects on mental health (Noh *et al*, 1992a)
Maghreb region	In The Netherlands elderly Turks 61.5% (csp n=330), elderly Moroccans 33.6% (csp n=299), compared with 14.5% of native elderly Dutch (csp n=304) (van der Wurff *et al*, 2004). In Spain, 15.2% (csp n=41; mean age 39 yrs) compared with 13.4% of the autochthonous Spanish patients (Pertinez Mena *et al*, 2002)	In all three samples, depressive symptoms were associated with sex, chronic physical illness and physical limitations (van der Wurff *et al*, 2004)
South Asia (Hindu, Bengali, Pakistani)	In Spain 23.2% (csp n=26; mean age 39 yrs) compared with 13% of the native Spanish population (Pertinez Mena *et al*, 2002). Bengali in London 77% compared with 25% of the white London population (Silveira & Ebrahim, 1998). Pakistani (csp n=77) in UK 42% (Husain *et al*, 1997)	Social factors (such as poor housing conditions) were strongly associated with SAD scores. Ethnicity became a statistically non-significant risk factor for high SAD scores after adjusting for age, weekly income, physical health and social problems (Silveira & Ebrahim, 1998). Difficulties associated with depression were most common in the marital, health and housing categories; overt racial harassment and discrimination were rare (Husain *et al*, 1997)
Latin American	Mexicans in USA (csp n=2823; age 65+ yrs) women 31.9% and men 17.3%. Female immigrants were at significantly higher risk for depressive symptoms than subjects born in the USA, whereas male immigrants were at lower risk (Black *et al*, 1998). Mixed Latino population in USA 36% (csp n=638) (Eisenman *et al*, 2003). In USA Latinos 25.4% (csp n=1798; 85% Mexicans; mean age 70.6 yrs; 58.2% women). Women were at greater risk (32.0%) than men (16.3%). Prevalence of depression was higher among immigrants (30.4%), bicultural participants (24.2%) and less-acculturated participants (36.1%) than in USA-born (20.5%) and more acculturated groups (16.1%) (Gonzalez *et al*, 2001). Mixed populations of Latinas in USA (csp n=5122) 11.7% (11.4%) who lived with their children, 181% who were separated from their children (Miranda *et al*, 2005b)	Gender, lack of insurance, financial strain, chronic health conditions and disability were associated with depressive symptoms. Several cultural factors were also associated with increased risk, including immigrant status, levels of acculturation and assimilation, health locus of control and recent immigration (Black *et al*, 1998). Controlling for age, sex, country, years lived in the United States, acculturation, income and health insurance status, those who reported exposure to political violence were more likely to meet symptom criteria for depression (AOR, 2.8; 95% CI, 1.4–5.4) than participants not reporting political violence (Eisenman *et al*, 2003). The least acculturated participants were at significantly higher risk of depression than highly acculturated Mexican Americans. The high prevalence of depression of the least acculturated group may be related to cultural barriers encountered by immigrants and less acculturated older Mexican Americans, and to poorer health status (Gonzalez *et al*, 2001). Separation from children during immigration may lead to increased risk of depression for immigrant Latinas (Miranda *et al*, 2005b

TABLE 1 *Prevalence of Depression in Different Ethnic Groups of Immigrants and Refugees (cont. from previous page)*

Ethnic Origin	Prevalence *(csp=complete study population)*	Correlates of Depression
African (Somalian, Ethiopian)	Somalis in London 25% compared with 25% of the native London population (Silveira & Ebrahim, 1998). Ethiopians (csp n=342) in Toronto (Canada) 9.8% compared with 7.3% in native Canadians and 3.2% in native population in Southern Ethiopian (Fenta *et al*, 2004)	Social factors (for example poor housing conditions) were strongly associated with SAD scores. Ethnicity became a statistically non-significant risk factor for high SAD scores after adjusting for age, weekly income, physical health and social problems (Silveira & Ebrahim, 1998). Younger age, experience of pre-migration trauma, refugee camp internment and post-migration stressful events (Fenta *et al*, 2004)
Eastern European (Russian, Bosnian)	Russian-Jewish immigrants (n=65) in Israel (43.9%) (Gutkovich *et al*, 1999). Adult Bosnians in USA (csp n=534) 45% (Mollica *et al*, 2001)	BDI and Ham-D scores were significantly correlated with the number of psychosomatic complaints, hopelessness, lack of optimism, anhedonia and dysfunctional attributional style (Gutkovich *et al*, 1999). Male sex, isolation from family and older age were associated with increased mortality (Mollica *et al*, 2001)
General refugee populations	In general refugee populations in Australia (csp n=6743) from 7 countries 5% (4–6%) (Fazel *et al*, 2005). 100% of children (csp n=10) (Mares & Jureindini, 2004). 60 (86%) of a mixed population in USA (csp n=70) (Keller *et al*, 2003). 16% of mixed population immigrant children in USA (csp n=1004; 8–15 yrs) (Jaycox *et al*, 2002)	Much was attributable to traumatic experiences in detention and, for children, the impact of indefinite detention on their caregivers (Mares & Jureindini, 2004)

For Ethiopian refugees, treatment of their pre-migrant trauma and of mental health problems related to refugee internment and stressful post-migration events should have priority. Somalis and Bengalis could be helped significantly by better housing conditions. North Africans need mainly acculturation programmes in order to integrate adequately in their new host land. The well-being of immigrants from the former Soviet Union might increase substantially if they were offered suitable work and professional guidance were available for their frequent marital problems. Pakistani immigrants need most a reduction of health, marital and housing problems.

And for all categories of refugees, improvement of the asylum procedure (faster and more transparent) might lead to a reduction in depressive symptoms.

Conclusions

Research indicates that refugees and immigrants do not all have the same needs in their host country, and that not all groups demonstrate the same risk for depressive disorder, higher than that of the autochthonous population. Refugees and immigrants are thus far from homogeneous. The consequence is that general programmes for all categories of asylum seekers and immigrants, which are applied in The Netherlands and many other Western countries, might not be very effective. Only programmes which are tailored to the specific needs of distinctive categories refugees and immigrants would be adequate and helpful in the long run.

It was very confusing that the terms ‘immigrants’, ‘refugees’ and ‘asylum seekers’ are used interchangeably in some studies. It is very difficult to compare the data from these studies with each other because of differences in study design, study populations, the cultural, religious, political and psychosocial background, the experiences of immigrants, mental health services and asylum procedures in different countries, and so on. However, the data analysed provide ample evidence that improvement in the situation and conditions of these categories vulnerable people is necessary and possible.

Some studies revealed that lack of acculturation in immigrants and refugees might be linked to depression. However, Bughra’s study (2003) indicated, using fluency in language as a proxy measure of acculturation, that acculturated individuals are more likely to be depressed. Acculturation can lead to integration, but there is also a risk of self-alienation that might be linked to depression. Further research is necessary to understand the associations between depression, on one hand, and emigration status, acculturation, social-economic status and social support on the other.

The remarkable differences in prevalence of depression in distinctive groups of immigrants and refugees (varying from 11% to 100%) could be explained by social support, quality of mental health services, tolerance, respect and safety in their new environment, and educational possibili-

ties in their host land. However, the presence and severity of mental disorders in the immigrant and their relatives, negative and positive experiences, sympathy for their new host land, coping skills and intelligence, and significant differences in cultural, religious and political background from the new environment play an important role in the assimilation and integration process and the etiology of the mental disorders that newcomers suffer.

Address for correspondence

Dr W.H. Martens, W. Kahn Institute of Theoretical Psychiatry and Neuroscience, Het Nateland 1, 3911XZ Rhenen, The Netherlands, tel 31 (0)317617708, email: Martens_92@hotmail.com, or MartensW2000@yahoo.com.

References

American Psychiatric Association (1980) *Diagnostic and Statistical Manual of Mental Disorders* (3rd edition) (DSM-III). Washington, DC, USA: APA.

American Psychiatric Association (2004) *Diagnostic and Statistical Manual of Mental Disorders* (4th edition) (DSM-III). Washington, DC, USA: APA.

Arorian, K.J. & Norris, A.E. (2003) Depression trajectories in relatively recent immigrants. *Comprehensive Psychiatry* **44** (5) 420–7.

Brown, G.W. & Harris, T. (1978) *Social Origins of Depression: A Study of Psychiatric Disorders in Women*. London: Tavistock.

Bhugra, D. (2003) Migration and depression. *Acta Psychiatrica Scandinavica Suppl*. **418** 67–72.

Black, S.A., Markides, K.S. & Miller, T.Q. (1988) Correlates of depressive symptomatology among older community-dwelling Mexican Americans: the Hispanic EPESE. *Journals of Gerontology: Series B: Psychological Sciences and Social Sciences* **53B** (4) S198–S208.

Dean, C., Surtees, P.G. & Sashidharan, S.P. (1983) Comparison of research diagnostic systems in an Edinburgh community sample. *British Journal of Psychiatry* **142** 246–250.

Eisenman, D.P., Gelberg, L., Liu, H. & Shapiro, M.F. (2003) Mental health and health-related quality of life among adult Latino primary care patients living in the United States with previous exposure to political violence. *Journal of the American Medical Association* **290** (5) 627–34.

Fazel, M., Wheeler, J. & Danesh, J. (2005) Prevalence of serious mental disorder in 7000 refugees resettled in Western countries: a systematic review. *Lancet* **365** (9467) 1309–14.

Fenta, H., Hyman, I. & Noh, S. (2004) Determinants of depression among Ethiopian immigrants and refugees in Toronto. *Journal of Nervous and Mental Disease* **192** (5) 363–72.

Gonzalez, H.M., Haan, M.N. & Hinton, L. (2001) Acculturation and the prevalence of depression in older Mexican Americans: baseline results of the Sacramento Area Latino Study on Aging. *Journal of the American Geriatric Society* **49** (7) 948–53.

Gutkovich, Z., Rosenthal, R.N., Galynker, I., Muran, C., Batchelder, S. & Itskhoki, E. (1999) Depression and demoralization among Russian-Jewish immigrants in primary care. *Psychosomatics* **40** (2) 117–25.

Husain, N., Creed, F. & Tomenson, B. (1997) Adverse social circumstances and depression in people of Pakistani origin in the UK. *British Journal of Psychiatry* **17** 434–8.

Jaycox, L.H., Stein, B.D., Kataoka, S.H., Wong, M., Fink, A., Escudero, P. & Zaragoza, C. (2002) Violence exposure, posttraumatic stress disorder, and depressive symptoms among recent immigrant schoolchildren. *Journal of the American Academy of Child and Adolescent Psychiatry* **41** (9) 1104–10.

Keller, A.S., Rosenfeld, B., Trinh-Shevrin, C., Meserve, C., Sachs, E., Leviss, J.A., Singer, E., Smith, H., Wilkinson, J., Kim, G., Allden, K. & Ford, D. (2003) Mental health of detained asylum seekers. *Lancet* **362**(9397) 1721–3.

Lai, D.W. (2004a) Impact of culture on depressive symptoms of elderly Chinese immigrants. *Canadian Journal of Psychiatry* **49** (12) 820–7.

Lai, D.W. (2004b) Depression among elderly Chinese-Canadian immigrants from Mainland China. *Chinese Medical Journal* (Engl) **117** (5) 677–83.

Lai, D.W. (2005) Prevalence and correlates of depressive symptoms in older Taiwanese immigrants in Canada. *Journal of the Chinese Medical Association* **68** (3) 118–25.

Mares, S. & Jureidini, J. (2004) Psychiatric assessment of children and families in immigration detention – clinical, administrative and ethical issues. *Australian and New Zealand Journal of Public Health* **28** (6) 520–6.

Marshall, G.N., Schell, T.L., Elliott, M.N., Berthold, S.M. & Chun, C.A. (2005) Mental health of Cambodian refugees two decades after resettlement in the United States. *Journal of the American Medical Association* **294** (5) 571–9.

Miranda, J., Siddique, J., Belin, T.R. & Kohn-Wood, L.P. (2005a) Depression prevalence in disadvantaged young black women African and Caribbean immigrants compared to US-born African Americans. *Social and Psychiatry and Psychiatric Epidemiology* **40** (4) 253–8.

Miranda, J., Siddique, J., Der-Martirosian, C. & Belin, T.R.

(2005b) Depression among Latina immigrant mothers separated from their children. *Psychiatric Services* **56** (6) 717–20.

Mollica, R.F., Seraglio, N., Chernoff, M., Lavelle, J., Vukovic, I.S. & Massagli, M.P. (2001) Longitudinal study of psychiatric symptoms, disability, mortality, and emigration among Bosnian refugees. Comment. *Journal of the American Medical Association* **286** (5) 546–54.

Noh, S., Speechley, M., Kaspar, V. & Wu, Z. (1992a) Depression in Korean immigrants in Canada: I. Method of the study and prevalence of depression. *Journal of Nervous and Mental Disease* **180** (9) 573–7.

Noh, S., Speechley, M., Kaspar, V. & Wu, Z. (1992b) Depression in Korean immigrants in Canada: II Correlates of gender, work, and marriage. *Journal of Nervous and Mental Disease* **180** (9) 578–82.

Pertinez Mena, J., Viladas Jene, L., Clusa Gironella, T., Menacho Pascual, I., Nadal Gurpegui, S. & Muns Sole, M. (2002) Descriptive study of mental disorders in ethnic minorities residing in an urban area of Barcelona (in Spanish). *Atencio Primaria* **29** (1) 6–13.

Silveira, E.R. & Ebrahim, S. (1998) Social determinants of psychiatric morbidity and well-being in immigrant elders and Whites in East London. *International Journal of Geriatric Psychiatry* **13** (11) 801–12.

Stokes, S.C., Thompson, L.W., Murphy, S. & Gallager, T.D. (2001) Screening for depression in immigrant Chinese-American elders: results of a pilot study. *Journal of Gerontological Social Work* **36** (1–2) 27–44.

van der Wurff, F.B., Beekman, A.T., Dijkshoorn, H. , Spijker, J.A., Smits, C.H., Stek, M.L. & Verhoeff, A. (2004) Prevalence and risk-factors for depression in elderly Turkish and Moroccan migrants in the Netherlands. *Journal of Affective Disorders* **3** (1) 3–41.

Yesavage, J.A., Brink, T.L., Rose, T.L., Lum, O., Huang, V., Adey, M., Leirer, V.O. (1983) Development and validation of a geriatric depression scale: A preliminary report. *Journal of Psychiatric Research* **17** (1) 37–49.

FEATURE

Paula T. McWhirter
University of Oklahoma

Domestic Violence and Chemical Dependency Co-Morbidity: Promoting Eclectic Responses to Concomitant Mental Health Concerns[1]

Key words: domestic violence; chemical dependency; comorbidity

ABSTRACT

Chemical dependency and a history of physical or sexual violence are problems commonly experienced concomitantly among women, yet barriers persist to implementing programs that deal with them together. This article describes an eclectic, cross-problem group intervention designed to acknowledge the specific needs of women who have experienced problems of both chemical dependency and domestic violence. Program evaluation data suggest a positive effect for the proposed intervention, providing support for creating and maintaining policies among mental health provider organizations to recognize and address common co-morbidity.

Literature review

Each year, an estimated four million American women suffer some form of physical, sexual, or psychological abuse from an intimate partner (APA, 1996). The emotional effect on those who suffer from domestic violence can be dramatic and complex. Whereas many women have had no significant psychopathology prior to the abuse, survivors commonly manifest the following symptoms: cognitive and memory disturbances, high arousal or anxiety, avoidance behaviors (Walker, 1995), major depressive episodes and suicidal ideation (Bergman *et al*, 1994).

The emotional impact of domestic violence is often traumatic, as are the effects of other forms of violence against women. Forms of violence commonly experienced can range from childhood sexual victimization (with prevalence estimates as high as 38%; Russell, 1988) to the more subtle and pervasive societal acceptance of male privilege (Walker, 1995). As a result, mental health professionals working in traditional treatment environments struggle to provide specialized services sensitive to an abuse history that is particularly relevant to female populations.

The anesthetic use of alcohol and other drugs (AOD) is quite common (Walker, 1995) among individuals who have experienced trauma. Women and female adolescents who witness or experience violence have a particularly high risk of developing substance abuse later in adulthood (Hart & Jans, 1997; Wanberg, 1992; Wanberg & Milkman, 1998). In fact, a study conducted by the U.S. Department of Health and Human Services (1994) estimates that 75% of women

[1]Clinical intervention, program evaluation and manuscript preparation supported by the State of Arizona's Governor's Innovative Prevention Grant #AD000281.

entering alcohol and drug treatment programs have been sexually abused, often by a known perpetrator. In 1991, Parisi-Dunne studied 60 women admitted to a substance abuse treatment center. Almost 67% of those studied reported using after being physically abused, and confirmed that substance use allowed them to deal with the psychological and physical pain. Over half of those studied (60%) admitted that their addiction was a factor in keeping them from leaving their abusive relationship sooner. Kilpatrick (1989) found that a history of domestic violence or sexual victimization was the single best predictor for a woman's abuse of alcohol or other drugs. Substance abuse allows survivors:

- to self-medicate fluctuations in mood
- to numb anxiety-arousing and depressive feelings
- to avoid psychological distress associated with heightened social and financial pressure that result from physical, sexual, and psychological victimization (Walker, 1995).

As a result of their unique vulnerability in our society, women are at increased risk of having co-existing problems with domestic violence or victimization and chemical dependency. Treatment centers, therefore, are challenged to develop programs that acknowledge the likely co-existence of these problems and thus provide more comprehensive intervention to their women clients (Hart & Jans, 1997).

This article describes an eclectic, cross-problem group therapy designed to acknowledge the specific needs of women who present with these dual problems. Eclecticism in this intervention involves integration of humanistic-cognitive theories, rather than strict alignment with a singular therapeutic approach (Norcross & Prochaska, 1988). The intervention:

- treats these dual problems holistically and effectively
- alleviates treatment barriers
- maintains standardized and efficient implementation.

Following a description of the individual components, I explain the program's implementation in a residential psychiatric hospital, and conclude with qualitative and quantitative summaries of program feedback from group participants.

Program components

Cross-problem interventions

Cross-problem interventions (National Research Council and Institute of Medicine, 1998) take the 'whole person' into consideration, including individual, family and societal systems. The Council formally requested increased focus on research involving cross-problem interventions (Chalk & King, 1998). Specifically, cross-problem research is an integrated examination of concomitant issues associated with violence, which can include addressing multiple variables simultaneously in order to understand better the dynamics that contribute to formation and perpetuation of violence.

Typically, community agencies provide treatment to address a single problem. In our experience, this has been the downfall of traditional domestic violence service provision. Shelter and safe-housing protocols typically disregard the necessity of treating both addictions and violence. They require victims of domestic violence to remain sober for the duration of their stay in shelters and safe housing. This has resulted in a tendency for women to conceal, or at least minimize, their **reported** substance use. Women with a long history of domestic violence, coupled with ongoing substance abuse, have learned to deny any chemical dependency before program admission. Others fear that admitting to an addiction might place them at greater risk in child custody disputes. Due to lack of treatment for their substance abuse, this risk seems greater than that of continued addiction. Interventions that bridge issues of addictions and violence create community agencies that require fewer treatment plans and create less retraumatization of victims. By treating the whole person, agencies are better able to acknowledge and address victims' complex histories and multiple treatment needs.

Gender-specific groups

Given the association between chemical dependency and female victimization, gender-specific intervention appears to be of fundamental importance. Separate programming allows women adequate opportunity to explore issues that they may find hard to discuss with male patients (Blume, 1992). Walker (1995) has suggested that men in mixed gender abuse groups might transfer their anger to women in the group. This creates a very intimidating atmosphere, where women may resume old patterns of behavior, allowing the men to be in control and to dominate the group, further subordinating the women to victim roles.

Separate gender-specific programming appears particularly important when providing cross-problem intervention to substance-abusing survivors of domestic violence. It has been well documented that 25%–50% of batterers have concomitant chemical dependency problems (Substance Abuse Treatment and Domestic Violence,

1997). It follows that some men in chemical dependency treatment programs are, or have been, perpetrators. Their presence in a group may place women in the same group at risk of retraumatization.

For example, Northrup (1998) noted the effectiveness of women-only breast cancer groups that featured sharing and emotional expression; group members lived twice as long as the control group. In fact, even if only one man was present in the group, Northrup observed the reluctance of women to initially discuss their personal experiences. Northrup suggests that self-awareness occurs for women only in safe environments. Women-only settings lend themselves to truth telling, instead of arenas where women might change their stories because of male participants.

Despite these findings, many chemical dependency units do not provide gender-specific groups. Given the common co-existing issues of many women participants (chemical dependency and a history of abuse by a male perpetrator), this presents a barrier to treatment that is unique to women and built into the treatment infrastructure. This was the case in our facility before the establishment of our group program. Women who presented to chemical dependency programming at our hospital also reported having suffered many abuses throughout their lifespan, including spousal abuse, parental abuse, sexual assault and victimizing experiences resulting from a social climate where male privilege is acceptable. In order to address these specific issues, gender-specific groups were created and met each week. Following these meetings, women at our facility frequently commented on their increased ability to discuss sensitive issues, especially early childhood trauma and domestic violence (described below).

Therapeutic foci

Our program used cognitive behavioral and gestalt therapeutic techniques in a gender-specific format. Cognitive behavioral interventions in our program addressed belief systems, thought reports, abuse education, self-esteem, trust, communication skills, problem solving (especially safety planning and relapse prevention), basic drug knowledge, stages of change, grief and loss, and healthy relationships. These topics have been thoroughly researched by Wanberg and Milkman (1998) in a substance-abusing population. The group facilitator presented topics during the first several minutes of the 90-minute group session. Once the material had been presented, these topics were then processed using gestalt therapy interventions. The gestalt influence of our group featured the following:

- exploring how individuals meaningfully organize their world
- identifying how an individual contacts or interrupts contact with their environment
- recognizing one's needs
- becoming aware of feelings and emotions that have been split from life's experiences (Clemmens & Matzko, 2005; Gladding, 1988; Perls, 1973).

Gestalt therapy challenges a client to re-experience past traumas in the here and now, since 'awareness always takes place in the present' (Perls, 1973 p65). Events that remain 'unfinished' stay alive and interrupted, waiting to be integrated into consciousness. The traumatic event and its details remain split from the survivor's feelings and perception of the event (Kepner, 1995). When a woman re-lives her past abuse experiences, she is afforded the opportunity to process the 'unfinished business', including thoughts unspoken and feelings unexpressed. The hope is that she will then feel empowered to create new strategies for old behavioral patterns that have stood in the way of healing.

For the purposes of this study, it was hypothesized that the group therapy participants would demonstrate movement toward increased readiness to change across a variety of psychosocial variables.

Method

Participants

Group participants

The investigation included women voluntarily enrolled in a residential psychiatric hospital in a large metropolitan city in the Southwest of the USA. During the time this research was conducted, the hospital admitted 725 men and 693 women. Of these women, 57 met the criteria, were referred, and participated in the group sessions. Women were referred initially to the hospital for substance abuse treatment. Those who met the criteria for involvement in this group intervention also reported, during an individual interview with their primary mental health care worker, an experience of domestic violence with a spouse or other intimate partner. Of those who were referred and participated in the group treatment, 40 (70%) attended at least two treatment group sessions and were thus included in the investigation for the pre- to post-analysis. The majority of participants participated in two to four group sessions, based on a residency typically lasting one week on average. The 40 participants ranged in age from 18 to 64, with a mean age of 48 and a median age of 37. The majority

identified as Caucasian (83%) while others identified as Hispanic (14%) and Native American (3%).

Factor analysis participants

Participants for the factor analysis described below were 116 (17%) of the 693 women who entered the hospital during the time the research was conducted. These participants included therapy group participants, as well as other women patients who volunteered to complete the measure. As described below, the previous version of the Psychosocial Readiness Ruler was used with a different clinical focus. The instrument, as conceived by Beiner and Abrams (1991), was designed to rate the stage of change for any therapeutically defined problem. The measure is designed to adapt to include any specific issue identified as requiring change. This allows for tailored and specific measurement of any mental health concern (Beiner & Abrams, 1991). Due to a paucity of instrumentation designed to measure change related to domestic violence, the 17-item questionnaire based on the Psychosocial Readiness Ruler was created for use in this study. A factor analysis was conducted to derive more specific information regarding the usefulness of this modified version of the instrument for continued use.

Instruments

Psychosocial Readiness Ruler

Readiness to make behavioral changes regarding a variety of psychological and social health variables was included in the 17-item questionnaire developed for this study. This questionnaire was used because of the wealth of potential information yielded, given its simplicity and ease of use. The measure is readily understood (from the taker perspective) and easy to acquire and administer (from the practitioner's perspective), and may be incorporated into a variety of program evaluation uses in a variety of mental health settings. The flexibility allows adaptation of the measure to individual or programmatic intervention goals, both short and longer term. The questionnaire is a modified version of the readiness ruler (Beiner & Abrams, 1991), which was originally designed to be used with smokers and has demonstrated concurrent and predictive validity. The group facilitators created the items based on the therapeutic objectives of the group treatment intervention.

A factor analysis of this modified version was performed and is included in this article. The 10-point response format ranges from 1 (not ready to change) to 10 (trying to change). Respondents also may choose a separate column labeled 'No need to make a change'. Scores were obtained by summing responses (omitting items labeled 'No need to make a change') and dividing by the total number of items completed, yielding an average total. This procedure was used to total individual subscales generated by the principal components factor analysis conducted for purposes of this study (discussed below). Alpha coefficients were calculated on pre-test scores for the full scale Psychosocial Readiness Ruler (.93), and for the four subscales generated by the factor analysis: intrapersonal coping (.92), interpersonal coping (.89), violence (.71), and social affiliation (.75).

Brief demographic items

The survey also included a two-item demographic questionnaire requesting participants' age and ethnicity.

Brief group impact items

At the time of the final group, the women were asked about the extent to which the group had helped them decrease domestic violence and alcohol or other drug use via the following two statements:

> *'Overall, this group is helping me to take steps toward a life free of violent and/or abusive relationships',*
>
> and
>
> *'Overall, this group is helping me to decrease my alcohol or other drug use'.*

The following response format was used: NO!, no, yes, YES!.

Procedure

Participants presented at the hospital with a history of both chemical dependency and abuse experience, and were thus referred to the group by their primary mental health care provider. The women participated in the group as a supplement to other individual and mixed-gender groups provided at the residential facility. The average duration of hospitalization in this facility was six days. Groups were conducted twice a week for sessions lasting an hour and a half. All the participants took part in at least two group sessions; most women attended three sessions (98%) and many attended all four sessions (87.5%).

The questionnaire containing the Psychosocial Readiness Ruler and the brief demographic items were distributed before each individual's participation (pre-treat-

ment), and again after her final participation (post-treatment) in the ongoing, drop-in group. The questionnaire containing the brief group impact items were completed on one form and the readiness ruler and demographic questions on another, making it impossible to link these responses during subsequent analyses.

Groups were ongoing, with session discussion topics that cycled every two weeks, ensuring that group members would be exposed to at least two of the four agenda topics deemed crucial, while minimizing repetition. Groups ranged in size from three to nine participants, and were conducted over a three-month period.

Results

Full-scale analysis

A paired comparison **t** test was performed to assess the overall effect of groups at pre/post intervals for the full scale readiness ruler. Results reveal an overall time effect on the full scale Psychosocial Readiness Ruler (**t** = 2.61, **p** =.01) suggesting a positive group effect. Descriptive data generated from the brief group impact items revealed that 75% reported that the group had helped them take steps toward a life free of violent and/or abusive relationships, and 95% reported that the group had helped them to decrease AOD use. Taken together, the results provide support for the effectiveness of the group intervention. Participants indicated improved readiness to engage in behavioral changes toward psychosocial growth. They also reported that the group had helped them to recognize the negative consequences of their AOD use, and to take mental and emotional steps toward a life free of violence.

Factor analysis of the psychosocial readiness ruler

In order to determine specific areas of change affected by the treatment intervention, a principal components factor analysis was performed on all 17 items, orthogonalizing variables for independence and more parsimonious understanding of study constructs (see ***Table 1***, below). Varimax rotation was performed yielding a four factor solution, satisfying Kaiser's criterion and Cattell's scree, and accounting for 80% of the variance. The first factor consisted of nine of the seventeen items and accounted for 34% of the variance. It was labeled 'intrapersonal coping', as it addresses readiness to change specific intrapersonal behavioral domains including self-defeating behaviors, self-confidence, own use of alcohol or other drugs for coping, empowerment, self-blame, own communication patterns, level of stress, ownership for actions, and need for personal change.

TABLE 1 ***Principal Component Factor Analysis of the Psychosocial Readiness Ruler with Varimax Rotation***

	Factors 1	2	3	4
Factor 1: intrapersonal coping				
Self-defeating behaviors	.834	.325	.320	.148
Empowerment	.829	.057	.315	.293
Self-blame	.816	.043	.095	.350
Self-confidence	.800	.341	.265	.161
Own communication patterns	.792	.034	.338	.240
AOD use in my life	.717	.394	.152	-.037
Stress sevel	.672	.336	.235	.176
Take ownership of actions	.657	.043	.383	.537
Need for change	.589	-.148	-.085	.574
Eigenvalue = 9.12 Percent of variance = 34%				
Factor 2: domestic violence				
Violence in my relationships	.147	.879	-.041	.002
Abusiveness in my life	.214	.744	.172	.246
Eigenvalue = 1.76 Percent of variance = 13%				
Factor 3: interpersonal coping				
Motivation	.255	.163	.836	-.051
Self-sufficiency	.362	-.031	.818	.222
Assertiveness	.489	-.082	.807	.082
Eigenvalue = 1.57 Percent of variance = 19%				
Factor 4: social affiliation				
Connection with family	.191	.513	.214	.682
Social support	.397	.200	.236	.799
Eigenvalue = 1.11 Percent of variance = 14%				

The second factor accounted for 13% of the variance, and represents a two items measuring readiness to change: violence in relationship and abusiveness in life. This factor was labeled 'domestic violence'. The third factor included three items, and accounted for an additional 19% of the total variance. The factor comprised items tapping readiness to change: motivation, self-sufficiency, and assertiveness. These variables appear to be related to functioning on a macro level or within the social environment, and the resultant factor was labeled 'interpersonal coping'. Finally, the fourth factor, accounting for 14% of the variance, was labeled 'social affiliation', because of its item loadings: connection with family and social support.

Subscale analyses

Once the factors had been determined, additional paired comparison **t** tests were performed with each factor of the

four-factor solution serving as dependent variables. Results reveal an overall time effect for (**t** = 2.93, **p** <.01) with no significant effect generated for the other three subscales: interpersonal coping (**t** = 1.85, **p** =.07), domestic violence (**t** = 1.35, **p** =.19), and social affiliation (**t** = 0.81, **p** =.43). Results of paired comparison **t** tests for the full scale and subscales of the Psychosocial Readiness Ruler are presented in ***Table 2***, below.

Participant feedback

Using a 60-item Q-sort, Yalom (1995) identified the ten most important therapeutic factors as described by clients:

- discover unknown or unacceptable parts of self
- articulate to others what was bothering them
- provide an honest impression from other group members as to how they see the individual
- discover how to express emotions
- educate participants on how they impress other members
- declare feelings toward other participants
- discover that each group member is responsible for how they live their own life
- discover how others perceive group members
- model risks-taking
- improve trust with group members to build trust outside the group.

Women were asked to provide a written comment on the group; the responses are noted below. Many of Yalom's factors were identified by women in our group, shown in ***Box 1***, below.

Women expressed in their writing a positive feeling toward the group, and also returned to the residential unit and continued processing their feelings with other women and staff. Night shift staff members began expressing concern that women would stay up half the night continuing to discuss topics that had begun in the women's group that afternoon. Women were also given the opportunity to return to this group after they had completed their substance abuse treatment, and many chose to do so.

TABLE 2 ***Summary of Pairwise Comparisons***

Psychosocial Readiness Ruler	Measure				
	Pretest X	Posttest X	df	t	ρ
Full scale	7.19	7.96	39	2.61	0.013
Intrapersonal coping	7.37	8.32	39	2.91	0.006
Interpersonal coping	7.19	7.85	38	1.85	0.072
Domestic violence	5.82	6.50	32	1.37	0.19
Social affiliation	7.21	7.64	39	0.81	0.425

BOX 1 ***Participants' Comments on the Group***

- I learned how to feel*
- Group made me think – had no idea I felt this way*
- I need to work on my patterns of choosing abusive relationships
- I can trust in safe places*
- I have the power over my life
- I have a plan
- Thank God there are support groups and people out there to help one another; crucial to a woman's wellbeing*
- (I was) surprised others had the same crazy family life*
- my wellbeing as an individual, young woman, daughter, and sister is part of my discovery*
- (It is) important for an individual to express feelings and emotions to others who will keep it confidential
- (One must) trust your own thoughts, feelings, and memories*
- It is important to really value and cherish yourself as human and woman*
- I was able to participate in serious, intense, and direct conversation*
- I am valuable and deserve to be treated with respect*
- I am very emotional and didn't even know it*
- I felt such a release of emotions*
- I feel more whole each day I work on my issues and unresolved pain*
- My life can change even if I can't change other people*

**indicates a match with one of the top ten factors Yalom identified.*

Facilitator feedback

Anecdotally, facilitators noticed the following benefits.

- Women were exposed to topics they had not considered important to their chemical dependency recovery and they responded positively to this information.
- Women knew the abuse and AOD use were affecting their children, but did not know how to help them become healthy.
- Women became dependent on other women in the group for strength. Women made up phone trees and called one another for support.
- Women discovered that they could talk with other women. Some had previously said that they felt women were competitive and difficult to connect with, so they preferred male friends and were wary of reaching out to other women in friendship. Yet following the women's group participation, women commented on how easy it was to talk with other women who had similar issues.

- Women did significant growth work and others began to feel more comfortable sharing with others, something previously outside of their 'comfort zone'.

Discussion

This article has described an eclectic, cross-problem group intervention designed to enhance women's readiness to change on a variety of psychosocial variables chosen by group facilitators as targets for intervention. This study's primary limitations, including lack of a control group and sample of convenience, made it impossible to control for various validity threats. Due to the paucity of measures available for use with this population, the use of measures without extensive previous standardization further limited this study. One of the measures, the brief group impact items, elicited participants' perceptions of the group's effect, and thus had limitations.

Despite these limitations, the overall significant change before and after group participation provides preliminary support for the therapeutic intervention. Analysis of the mean scores revealed an overall movement from preparation toward action. The significant findings suggest a need for further research of an experimental nature with some greater control of external validity threats. Further factor analysis reveals that those variables most subject to change were those which were considered intrapsychic or psychological in nature, and were thus labeled 'intrapersonal coping'. This is consistent with the group's therapeutic focus on empowering personal choice toward healthy psychological and behavioral change. Lack of significance in the other factors is probably due to the fact that the majority of participants had recently terminated formerly violent relationships and were in residential treatment at the time of group participation, rendering concerns about these factors (interpersonal coping, domestic violence, and social support) less immediate.

Significant results on the brief group impact item concerning domestic violence indicated that the group was helpful to participants in taking steps to decrease violence in their interpersonal relationships. This seems to contradict the non-significant findings of the third factor of the Psychosocial Readiness Ruler, suggesting no effect over time on readiness to change violence in an interpersonal relationship. Unfortunately, because these surveys were not linked, it is impossible to examine the relationships between these variables more interactively. A closer examination of the results (means and df) seems in order. First, the means indicate an increase in readiness to change, congruent with significant increase found for the brief group impact. Second, this is the only analysis that indicates a greater attrition for inclusion in the analysis due to missing data. A potential problem with power related to decreased sample size may explain non-significance in this case. Though it was not strong enough for statistical significance, it appears that the majority of individuals in the group did improve on this variable, and further investigation is warranted.

Implications for mental health counseling and implementation

This cross-problem therapeutic intervention was developed to address the issues of domestic violence and substance abuse in a residential chemical dependency treatment center housed in a mental health facility. Few chemical dependency programs are willing to assess for abuse issues in a woman's life, and even fewer develop programs that address these issues holistically. Women coming into our facility might have discussed experiences of victimization in individual sessions with case managers, yet few felt comfortable in opening these wounds in mixed-gender groups. Women also failed to understand the connection between their abusive histories and their current drug use. When women are afforded an opportunity to process in gender-specific groups, they are motivated to delve deeply into layers of pain and to release the feelings that may have been interrupted during violent traumatic events.

Women with histories of abuse are at higher risk of using AOD to escape emotional pain. Alcohol and drug dependence is classified by some as a disease, with a predictable genetic marker, predisposing individuals to addiction. However, social triggers and high-risk situations have been shown to contribute to the relapse of many well-meaning individuals in recovery (Wanberg & Milkman, 1998). In order to effect long-term change, government agencies are calling for collaboration between the domestic violence and chemical dependency treatment communities. By combining the efforts of both communities, women would be offered safety, education, comprehensive services, and appropriate referrals with the hope of maintaining safety and sobriety (U.S. Department of Health and Human Services, 1997).

Our program was developed in an attempt to address abuse and victimization throughout the life span, as well as chemical dependency. Women placed in gender-specific groups received specialized programming that combined cognitive behavioral and gestalt interventions. Every topic chosen was amenable to discussion of both abuse and chemical dependency and the interplay between these

problems. The problem-solving component, for example, dealt with both safety planning and relapse prevention. The belief system discussion focused on beliefs about how we perceive both alcoholics and victims. The topics chosen for discussion in our groups were validated empirically with other substance-abusing populations, and our results indicate that these behavioral topics, coupled with a gestalt approach to processing resulting feelings, were quite appropriate to a female population that had experienced abuse and chemical dependency. We learned that, once afforded an opportunity to process in women-only groups, participants were motivated to uncover layers of pain and explore the feelings that may have been split-off during traumatic events.

Our program looked at the individual developmentally and holistically, and attempted to address underlying issues that serve as triggers for continued alcohol and drug use. Women were challenged to re-experience past abuses and deal with the feelings that they continued to numb in their present life circumstances. After these groups, women felt empowered to change, especially in an intrapersonal manner. Cross-problem interventions appeared to help women leave our facility with an improved attitude and the belief that they could make affective change in their lives.

Acknowledgements

The author wishes to extend gratitude and appreciation to Terri Rosa and to Terri Leveton, CEO of Halo of Hope, for their invaluable contributions.

Address for correspondence

Paula C. McWhirter, Assistant Professor, Department of Educational Psychology, University of Oklahoma, Collings Hall, 820 Van Vleet Oval, Norman, Oklahoma 73019-2041, USA. Email: paulamcwhirter@ou.edu, tel: 010 405 325 1504.

References

American Psychiatric Association (1996) *Violence and the Family: Report of the American Psychiatric Association presidential task force on violence and the family*. Washington DC, USA: Author.

Beiner, L. & Abrams, D.B. (1991) The contemplation ladder: validation of a measure of readiness to consider smoking cessation. *Health Psychology* **10** 360–5.

Bergman, G., Larson, G. & Brismar, B. (1994) Battered wives and female alcoholics: a comparative social and psychiatric study. *Journal of Advanced Nursing* **14** 727–34. Cited in *Practical Approaches in the Treatment of Women who Abuse Alcohol and Other Drugs* (Contract No. CSAT-93-0006). Washington DC: US Government Printing Office.

Blume, S.B. (1992) Alcohol and other drug problems in women. In: J.H. Lowinson, P. Ruiz, R.B. Millman & J.G. Langrod (Eds) *Substance Abuse: A comprehensive textbook*. Baltimore, MD, USA: Williams & Wilkins.

Bureau of Justice Statistics (1994, November) *Selected Findings: Violence between intimates*. (NCJ-149259). Washington DC, USA: Author.

Chalk, R. & King, P.A. (1998) *Violence in Families: Assessing prevention and treatment programs.* Washington DC, USA: National Academy Press.

Clemmens, M.C. & Matzko, H. (2005) In: A.L. Woldt & S.M. Toman (Eds) *Gestalt Therapy: History, theory, and practice*. Thousand Oaks, CA, USA: Sage Publications.

Department of Justice, Bureau of Justice Assistance (1993) *Family Violence: Interventions for the justice system*. Washington DC, USA: Author.

Gladding, S.T. (1988) *Counseling: A comprehensive profession*. Columbus, OH, USA: Merrill Publishing Company.

Hart, B. & Jans, F. (1997) *Drugs, Alcohol, and Addiction: A resource manual for advocates working to end domestic violence*. Reading, PA, USA: Pennsylvania Coalition Against Domestic Violence (PCADV) Publication.

Kepner, J.I. (1995) *Healing Tasks: Psychotherapy with adult survivors of childhood abuse*. San Francisco, CA, USA: Jossey-Bass.

Kilpatrick, D.G. (1989) Victim and crime factors associated with the development of crime-related posttraumatic stress disorders. *Behavior Therapy* **20** 199–214.

National Research Council and Institute of Medicine (1998) *Violence in Families: Assessing prevention and treatment programs*. R. Chalk & P. King (Eds) Washington DC, USA: National Academy Press.

Norcross, J.C. & Prochaska, J.O. (1988) A study of eclectic (and integrative) views revisited. *Professional Psychology: Research and Practice* **19** (*2*) 170–4.

Northrup, C. (1998) *Women's Bodies, Women's Wisdom: Creating physical and emotional health and healing*. New York: Bantam Books.

Perls, F. (1973) *The Gestalt Approach & Eye Witness to Therapy*. United States of America: Science and Behavior Books, Inc.

Parisi-Dunne, D. (1991) Chemically dependent battered women: some women's reality. Unpublished doctoral dissertation, University of Pittsburgh, USA.

Russell, D.E.H. (1988) Incidence and prevalence rates of

intrafamilial and extrafamilial sexual abuse of female children. In: L.E.A. Walker (Ed) *Handbook on Child Sexual Abuse: Assessment and intervention*. New York: Springer.

U.S. Department of Health and Human Services (1994) *Practical Approaches in the Treatment of Women who Abuse Alcohol and Other Drugs* (Contract No. CSAT-93-0006 from CSAT). Washington DC: U.S. Government Printing Office.

U.S. Department of Health and Human Services (1997) *Substance Abuse Treatment and Domestic Violence* (DHHS Publication No. (SMA) 97-3163). Washington DC: U.S. Government Printing Office.

Walker, L.E.A. (1995) *Abused Women and Survivor Therapy: A Practical Guide for the Psychotherapist*. Washington DC, USA: American Psychological Association.

Wanberg, K.W. (1992) *A User's Guide for the Adolescent self assessment profile*. Arvada, CO, USA: Center for addictions Research and Evaluation.

Wanberg, K.W. & Milkman, H.B. (1998) *Criminal Conduct and Substance Abuse Treatment: Strategies for self-improvement and change (Provider's Guide)*. Thousand Oaks, CA, USA: Sage Publications.

Yalom, I.D. (1995) *The Theory and Practice of Group Psychotherapy* (4th edition). New York: Basic Books.

NOTES FOR CONTRIBUTORS

Preparation and submission of articles

The aim of The International Journal of Mental Health Promotion is to establish a high quality source of information and intelligence for managers and practitioners involved in the policy-making and implementation of mental health promotion and mental disorder prevention. The intention is to link theory and practice.

Articles submitted to the journal must be original work (not published or simultaneously submitted to another journal) and must be copyrighted to this journal unless the authors reserve the rights to themselves, before publication, by agreement with the editor.

Any illustrations, charts or graphs that are being reprinted from elsewhere will need copyright clearance. Obtaining permission to reproduce such items is the responsibility of the author, together with any payments that the copyright holder deems necessary. If you have difficulty obtaining permission to reprint an item, please inform the editor.

Original papers should normally be no more than 5,000 words in length. Two copies of the manuscript should be accompanied by a covering letter detailing permissions to reproduce published material or to use illustrations that may identify individuals. A disc of the article in any word processing or text-only format must accompany the two copies of the manuscript.

Manuscripts should be typed in the English language, on one side of the paper only and double-spaced with a minimum of 3cm-wide margins. The following information should also be included: name, address, status of author, e-mail address and address for correspondence.

Articles should be prefaced with an abstract, of between 100 and 150 words in length, summarising the main points discussed in the article. This will greatly help the speed and accuracy with which the article can be included on major library databases.

All references cited should be included in full at the end of the article and give the following information: author, date, title of book or title of article and journal, journal volume, page numbers, place of publication and publisher.

Example:

Emerson, E., Beasley, F., Offord, G. & Mansell, J. (1992) An evaluation of hospital-based specialised staffed housing for people with seriously challenging behaviours. *Journal of Intellectual Disability Research* **36** 291–307.

In the text, refer to references by name and date; for example: (Smith, 1994) or (Emerson *et al*, 1992).

Where there is more than one reference by the same author, add a, b or c to distinguish them: (Smith, 1994a).

Formatting and layout should be kept to a minimum. This will be done at a later stage. Line figures should be in black ink with clear symbols and lettering. Black and white photographs should be supplied as black and white prints and not as photocopies or previously published material. Both drawings and photographs should be clearly identified with the author's name and the figure number. Legends should be typed on a separate sheet and be clearly identified for the appropriate figure. Tables should not repeat data that are available elsewhere in the article eg in a line drawing.

Copyright

Copyright for all published material in the journal is held by The Clifford Beers Foundation unless otherwise specifically stated. Authors and illustrators may use their own material elsewhere after publication without permission but The Clifford Beers Foundation asks that this note be included in any such use: 'first published in the International Journal of Mental Health Promotion… issue no…'

EDITORIAL BOARD

Michael Murray
Editor, Chief Executive Clifford Beers Foundation, Stafford, England

Professor Almeida-Filho
Brazil

Dr Margaret Barry
National University of Ireland, Galway, Ireland

Dr Carlos Berganza
Guatemala

Professor Lynne A. Bond
University of Vermont, USA

Professor Odd Steffen Dalgard
Folkehelse, National Institute of Public Health, Norway

Professor Steve Edwards
University of Zululand, South Africa

Dr Bret Hart
North Metropolitan Health Service, Australia

Professor Clemens Hosman
University of Nijmegan, The Netherlands

Dr Moshe Israelashvili
Tel Aviv University, Israel

Dr Rachel Jenkins
WHO Collaborating Centre at the Institute of Psychiatry, London, England

Dr Michael Killoran Ross
Greater Glasgow Health Board, Scotland

Professor Dusica Lecic-Tosevski
University of Belgrade, Yugoslavia

Professor Maurice B. Mittelmark
University of Bergen, Norway

Professor Ricardo Muñoz
University of California, San Francisco, USA

Dr John Orley
The Clifford Beers Foundation, Guernsey

Jennie Parham
Auseinet, Australia

Associate Professor John Raeburn
University of Auckland, New Zealand

Professor Beverly Raphael
New South Wales Health Department, Australia

Dr Colin Reed
The Clifford Beers Foundation,Stafford, England

Professor Irv Rootman
University of Toronto, Canada

Professor David Seedhouse
University of Auckland, New Zealand

Professor Leslie Swartz
University of Stellenbosch, South Africa

Professor John Tsiantis
Athens University Medical School, Athens, Greece

Professor Katherine Weare
University of Southampton, England

Professor Mark D. Weist
University of Maryland, USA

The Journal co-ordinates the dissemination of new research outcomes to all those involved in policy making and the implementation of mental health promotion and mental disorder prevention policies. It is essential reading for those with a personal or professional interest in this work.

Peer reviewed by an expert international editorial board, the Journal is a comprehensive information system which publishes material of distinction submitted by clinical/medical staff, health service researchers, managers, health promoters, educationalists, sociologists, health economists and practitioners from all branches of health and social care.

The International Journal of Mental Health Promotion is designed to increase awareness, foster understanding and promote collaboration between the different disciplines engaged in this diverse activity of study and practice. It is the official journal of GCAPP, the Global Consortium for the Advancement of Promotion and Prevention in Mental Health.

The Clifford Beers Foundation
Mariazell
5 Castle Way
Stafford ST16 1BS

Telephone/Fax	0044 (0) 1785 246668
Email	editor@ijmhp.co.uk
Journal website	www.ijmhp.co.uk
Clifford Beers Foundation website	www.cliffordbeersfoundation.co.uk

THE CLIFFORD BEERS FOUNDATION

ISSN 1462-3730